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PHD

Inside the black box

an exploration of change mechanisms in drug and alcohol rehabilitation projects

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Award date:
2017

Awarding institution:
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Inside the Black Box: an exploration of change mechanisms in drug and alcohol rehabilitation projects

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(known as Tim Leighton)

A thesis submitted for the degree of Doctor of Philosophy

University of Bath

Department of Education

March 2017

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Acknowledgements

I would like to thank my first supervisor, Dr Seth Chaiklin, who accompanied me on quite a convoluted journey to the right conceptual framework to address my research question, and with whom I had many stimulating conversations. I owe a debt of gratitude to my subsequent supervisors, Dr Jenny Scott and Professor Jill Porter, who continued to supervise me despite her transfer to another university, from both of whom I received invaluable support and advice.

I would like to thank the researchers who inspired me, in particular Professor Keith Humphreys, Professor John Kelly and Professor David Best.

Thanks as well to Nick Barton, former chief executive of Action on Addiction, who encouraged and supported me unflinchingly to attempt this doctorate, and to the current leadership team and to the board of trustees of the charity, who agreed to allow me a six month sabbatical to write the thesis.

I am especially grateful to the clients, former clients and counsellors at SHARP Bournemouth, SHARP Liverpool and SHARP Essex, who were so willing to collaborate with me.

Lastly, thank you to my wife Ginny, who supported me and put up with me during some stressful times during the period of study.

This thesis is dedicated to my late friend, Alex Georgakis.

Abstract

This research addresses the question 'How does transformative change occur in rehabilitation programmes, and how is it facilitated or constrained by contextual factors?' The study, carried out in three community-based intensive rehabilitation projects for alcohol and drug dependent people, is designed to specify and explain change mechanisms, understood as the processes through which programme resources influence the intentional actions of participants. A critical realist theoretical frame is used, drawing on the work of Margaret Archer and John Greenwood.

The study consisted of two phases: in Phase 1, fourteen client interviews and eight counsellor interviews were carried out in two treatment programmes, and these were analysed abductively to produce a set of tentative contexts, mechanisms and outcomes. Phase 2 consisted of ten theory-driven interviews (Pawson 1996) with clients in a third programme, designed to elaborate the emerging theory. An explanatory model was produced, in contexts-mechanisms-outcomes form. This showed that the institutional context of active warmth and acceptance, combined with a clear, predictable and transparent structure, allowed participants to build trust, bond with the peer group and become ready to accept and process respectful challenges to their perspective or their interpersonal behaviour. This facilitated a change in the clients' internal conversation (Archer 2000), permitting new emotional responses and the formation of new attachments, values and commitments. The programme was seen as a place which facilitated the development of a revised personal and social identity.

The study contributes to the understanding of these programmes by clarifying how participants change or fail to change. It responds to recent calls for more useful forms of evidence, to complement the sparse and equivocal experimental evidence base. The study findings have the potential to improve counsellor training and programme development.

Chapter 1

1.1. Introduction

Addiction is a contested concept, but what is not in doubt is that for at least 200 years, people have described their own struggle to leave off the drinking of alcohol or the taking of other drugs (Porter 1985). The perceived problem was so widespread that throughout the 19th and 20th centuries many resources have been made available in various guises to address the issue. In the 21st century in the United Kingdom, prevalence of alcohol dependence has been estimated at 5.9% of the adult population (approximately 2.36 million people, of whom 200,000 are estimated to show moderate or severe dependence (APMS 2007). Drug dependence has been estimated at 3.4% of the adult population (1.36 million people) (ibid.), and the number of 'Class A' drug users in England, using mainly heroin and crack and powder cocaine, considered along with alcohol, to be among the most harmful drugs (Nutt et al. 2007, 2010), is thought to be just under 300,000 (Lifestyles Statistics, HSCIC, 2014). The amount of distress associated with these addiction problems is enormous: the users frequently suffer serious harm to their physical and mental health, losses of jobs and relationships, financial losses, and often criminal convictions. Family functioning is also usually threatened, with problems in couple relationships and parenting, as well as disruption to family finances and routines. The experience of partners, children, parents and friends of addicted people is often painful and devastating (Barnard 2006, Pernanen 2001). The problems bring a significant social burden (Klingemann & Gmel 2001), consisting of healthcare costs, policing and criminal justice costs, work absences and loss of productivity (Rehm & Rossow 2001), accidents, increased risks of suicide and violence (Rossow, Permanen & Rehm 2001).

In the late 1970s and 1980s a small number of residential treatment centres opened in the South of England, including Clouds House in Wiltshire, where I began my training as an addictions counsellor in 1985. It was run by a charity which later became part of Action on Addiction, and it was based on the 'Minnesota Model', described below in **1.3**. Within a few years the evolved

programme was adapted for delivery as a day programme, first in London, then in Liverpool and Bournemouth, and most recently in Essex.

It is these programmes and their participants which are researched in this study. The three programmes in question are intensive structured day treatment of several weeks' duration provided by the charity Action on Addiction under the name SHARP (Self-Help Addiction Recovery Programme) in Liverpool, Bournemouth and Braintree, Essex.

This model of treatment is in most respects similar to a Minnesota Model residential programme (Leighton & Barton 2005), transposed into a structured day format of somewhat longer duration (4-6 weeks for Clouds House, Action on Addiction's residential programme; 9-10.5 weeks for the SHARP programmes). The SHARP model does not include the integrated medical detoxification and care of the residential model. The SHARP model is not yet widely recognised and is absent from influential evidence-derived guidelines such as those published by NIHCE (2008, 2011). In the guideline relating to psycho-social interventions for adult drug misusers, the closest type of programme is referred to as multi-modal structured day treatment, but it is clear that the interventions in the three studies included are very different from the SHARP programmes. In the case of Avants et al. (1999), the interventions are in the context of a methadone maintenance programme, and in Marlowe et al. (2003), "urban, poor crack-dependent clients" were referred to two programmes, the more intensive of which was delivered over 20 hours a week but with very different treatment activities and programme structure from SHARP. As far as Coviello et al. (2001) is concerned, this is reported in the guideline as being a trial comparing an intensive day treatment of 60 hours per week with a day treatment of 18 hours per week (NIHCE 2008, appendix 15b, p.75), whereas in fact the comparison was between a 12 hour per week hospital based day programme and a 6 hour per week outpatient programme, each lasting 4 weeks. There is an equal dearth of anything resembling the SHARP model in the alcohol guideline (NIHCE 2011). It is also notable how little evidence there is for residential programmes for addiction, as noted by both the NIHCE guidelines and, for another example, by Simeon et al. (2002).

The NIHC guideline for drug misusers recommends that “the same range of psychosocial interventions should be available in inpatient and residential settings as in community settings. These should normally include contingency management, behavioural couples therapy and cognitive behavioural therapy. Services should encourage and facilitate participation in self-help groups” (NIHC 2008, para.1.5.1.1. pp.14-15). It is clear from the chapter on residential programmes that they are conceived of as bundles of interventions that happen to be delivered in a residential setting. There is no appreciation, and perhaps considering the NIHC methodology this should not be expected, that residential programmes (and structured day programmes deriving from them) might be integrated, holistic interventions in their own right.

1.2. The significance of the research settings: SHARP as the future of ‘rehab’

Since the Board of Trustees and Executive Team of Action on Addiction hope that, in an age of austerity and of increasingly visible ‘communities of recovery’, the SHARP programme and its like may come to take the place traditionally occupied in the 20th century by residential programmes, there is a perceived need for research of all kinds to describe and investigate such programmes for efficacy and to understand the processes by which they exercise their effects.

Residential treatment for addictions seems to be a declining sector. It is hard to obtain properly attested figures concerning recent closures but evidence submitted to the Home Affairs Select Committee on “Drugs: Breaking the Cycle” claims that there were 32 closures of residential centres in the 24 months leading up to July 2010 (Drugs: Breaking the Cycle 2010). There are fewer than 100 centres in total. A report on the state of the residential sector published by Public Health England in 2014, which consulted commissioners and providers, stated that at that time a third of commissioners were expecting to reduce procurement of residential services, and 60% of providers “have felt the threat of closure” (PHE 2014, p.13). Despite finding that slightly over half of commissioners were expecting to maintain spending on residential services in the immediate future the report foresaw that there might well be increasing

pressure on local authority budgets and that commissioners would be likely to commission more community –based abstinence services (ibid. p.7-8).

The establishment by Action on Addiction of three SHARP programmes in different parts of the country offers an excellent opportunity to research and compare the processes of change for participants as they undergo the programme. Each has a distinctive local context (as explained in Chapter 3, page 61), and a different history in terms of how it was set up, although the model is guided in each setting by the same treatment manual. A detailed description of the origins and development of the SHARP programmes is given in two recent book chapters (Leighton 2013, 2016). Independent evaluations of the specially commissioned SHARP Essex programme carried out over the three years it has been running are beginning to show that the SHARP programme there is not only successful in terms of outcome (79% of those tracked by the county’s case management system did not return to any form of substance misuse treatment in the 3 years between September 2013 and September 2016 (Essex CC Organisational Intelligence 2016)), but also is contributing significantly to the development of a ‘recovering community’ in Essex (Senker 2016 pp.16-18).

Treatment models such as SHARP have emerged as part of an evolution of cultural-historical practice, namely the psycho-social treatment of alcohol and drug dependence in small group-based therapeutic communities. The next section will set out the historical context of the practice, and its relationship to other forms of intervention; it will then describe the kind of practitioner who works in these programmes and the training they receive, the extent to which this is informed by tradition and by ‘evidence-based practice’ and how this is problematic. The chapter will conclude with the formulation and exploration of the research question.

1.3. Historical context

During the second half of the nineteenth century, and throughout the twentieth, there have arisen and evolved a series of social interventions designed to help people with alcohol and drug problems, often characterised as addiction, to extricate themselves from their predicament and to live a different kind of life,

free from such problems. These programmes have drawn from a range of social practices, from medicine, both institutional and informal, from psychotherapy, from programmes of moral reformation and social support. They have been aimed at groups of people differently positioned in society, from the affluent and respectable bourgeois, to disaffected and likely gang- or criminally-involved working class youth. The strands of practice are intertwined and have separated and converged in complex ways, but it is possible to see their origins, as Jim Baumohl has done, in three distinctive approaches to 'inebriety' which arose in the nineteenth century in the wake of the Temperance Movement, in the United Kingdom, in Scandinavia and northern Europe, and perhaps pre-eminently in the United States.

The first of these Baumohl calls 'environmental therapeutic', and consisted of (typically temperance society sponsored) social spaces, such as hotels, reading rooms, coffee houses and billiard halls, aimed at providing salubrious company and alternative occupation to drinking in the public house or tavern (Baumohl 1990, p.1188). The 'moral therapeutic' approach, closely associated with this, arose, according to Baumohl, from a tradition of self-help typified by the Washingtonians in the middle decades of the nineteenth century, which saw the reformation of the inebriate as a matter of moral reclamation and practical involvement in assisting others in a similar predicament. There followed, on both sides of the Atlantic, an upsurge of small private 'inebriate homes' where people would stay for a few weeks or months, with daily prayer and support, in a small community with an "exhortative, evangelical" (Baumohl 1990, p.1189) ethos. These homes were provided for both middle class alcoholics and "miserable inebriates . . . taken out of the gutter" (Harrison 1860).

The 'moral therapeutic' approach was essentially voluntaristic, and reliant on religious faith, pledges, heroic examples of redemption (reformed drunkards were popular on the public lecture circuit) and mutual support. A third strand can be traced in opposition to this which can be termed 'Victorian psychiatric', deterministic, somaticist, explaining inebriety and intemperance in terms of neurology, whose variations were seen to be due to heredity and degeneracy. Neurologists such as Thomas Crothers and George Beard became specialists,

and two types of alcoholic were clearly delineated by these on class lines. Beard thought inebriety a middle-class nervous disease brought on by too much 'brain work', whereas intemperance was a vice of the ignorant and degraded 'criminal classes' (Beard 1876). Parssinen & Kerner (1980) show that this individualised conception of a neurotic predisposition brought on by the stresses of modern civilisation also extended to the middle-class drug addict as well as the drinker. Crothers was sure that the degenerate drunkards from the lower orders were incorrigibly morally impaired and "always more or less incurable". The recommended responses were also divided along class lines too, with care, rest and a variety of remedial therapies offered to the respectable middle class inebriate, and coercive control including indefinite punitive confinement in asylums for the troublesome and feckless underclass (Baumohl 1990, pp.1194-95).

It is possible to trace the vicissitudes of these three approaches, from the 19th century to the present day. The 19th century saw rise and fall of the Washingtonians and the temperance movement generally, and the age of the drug and alcohol addiction 'cures' (e.g. patent medicines, the Keeley cure). The early decades of the 20th century saw the establishment of 'drying out' or detoxification hospitals such as the Towns hospital in New York, the arrival and repeal of Prohibition in the United States, and the report to the British parliament of the Rolleston committee on the problem of drug addiction. During the 1930s and 40s Alcoholics Anonymous emerged, first in the United States and then internationally, and in the 1950s there commenced the rise of an alcoholism (and later other drug dependence) treatment movement in the wake of the lobbying by the National Council on Alcoholism for the acceptance of alcoholism as a disease by the political and medical establishment.

The succeeding three decades saw the rise of two traditions of treatment programme. Both of these had roots in Alcoholics Anonymous but they evolved contrasting philosophies and tended to serve different demographics. The first became known as the Minnesota model, as it emerged from separate but related enterprises in that State in the early 1950s. These were the reform of the alcoholic ward at Wilmar State Hospital by Nelson Bradley and Daniel

Anderson, the establishment of a hostel in St Paul, Pioneer House, the employment there by Patrick Cronin of former alcoholics as 'alcoholism counsellors', and the conversion of part of a farm into a retreat for alcoholics which would eventually become the archetypal and internationally influential treatment centre Hazelden. The individuals concerned in supporting and practising in these settings were responsible for the emergence of the best known model of treatment for alcoholism in the United States. Moreover, it was at Hazelden that the extension of this treatment model to those with other drug addictions took place in the late 1970s and 1980s, under the rubric of 'chemical dependency'. The treatment programme is based on group cohesiveness and support, and an introduction to the Alcoholics Anonymous 12 Step programme and mutual aid society. It is often combined with a medical detoxification and is multi-disciplinary in its staffing. The mechanism of change in this programme has been described by its primary architect, Daniel Anderson, as "the shared honesty of mutual vulnerability openly acknowledged" (Anderson 1981, p.29), a phrase borrowed from Kurtz (1979).

The second model has become known as the 'classic' Therapeutic Community, also called the TC or 'concept house', which has its origins in Synanon, a community for drug addicts established in California in the 1950s. This type of programme was taken up and evolved by other organisations such as Phoenix House, Samaritan Village and Daytop, all in New York. The philosophy of this model of intervention posits that drug use and addiction are symptomatic of an irresponsible, anti-social lifestyle, emerging from an inadequate social environment. The TC is a highly structured, hierarchical drug-free programme that mobilises peer influences to provide a predictable environment in which residents are held strictly accountable for their behaviour. Vestiges of irresponsible 'addict' behaviour are met with confrontation and punitive consequences (in the early days these were intentionally humiliating, for example head-shaving and the wearing of demeaning placards), whereas responsible and constructive behaviours are rewarded with promotion and increased authority. The pro-social attitudes and behaviours which the programme aims to instil are known as 'right living' (deLeon 2000). The programmes were of much longer duration than the Minnesota model, typically

one to two years, and consisted not only of structured daily tasks and responsibilities but also intensive group experiences based on the 'encounter group'. Traditionally the residents in these programmes have been younger, more likely to have been involved with the criminal justice system, and more likely to be primarily users of illicit drugs.

It is possible to see these two models as the heirs of Beard's recommendations for middle class inebriates and the intemperate underclass, transposed to a somewhat kinder and more humanistic period in American culture. Both models crossed the Atlantic to the United Kingdom in the 1970s (Mold & Berridge 2010, Leighton & Barton 2005) and although often supported by medical experts in the field, the British examples were generally provided by voluntary organisations rather than from within the National Health Service.

Throughout the entire period described there has been a tendency to link dependence on alcohol with dependence on other drugs, both in terms of explanation (the same people are often thought to have a common vulnerability to alcohol, 'narcotics' and 'stimulants') and of treatment responses. In 1990 the National Council on Alcoholism became the National Council on Alcoholism and Drug Dependence. There have been arguments for and against combination and separation (e.g. Pittman 1967, 1988; Raistrick 1988). The issue is relevant to this research as currently in the U.K. treatment centres both in the Therapeutic Community (TC) tradition and in the Minnesota Model/12 Step tradition usually admit people with either alcohol or other drug dependence or both. The participants of the programmes under study include examples of all of these.

Another analysis of the development of drug policy in particular, but which also applies to alcohol policy, has been offered by Rachel Lart (1992). She builds on the work of Armstrong to suggest that social responses to drug problems (which have been predominantly in the medical domain) have shifted and divided during the 20th century as result of such problems having come under a changing medical 'gaze'. Foucault (1973) had described how 19th century medicine directed its gaze on the individual body, creating anatomical atlases, and diagnostic schemes based on signs and symptoms, and locating disease,

including the neurotic, in abnormalities of bodily function and structure. As far as the medical relationship between middle class patient and doctor was concerned, the construction of disease as an entity located in the patient resulted in a private, 'bourgeois' model of practice (Lart 1992). However Armstrong (1983) contends that during the 20th century,

“the medical gaze, which had, for over a century analysed the microscopic detail of the individual body, began to move to the undifferentiated space between bodies and there proceeded to forge a new political anatomy.”

This heralded the gathering of epidemiological data through population level surveys, and the monitoring of disease not in the hospital but in the community. In particular, this public health perspective led to the location of disease in not just the physical space between people but in their relationships. Lart applies this analysis to the shift in the response to drug addiction from a bourgeois, private individual model to a public health model as the spread of drug use among groups of young people in the 1960s was envisaged as a 'social infection' (Lart 1992).

However, this analysis, useful though it is, does not adequately meet the complexity that has resulted in the treatment models which concern this study, nor the kind of practice conducted by counsellors in these settings and the professional training they are offered. For it is clear that these programmes both hark back to the 'moral therapeutic' tradition described above and also look towards the currently burgeoning 21st century 'recovery movement' with its 'recovering communities', neither of which are predominantly governed by medicine. The legacy of Alcoholics Anonymous (AA) as a mutual aid society in this tradition is also plain in these treatment programmes: AA in its first decade positioned itself to a great extent in opposition to mainstream medical and psychiatric approaches to the problem of alcoholism, and Kurtz has shown convincingly that the AA conception of alcoholism as a disease is not a medical conception at all, but a pragmatic combination of the physical, the psychological and the spiritual. It is predominantly metaphorical, but utilises the medical signification of 'disease' both to inject a certain scientific authority but more importantly to uphold the respectability of the condition of alcoholism, differentiating it from a vice or moral failing (Kurtz 2002).

Moreover the picture is made more complex by the fact that a very significant alternative social response to problematic drug use is the widespread use of prescribed substitute drugs, predominantly methadone, as an intervention very much in the medical domain, but whose rationale has shifted from purely a medical treatment of addiction conceived of as a metabolic disorder (Dole & Nyswander 1967, 1976) to at least partly a mechanism of social control, designed to reduce drug-related crime and the spread of blood-borne viruses by reducing injecting and the sharing of injecting equipment. The vast majority of drug users in 'treatment' in the U.K. are on substitute prescription treatment, and pharmacological interventions have a high profile in the treatment of alcohol problems too (EMCDDA 2015, Public Health England (2015a, 2015b). There is a philosophical tension between proponents of this type of treatment and those who support abstinence-based approaches and in the last few years this has become an area of political contention (Home Office 2010, Centre for Social Justice 2015). A proportion of clients entering the abstinence-based programmes studied here will have been at some time in receipt of substitute prescription treatment.

Furthermore, the range of so-called evidence-based psycho-social interventions for people with substance use problems, derived from ways of conducting psychotherapy in the domains of psychology and psychological medicine, are clearly in the individualist, private, bourgeois model described by Lart, usually delivered in one-to-one settings under conditions of 'client confidentiality'. These types of intervention are particularly amenable to research, particularly research based on the analogy of such interventions with a drug treatment, which privileges the randomized controlled trial as the 'gold standard' in the provision of evidence of efficacy. Due to pressures to demonstrate that programmes are "evidence-based", multi-modal programmes in both the Minnesota and TC traditions now find themselves obliged to claim that they integrate such things as Motivational Interviewing and Cognitive-Behavioural Therapy, and their counselling staff may be exposed to training in these interventions. What the effect of this has been, and whether such training is appropriate or useful is the subject of the following section.

1.4. The professional education of addictions counsellors

The website of one of the best known Therapeutic Communities in the United States, Samaritan Daytop Village, claims that “we are focused on the validation of outcomes, using evidence-based practices to set in motion and maintain recovery for substance abuse and dependence”, and that, “trained to use state-of-the-art, science-based approaches of treatment, the Samaritan Daytop Village staff combines its compassion and intuition with proven methods necessary for healing and recovery” (Samaritan Daytop Village 2016). Such claims are unlikely to have been made two decades ago, nor is it likely that any of the staff would have received such training. As Barlow (1996) explained, the evolving criteria for reimbursement by insurers in the United States were to be based on evidence for effectiveness, and this put pressure on providers to demonstrate that evidence-based interventions were offered in their programmes. A similar pressure has subsisted in the commissioning of statutory drug and alcohol services in the U.K.

Similarly, the brochure for the Master of Arts in Addiction Counseling offered by the Hazelden-Betty Ford Graduate School of Addiction Studies claims that “courses focus on evidence-based practices that will prepare you to treat addiction and its complications” (Hazelden-Betty Ford 2016). A testimonial quotation from a student that appears on the front of the brochure is telling: “It’s really useful to go to class and listen to a good lecture about say, cognitive behavioral approaches, and then go to your unit and put it into practice.”

It is certainly the case that the trainings offered to counsellors in the evidence-based models are often very brief, and there is a substantial literature concerning how it might be possible to transfer evidence-based practice into treatment settings. Exactly what constitutes evidence-based practice and the problems with the assumptions underlying faith in such evidence will be explored in depth in Chapter 2. However, it is worth briefly discussing some of the issues here. The models of counselling in which practitioners are most commonly offered training are Motivational Interviewing, some form of cognitive-behavioural counselling (CBT), and “Twelve Step facilitation”. Each of these is supported by a number of randomised controlled trials. Researchers such as

Morgenstern et al. (2001) have been concerned by the gap between evidence-based practice and practice in real world settings (that such a gap exists is not in doubt as will be shown), and have shown that training counsellors in CBT using a manual is possible to an 'adequate' standard. The counsellors in this study received around 100 hours of "didactic and clinical training" including supervision from doctoral-level clinical psychologists over a 5 month period (Morgenstern et al. 2001, p.85). This seems very much more intensive than what most counsellors are likely to receive as is shown by the quote above. The foundation and bachelor's degrees in Addictions Counselling from the University of Bath, which several of the counsellors in this study hold, offer about 30 hours of theoretical teaching and basic skills practice in CBT and Motivational Interviewing, and 18 hours in Twelve Step facilitation, each followed by a brief opportunity to try to apply the approach in a work placement. On-going supervision by experts in the models is very unlikely to occur.

As far as 'real world' settings are concerned there is good evidence that counsellors in typical treatment programmes in the United States rarely use recognisable forms of these counselling models in sessions. Carroll and Rounsaville (2007b) found that:

"Based on independent, blind ratings of over 400 audiotapes from the 'treatment as usual' condition from two multi-site effectiveness studies conducted as part of the Clinical Trials Network (CTN), interventions associated with empirically supported therapies (ESTs) were essentially so rare as to be undetectable. Moreover, even interventions that common sense would dictate be part of 'good clinical practice' (case management, discussion of treatment goals) were present at surprisingly low levels."

There is no reason to believe that the situation is different in similar treatment programmes in the U.K. Audio tapes of counselling sessions submitted for a post-graduate diploma in addictions counselling at King's College London also failed to show any trace of 'empirically supported' counselling approaches. This may sometimes be a matter of deliberate choice. A senior counsellor at SHARP Liverpool, interviewed in a previous study, said that the counselling staff "express attitudes and behaviours towards clients that are non-threatening and convey honesty, respect, caring and understanding. In my view SHARP follows

this basic philosophy rather than simply implementing certain counselling techniques or methods.” (Leighton 2013 p.176).

Each of the evidence-based approaches has an underlying theoretical rationale which includes or implies certain mechanisms of action. Since the concept of mechanism is crucial to this study, these will be explored in depth in Chapters 2, 3 and 4. However it is clear that whatever mechanisms of action there may be, they fail to be activated in many circumstances and certainly there is little evidence that the mechanisms posited by the underlying theory (for example of cognitive-behavioural therapy) actually account for the outcomes (see for example Morgenstern & Longabaugh 2000). As one of the commentators on this paper titled his response “human beings behave in a more complex way than our treatment studies would predict!” (Bühringer 2000). Motivational Interviewing (MI), about which several very high quality meta-analyses have been conducted, has very mixed outcomes. As Magill et al. (2014) note, “MI has support for efficacy, but effect sizes are generally small to moderate and vary across delivery contexts, populations, and intervention targets. This indicates a need to better specify how MI is associated with client behavior change.” And a very recent meta-analysis of MI with adolescents failed to show that it is effective in reducing drug use (Li et al. 2016). All of this mixed evidence points to the fact that these conversational interventions are not technologies.

In the conventional training in these models some attention is paid to the contexts in which they should be applied, but these typically derive from other theoretical models such as the Stages of Change (Prochaska, DiClemente & Norcross 1992), so that Motivational Interviewing might be seen as the intervention of choice for someone in the ‘contemplation stage’ as it is presumed such a person will be ambivalent about change, whereas for someone in the ‘action stage’, a cognitive-behavioural approach might be seen as appropriate. The Stages of Change model has come under considerable criticism for its coherence (Sutton 2001, West 2005) and for its application (Adams & White 2004, Brug et al. 2004). A point made by Adams & White, among others including Bühringer (2000), is that the model does not account for the complexity of human behaviour.

The technology model with its prescribed, often manualised interventions has come under sharp critique from Orford (2008). His critique and that of others will be examined in detail in Chapter 2, but among his counter-proposals to researching named techniques is his recommendation to take seriously and find ways of researching the tacit theories of effective practitioners. The Samaritan Daytop Village website citation above refers to the “compassion and intuition” of the staff as being in combination with “proven methods”. It is highly probable that a great deal of counsellor practice in treatment is based on things like “compassion and intuition”, and a serious question for the professional education of counsellors is how to articulate and understand such practice and how to develop and integrate this with the formal models taught. In the literature there is often an assumption that ‘scientifically-based’ highly specified interventions are superior to intuitive interventions based on the ‘folk’ knowledge of lay counsellors. But Donald Schön says in the preface of his book *The Reflective Practitioner*,

“I have become convinced that universities are not devoted to the production and distribution of fundamental knowledge in general. They are institutions committed, for the most part, to a *particular* epistemology, a view of knowledge that fosters selective inattention to practical competence and professional artistry.” (Schön 1983, p.vii)

This seems to apply to the move to professionalise the education of addiction counsellors by requiring qualifications privileging academic knowledge of this kind over intuitive shared knowledge generated and passed on in communities of practice. Yet as Trochim (1985) has pointed out practitioner and client theories are probably more complex than those of social scientists, including psychologists, and thus may be more comprehensive and responsive. However, it is likely that they lack articulation. Indeed, there appears to have been very limited research into client or counsellor theories in the area of addictions treatment. It is to lessening this gap that this study intends to contribute.

1.5. The Research Question

The question this research intends to address is:

How does transformative change occur in rehabilitation programmes, and how is it facilitated or constrained by contextual factors?

It is important to clarify what this study is and is not attempting to do. It is not an outcome study and cannot provide evidence of efficacy after treatment. It is rather an investigation into the mechanisms of change that take place for programme participants, the contexts in which such mechanisms are activated or constrained, and what within-programme outcomes are produced as a result of the change process. The main rationale is to try to shed light on processes of change that lead to desired outcomes, so that the number of people who can derive benefit from such programmes may be significantly extended.

It is certainly true that many people enter such programmes and achieve durable abstinence and recovery as a result, but it is equally the case that many fail to achieve benefit. The evidence for this comes both large scale longitudinal studies in the United States and in the United Kingdom (Simpson, Joe & Brown 1997, Gossop et al. 1999), and from local outcome studies such as that of Clouds House by Georgakis (1995). Georgakis showed that for a cohort admitted over a six month period, a third maintained continuous abstinence for a period averaging 30 months after the treatment episode, together with a range of other benefits including improved quality of life and well-being, and a third failed to respond to the programme, typically dropping out before completing and returning to their addiction in short order. The remaining third showed good outcomes at 30 months but many of these had lapsed or relapsed and some had had further episodes of treatment, before achieving a more stable recovery pattern. The Clouds House programme resembled the SHARP programme in its philosophy and components but was delivered in a residential setting. The client group was similar to that at the SHARP programmes in terms of demographics, and duration and severity of substance dependence.

It is conceivable that alongside those people for whom the programme was simply unsuitable (for example someone who had no motivation to maintain abstinence and for whom there was no prospect of interesting them in that at that time, but who had been referred as a 'last resort', by family, the drug treatment system or the criminal justice system), both thirds of the cohort who

had less than optimal outcomes will have contained persons who could have been helped to respond more successfully. And the likelihood of that happening is increased if the treatment staff understand the kind of mechanisms that lead to change, and the contextual enablements and constraints acting on those mechanisms.

The ontological position of this study is realism, and the conceptual framework derives from the work of Margaret Archer and John Greenwood (see Chapter 4). It is proposed that humans have projects (by which is meant “any course of action intentionally engaged upon by a human being” (Archer 2007, p.7)) Projects are developed with the intention of realising a person’s concerns. Entry into a demanding and time-consuming treatment programme is not something done lightly. It can be assumed that each participant arrives at the programme with some kind of project (even those who are not coming for the “right reasons”). Attempts to realise any kind of human project meet with enablements and constraints in the three orders of reality, the natural order (is this physically/biologically possible for me?), the practical order (am I competent to achieve this?) and the social order (how do social structures and cultural properties tend to facilitate or constrain my project?). Archer’s contention is that it is reflexivity which mediates between agency and structure, and that through reflexivity emerge powers to modify or circumvent constraints and to avail themselves of enablements, or to alter or elaborate projects, through resistance and subversion or co-operation and adaptation. Archer also points out that the way a person uses their reflexive powers is individual: “Subjects who are similarly situated can debate, both internally and externally, about appropriate courses of action, and come to different conclusions.” (Archer 2007, p.12). Therefore, what is likely to be discovered in the search to uncover mechanisms of change in a study such as this is considerable variability. Different individuals will find different ways to elaborate or truncate or abandon their projects and different ways of responding to constraints and enablements.

According to Pawson (2002a), “Interventions offer subjects resources, which they then accept or reject, and whether they do so depends on their characteristics and circumstances.” The point he is making is that from a realist

point of view, programmes do not have causal powers of their own. If a person enters a programme and as a result makes certain changes which are transformative, it is because they have in some way made use of the resources offered. By transformative change is meant change which permits the person to live in a different way, to “make their way through the world” more successfully, as the title of Archer’s book has it (Archer 2007). Moreover, Pawson and Tilley suggest that social programmes consist essentially of “suggestions for future action” whose success depends on these suggestions “entering the reasoning of subjects” (Pawson & Tilley 1997, p51). This idea is certainly relevant to drug treatment and rehabilitation programmes and also to psychotherapeutic or counselling conversations generally, an idea that goes back 50 years to Jerome Frank’s classic ‘Persuasion & Healing’ (Frank 1961). Rather than a dose of technology, these programmes consist of human interactions involving persuasion. This research aims at understanding how this process of persuasion works, and what contextual influences are occurring within the activity of the programme.

What is meant by “entering the reasoning of subjects” and how this new reasoning acts as a generative mechanism also requires explication. There are reasons to hold that a person’s ‘internal conversation’ does indeed have causal powers. As Archer has it, the internal conversation crucially includes human emotions, which she formulates as “commentaries on human concerns” (Archer 2000, Ch.6), and as part of the internal conversation, subjects may engage in reflexive processes such as ‘mulling over’, ‘imagining’, ‘deciding’, ‘rehearsing’, ‘prioritising’, or ‘clarifying’. Different people do this in different ways, but in Archer’s view, this is part of a process of identity formation following the pathway Concerns → Projects → Practices. Moreover, she sees the internal conversation not at all as “subjective solipsism”, a way of construing the world independently of how it is:

“Social reality enters objectively into our making, but one of the greatest of human powers is that we can subjectively conceive of re-making society and ourselves. To accomplish this entails objective work in the world by the self and with others.” (Archer 2000, p.315).

The internal conversation retains intentionality, it refers to relations between external reality and the self (although it is of course fallible, it can be wrong about things, which in Archer's view leads to problems in the formation of personal and social identity). It mediates between the causal powers of society and culture and "the powers of our own which emerge in our relations" with these (Archer 2000, p.315).

The general correctness of Archer's account of developments in the internal conversation acting as causal generative mechanisms for the re-making of self is assumed in this research. This understanding will be applied to the microcosms that are the treatment programmes under study. It is hoped to get a glimpse of these processes and to explain how they come about in that brief moment at the beginning of recovery during which a person participates in a structured group experience. While terms like 'addiction' and 'recovery' require definition in this context (which will be provided in Chapter 3), the idea that recovery from the predicament resulting from addiction involves the remaking of identity is one that has been put forward by a number of authors (Biernacki 1986, Kellogg 1993, Koski-Jännes 1998, 2002, McIntosh & McKeganey 2000, Best et al. 2016). Most of these have looked at the process over a longer time period and have used retrospective interviews looking back over several years of addiction and recovery. This literature will be examined more closely in Chapter 3.

Despite some of these authors positing that identity change/development/transition is (sometimes) socially negotiated, none of these contributions have looked in any detail at how this process begins to take place in the context of a group-based programme, nor have any made use of Archer's theoretical framework. In her view "the prioritisation of our ultimate concerns, and the accommodation of other concerns to them" is the source of our personal identity. And the formation of a social identity involves the person becoming a social actor through commitment to a social role or roles, whose delineation is produced by socio-cultural conditions. Archer thinks that some people have problems developing personal identity and specifically mentions the downward spiral of addiction in this context (Archer 2000, p.247). What

goes wrong will be explored in Chapters 3 and 4, but the relevance of this to the research question is that if someone has an inadequately developed personal identity (and without this is unable to invest in a successful social identity either), if recovery is to entail improved well-being, practical competence and self-worth, then the transformations required will be in the direction of a more secure personal identity and thus the potential to invest in a social identity.

1.6. Research outline

How is it possible to research these processes? It is rather clear that programmes such as SHARP encourage reflection. The interactions which are of significance in the programme 'working' for the participants go beyond dyadic counsellor-client conversations. In group therapy and the entire range of group-based treatment activities the interactions between the clients and how the counsellors facilitate these seem of primary importance. All of them appear rather obviously to help the participants exercise their reflexivity, whether it is in a group therapy session, an individual counselling session or a 'recovery skills' workshop. Despite some of the addictions literature claiming that addicted persons have great difficulty reflecting on themselves, their own and others' mental states (e.g. English 2009, 2011), what is very striking to an observer or staff member of a programme such as SHARP is the extent to which participants are reflecting on and articulating these things. There is a range in the extent to which this is observed in different participants and individual participants tend to become freer and more articulate as they progress through the programme. Reflective expression is thought of by counselling staff as a sign of good response to the treatment programme and is also respected and regarded highly by other participants. Those perceived to be holding back in this expression (whether or not they are internally reflective) are encouraged to be more open, to share their thoughts and ideas more freely with the group. In particular articulation of emotional states is encouraged. The research method must try to mine to the greatest possible extent the reflexive processes going on within the programme participants and how these are influenced by interactions with others.

Formally, the research proceeds by a number of steps designed to identify generative mechanisms, the contexts in which they are enabled or constrained and the outcomes which these mechanisms produce, and to combine these into an explanatory model of client change.

The collection of data in the first stage is by field observations of various programme activities, and a set of interviews with currently participating clients of the programmes and with the counsellors. As the interview subjects are likely to be willing participants at least currently engaged with the programme, material concerning those clients who are struggling, failing to engage or dropping out will be obtained from observation of those processes, including the views of fellow participants and staff members expressed at the time. The justification of the value of these data as material for analysis will be presented in Chapter 5.

A thematic analysis of the interviews and observed vignettes, for ideas about change mechanisms explicit or implicit in the interactions, will be combined with evidence from the research literature about variables associated with differential outcomes, and with documentation from programme manuals and training materials concerning how the programme is 'supposed to work'. Key components will be identified, what Bygstad & Munkvold (2011) call "the real objects of the case".

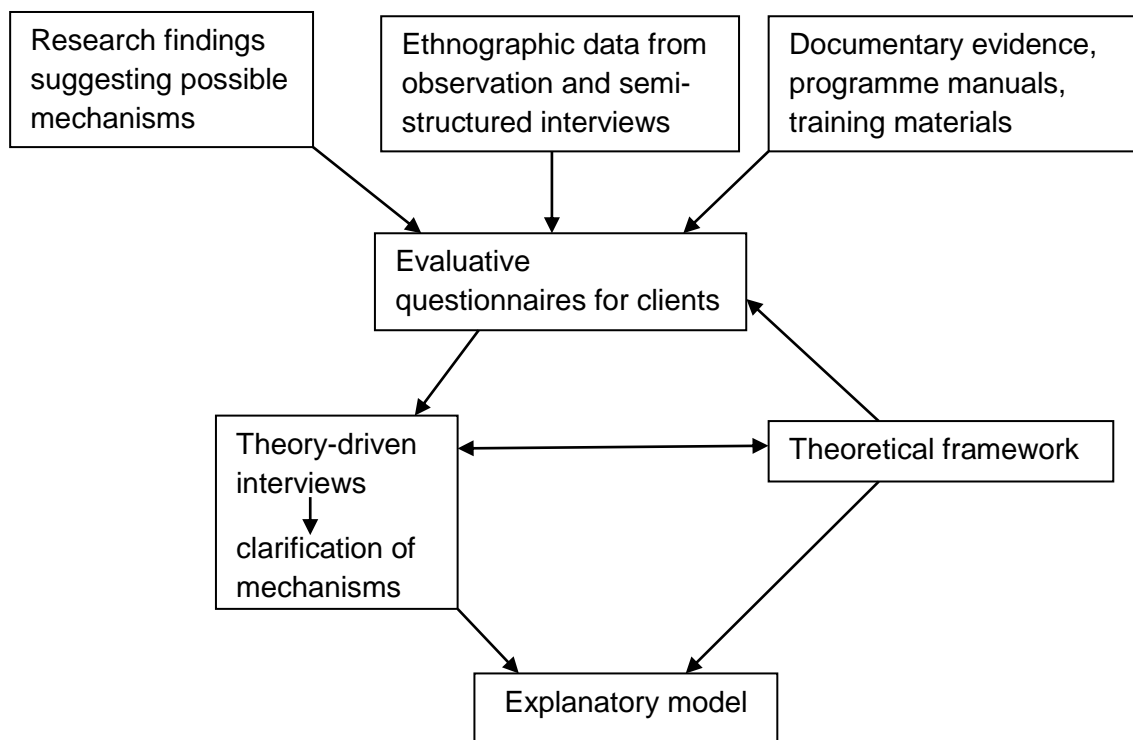
These will be redescribed using the theoretical framework derived from Greenwood and Archer. In order to refine and clarify potential mechanisms an evaluative questionnaire will be produced which will serve as the basis for a second set of interviews, this time 'theory-driven' interviews as suggested by Pawson (1996): collaborative conversations in which programme participants and staff will be asked to contemplate and expand on their questionnaire responses and to help the researcher elaborate his theory, in this case the mechanisms and how they were activated.

From these findings the conceptual framework will be used to create an explanatory model, linking contexts, mechanisms and outcomes. The outcomes in this case are not the recovery outcomes which may be achieved in the longer

term, but the changes in the internal conversation and the immediate implications of those. The mechanisms are the processes by which these changes come about, and the contexts are those situations which facilitate or constrain the activation of the mechanisms.

A discussion of the limitations of the model and a comparison with alternative models of explanation is followed by an exploration of how the model could be used to improve practice and how the research has contributed to theory. The general logic of the research programme is shown in Figure 1.1.

Figure 1.1 Outline of research process



1.7. Critique of positivist research into addiction treatment

As will be seen in the following chapter, the vast majority of research into treatment for addiction has been in a positivist paradigm. Certainly all the research studies that have had any influence on policy and institutional practice have been in this vein. It is not intended here to employ the term positivism pejoratively. It is in fact rather a crude label often carelessly used as a synonym for quantitative, statistical research. However, there are certain features of the

positivist tradition which have resulted in some limitations and anomalies in the research literature and which cast doubt for some on the conclusions that have emerged from the vast volume of research into treatment for alcohol and drug use disorders.

Probably the most serious of these limitations derives from the insistence that causality can only be demonstrated by statistically significant correlation in conditions where all other possible influences are controlled for (of course correlation in itself does not imply causation). This has led to the hegemony of the randomised controlled trial. Since on this view the case for causality is strengthened by replicated findings, the best evidence is produced by meta-analyses of randomised controlled trials. The quest for internal validity in this research design has required highly specified and standardised interventions and research subjects selected for the relative absence of confounding issues such as multiple problems and complex needs. The former has resulted in interventions being tested that are unlike the improvised, collaborative and interactive therapies employed in the 'real world' and the latter has resulted in the subjects not looking very similar to 'real world' treatment populations. A variety of responses to this rather basic criticism have been mounted, for example by testing the interventions with a range of different populations and, as will be described in the next chapter, the exploration of the 'matching hypothesis': the idea that the heterogeneity of response in a trial might be explained by the fact that certain interventions are differentially effective with different types of people and that by setting up another type of hypothetico-deductive research design this idea could be tested. The result of all this has been the discovery that some interventions do seem to be reasonably consistently effective, but the effect sizes are rather modest and the range of effectiveness across studies varies a great deal. The matching studies have consistently failed to produce support for the proposed matching hypotheses, except in one or two (for the realist, very interesting) instances.

As several Cochrane reviews show (Smedslund et al. 2011, Foxcroft et al. 2014) the evidence is often of low quality or with high heterogeneity, and as Davoli & Amato say, commenting on Foxcroft et al.:

“. . . the quality of evidence was judged as moderate, due to selection and detection bias in the studies and high heterogeneity showing variability across studies. A marginal statistically significant effect was found for alcohol problems . . . with low quality of evidence due to selection, detection and attrition bias, and again high heterogeneity. There was low-to-moderate quality evidence that MI has very little impact on binge drinking, average blood alcohol concentration, drink-driving, or other alcohol-related risky behaviour. Based on these results, the authors conclude that "there is no substantive, meaningful benefit of MI for alcohol misuse by young adults". (Davoli & Amato 2014)

From a realist point of view this last sentence indicates one of the main limitations of this approach to research. It is quite common to find in the group of studies that is meta-analysed, one or two which seemed very successful and others where the intervention seemed to have failed entirely. The realist takes the results of a particular trial as an instance of something real, and is interested to investigate what caused a trial to produce the effects it did. In particular, the context that allowed the mechanisms of change to be activated or constrained. This contrasts with the 'mincing-machine' of meta-analysis, in which as Pawson points out, "at every stage of the meta-analytic review, simplifications are made. Hypotheses are abridged, studies are dropped, programme details are filtered out, contextual information is eliminated, selected findings are utilized, averages are taken, estimates are made." (Pawson 2006, pp.42-43).

These limitations have not been missed by creative mainstream researchers, and there has been a resurgence, particularly since the turn of the century, of an interest in mechanisms and recommendations that research should move in that direction. For example the Cochrane Review by Smedslund et al. (2011) on Motivational Interviewing says in its conclusion "This is a field where there is no lack of randomised controlled trials. Perhaps it is time to move from only studying **whether** MI works to also studying **how** it works, that is to study the mechanisms behind MI." (Smedslund et al. 2011 p.28, emphasis in original). As the review in the next chapter shows, many researchers have already moved to study what they call mechanisms and causal chains, but because of their commitment to the positivist view of causality, their investigations remain dependent on a statistical analysis of the association between variables. From a

realist point of view this still fails to explain: it remains at the surface, empirical level, and does not actually produce an understanding of the underlying mechanism and how it works.

This is not to say that this research is not very valuable, as becoming aware of what measurable attributes mediate or moderate outcomes, and developing better methods of investigating these makes a highly significant contribution, not least by suggesting starting points for realist research. Neither is it suggested here that realist research into local highly contextualised cases is superior, or can replace this body of research. It is contended that examining cases qualitatively with a realist design, in order retroductively to identify mechanisms and contexts, is complementary and supplementary to the mainstream 'mechanisms' research, and is more likely to shed light on the special qualities of effective and less effective treatment so that the former can be attained more reliably, by providing more conducive contexts and by more skilful activation of mechanisms. The following chapter will describe the historical arc of major research initiatives in the field and review the key studies in detail.

It will show that there was, from around 1980 to 2000, a serious attempt in American treatment research to explore mechanisms and contexts, and formulate models of treatment process, in particular by Rudolf Moos, John Finney and their colleagues in Palo Alto, California, and by Dwayne Simpson and his colleagues in Texas, but that this effort and direction of interest was seriously weakened by the rise of 'evidence-based medicine' with its privileging of the randomised controlled trial. Furthermore it will show that the recent upsurge in interest in mechanisms, while producing work of great interest and increasing sophistication, is hampered by its allegiance to a positivist framework and a reliance on statistical associations between variables.

Chapter 2

The Evidence Problem in Drug & Alcohol Treatment – a literature review

2.1 Introduction

This review will trace the history of a rising critical discontent with the 'technology model' of interventions for drug and alcohol problems, which is coupled with a rather wide ranging critique of the experimental paradigm for evaluation. The period of domination of efficacy studies and the establishment of the randomised controlled trial as the 'gold standard' was in fact preceded by a fairly extensive period of interest in what happens inside the 'black box' of complex interventions or programmes: an attempt to address the 'how does it work?' question as well as the 'does it work?' question. The development of these investigations will be presented first.

Then it will be argued that the rise of evidence-based medicine in the 1980s/1990s focused the international research community on demonstrating efficacy. This led to a cementing of the medical intervention paradigm for drug and alcohol treatment and the establishment of the Randomised Controlled Trial as the 'gold standard' for research. This further led to the side-lining of process research in the quest for a set of evidence-supported interventions. However, by the late 1990s several leading researchers were beginning to question the achievements of this approach and to posit the need for re-evaluating the research project. This review will consider several key articles criticising the dominance of the experimental paradigm.

Finally, in the past decade, a new wave of research has begun to be published with an interest in mechanisms. It is clear that the 'how does it work?' question has begun to reassert itself. This literature will be examined and its contributions evaluated. It will be argued that this research has provided some intriguing new insights but that as it remains reliant on statistical correlations to identify moderators and mediators associated with differences in outcome, it does not go far enough in understanding the underlying processes by which change occurs. This is at least partly due to the positioning of this research solidly in a positivist, empiricist epistemology, which restricts itself to observable

associations. The use of the term 'mechanism' in this tradition has a more limited use, referring essentially to such empirical regularities of association, whereas the realist tradition posits mechanisms as causal processes by which an event leads to an outcome.

The review will consider the relevance of mechanisms research to the improvement of interventions and for better training of practitioners, in line with a central argument of this thesis, that there is a gulf between research and practice in the field of drug and alcohol treatment, and that the dominance of the experimental paradigm has produced anomalies, which make it difficult to train counsellors as anything more than skilled technicians, delivering supposedly effective interventions in contexts where the effectiveness is doubtful, and suppressing reflective and creative practice. A realist understanding of mechanisms and their contexts has the potential to help practitioners navigate between the Scylla of over-specified manualised interventions designed to promote fidelity to supposedly pure evidence-supported interventions and the Charybdis of unexamined, untested 'traditional' approaches to which the practitioner has emotional allegiance. Both of these are likely to result in attenuated, disappointing outcomes for reasons explained previously.

2.2 Early black box research

Already by 1983, there was an awareness of the need for theory-based evaluation of what were then known as alcoholism treatment programmes. Moos & Finney noted the need to expand beyond the experimental model due to "divergent findings" which they believed indicated a "contextual, multicausal approach" (Moos & Finney 1983, p.1037). They included in their paper a process oriented framework which included 'context' before, during and following the intervention. Before moving to review the subsequent publications of Moos and Finney and their colleagues, alongside those of other groups publishing between 1980 and the present, it is of interest to note that Longabaugh & Magill, in a commentary on a recent article by British researchers claiming to identify 'behaviour change techniques' (Michie et al., 2012), while acknowledging Moos & Finney's 1983 paper (incidentally misattributing to it the use of the phrase "black box" to describe treatment

programmes), make it clear that despite this 30 year history, “we are at the beginning of this research agenda, and all strategies and methods will be necessary to enhance this knowledge base.” (Longabaugh & Magill 2012).

The review will describe how, despite over three decades of studies and theoretical work by respected scholars with a high profile in the field, their work has had surprisingly little success in influencing the dominant notion of evidence, as used to inform practice guidelines and to support policy. Yet the published conversation concerning mechanisms and change processes continues to increase in insistence (Morgenstern 2007a). I will show that despite this move in emphasis from outcomes to processes, all the literature reviewed remains exclusively committed to a successionist concept of causality in which explanations of mechanisms are reduced to establishing “regularities of sequences of contingently related things” (Sayer 1992, p158).

The search method to assemble the publications reviewed was as follows. Having collected a selection of papers already familiar to me, keyword and title searches were made in Psycinfo and Google Scholar, combining ‘mechanism’, ‘behavio(u)r change’, ‘process’ ‘mediator’ with ‘substance misuse/abuse’ ‘alcohol/drug dependence’ and ‘addiction’. The search included articles published between 1980 and 2013. Further searches on the same keywords were made in 8 individual on-line journals specialising in drug and alcohol problems and treatment. Papers that described neural or other biological mechanisms were excluded. This search produced approximately 40 papers which were of relevance. These clustered into publications over time by research groups, whose accumulated publications will be considered in turn.

2.3 Moos, Finney and colleagues

Rudolf Moos and John Finney, together with their colleagues at Stanford University Medical Center and the Veterans Administration Medical Center, Palo Alto, California, published a series of articles from the early 1980s (based on research into the environments of psychiatric wards and therapeutic communities in the 1970s (e.g. Moos 1974)) in which a number of key ideas were proposed for the expansion of treatment programme evaluation.

Significant articles were published by Cronkite & Moos (1978 & 1980), who performed regression analyses on 'blocks' of variables to show that both programme variables and patient variables both accounted for substantial variance in outcome, but that these together did not explain more than a quarter of the variance. As already mentioned, Moos & Finney (1983) presented a process oriented framework based on a review of previous research, which hypothesised that interactions between 'life context' prior to and following treatment, 'client factors' prior to and following treatment, and factors in the intervention itself, were determinant of outcome. The intervention factors included both implementation (fidelity to model criteria, intensity, components) and quality (interpersonal skills of counsellors, programmes well-organised, cohesive and involving). The life context included family and work environments and stressful events. The 1983 paper introduces the idea of intermediate changes produced in the client, during the intervention, which would lead on to the desired ultimate outcome. These intermediate changes were renamed 'proximal outcomes' in later research by the group, described below, and this concept led to an explicit link with programme theory: different models of intervention had theoretical rationales which would postulate specific proximal outcomes for the approach.

The 1983 paper was influenced by contemporary developments in evaluation theory: six years later this influence is more explicit, as the citations in the 1989 article 'Theory and Method in Treatment Evaluation' (Finney & Moos 1989) include publications by Weiss (1972,1978), and Chen & Rossi (1980, 1983, 1987), some of the most influential early advocates of theory-based evaluation. This paper discusses types of theory (what processes lead to what outcomes? what mechanisms are involved? what components are linked with what outcome variables? what intervening variables mediate the outcomes?) and significantly the authors distinguish 'scientific theories' from 'practitioner theories'. While Chen & Rossi (1983) insist that researchers should consider only theories consistent with social science knowledge, dismissing practitioners' theories as "likely to be simply the current folklore of the upper-middle-brow media", these authors point out that, as Trochim (1985, p.586) says, practitioner and client theories are probably more complex than those of social scientists

but lack articulation. Finney and Moos's position is that useful theories, whether practitioner-generated or scientific, should be relevant and should specify "intervening processes or mechanisms that link, and thus explain, the connection between program activities and ultimate outcomes."

Despite the pioneering importance of this group's contributions, it is clear that the processes and mechanisms adumbrated in the early papers may indeed link (through statistical association) but fail to explain, from a realist perspective, the connection, as what are counted as mechanisms in this literature as well as in the other sets of publications reviewed here, are reduced to associations of variables. For example, in this group's early research (Billings & Moos 1985), close friends and network contacts are included as part of the social resources measured. This pre-figures attention to the social network, something which becomes more and more clearly significant to understanding outcomes in publications from the late 1990s to the present (e.g. Longabaugh et al. 2001, Kaskutas et al. 2002, Litt et al. 2007, 2009, Kelly et al. 2012). By 1989 the explicit observation is made that "treatment evaluators are realizing that powerful extra-treatment or life context factors can mediate the effects of intervention programs, and can directly affect post-treatment functioning" (Finney & Moos 1989, p.308), but what does not appear in their modelling is any explanation of how these factors operate, or how resources are taken up by participants, or how the treatment intervention facilitates this.

However, in their 1986 paper, 'Matching patients with treatments: Conceptual and methodological issues', Finney and Moos begin to discuss how resources might be used by a person "to prevent and reduce relapse-inducing situations and thus promote recovery" (Finney & Moos 1986, p.124). Such resources include 'ego strength' and 'abstract reasoning and problem-solving skills'. They also consider environmental resources (e.g. 'social support'). Treatment conditions are then considered, including 'therapeutic components', treatment environment and structure. Here they make reference to "specific acts of therapists during the treatment process" (ibid. p.125). In their consideration of patient-treatment matching, the authors are addressing interactions which make a difference, and contexts which might influence the process. They suggest that

as well as relying on clinical judgment, and two categories of statistical analysis (exploratory data analysis and data reduction via factor and cluster analysis), a possible strategy for understanding how patient characteristics and treatment processes interact is theoretical analysis.

This rich paper also considers the complex predicament of a person with a substance use problem and the multiplicity of changes a treatment programme might aim at bringing about: not only what substance use goal would be most beneficial (abstinence or moderation) but also which deficits, psychological and social, need to be addressed to reduce the risk of relapse. This paper introduces the idea of staged matching, so that for example there is the need to understand which type of programme might be best suited to a patient based on pre-treatment variables associated with differential outcomes, and then the specific ways in which interactions during the treatment process can affect the outcomes also need to be explored:

“First, broad patient variables . . . can be explored for their interactions with general treatment modalities. Such macro-level studies can inform the initial assignment of patients to different types of treatment programs. Second, micro-process studies and observations of treatment providers can be brought to bear on the interactions of more specific and malleable patient characteristics with specific acts of therapists. Such studies should help to clarify the dynamics of adapting treatment to intra-patient change.” (Finney & Moos 1986 p.127-128).

It is possible to trace, alongside the rise to hegemony of Evidence-Based Medicine in the last years of the 20th century, how the first of these stages was concentrated on in major research studies, while the second was essentially neglected, and that this neglect has become one of the causes of complaint for the critics of traditional outcome research (see for example Orford 2008). It will be a substantial part of the argument of this chapter that the ‘technology’ model of treatment, in which it is assumed that treatments have causal efficacy in themselves, and for which a search for comparative efficacy and for patient matching characteristics which might guide treatment allocation has been the dominant focus, has resulted in many of the disappointments and uncertainties that remain about how ‘treatment works’.

2.4 Project MATCH

An example of this is the large-scale and very well-known research study Project MATCH, which published its first results in 1997. This study was designed and implemented by a team of some of the best known researchers in the United States. The design was intended to test a large set of (16 primary and 11 secondary) matching hypotheses of the form “for patients with characteristic X, treatment A will outperform treatment B”. These hypotheses were formulated from predictions based on the theoretical mechanisms of action of three contrasting treatments, cognitive-behavioural coping skills training, motivational enhancement therapy, and 12 step facilitation. The first two were considered well-researched and with an established record of efficacy, and the third was selected, despite the lack of efficacy evidence, as a representation of the most commonly implemented treatment in the United States, that is, treatment based on the concepts of the 12 Step programme of Alcoholics Anonymous. The research team took great pains to discriminate the therapies, to create treatment manuals and to train and supervise therapists to deliver the treatment interventions faithfully. Two groups of research subjects were recruited, those who had entered a brief intensive treatment programme for alcohol dependence (named the ‘aftercare’ sample) and a similar sized group of subjects recruited via media advertisements from the community (the ‘community sample’) The research took place in nine different treatment sites, and 1736 people received the treatments. These were delivered as a series of weekly individual (one-to-one) sessions over 12 weeks (the Motivational Enhancement Therapy was delivered as only 4 sessions over the 12 week period and some sessions included a family member if available). The agreed treatment goal for all the interventions was alcohol abstinence. Despite the grand scale and ambition of this study, and many efforts to optimise the internal validity of the design, the results failed to confirm any of the primary hypotheses, and only two of the secondary hypotheses had any support. Once again, all three treatments had comparable drinking outcomes with no significant differences at any of the follow-up points.

There has been a very large amount of commentary, critique and speculation about Project MATCH in the field ever since the publication of its results began, but one of the ideas that has taken root in the research and treatment communities is that MATCH and similar studies have shown that patient matching based on current knowledge is not supported by the evidence (see, e.g., Ouimette et al. 1999, UKATT Research Team 2001). To the extent that attempting to match patients to distinct types of intervention is not useful, this constitutes support for the argument against the 'technology model' discussed below.

By the late 1990s, then, research into the efficacy of treatments had established that some were indeed efficacious. Compared to no treatment, or interventions considered to be ineffective, psychosocial interventions, especially those based on cognitive-behavioural principles, seemed to be consistently, if modestly, more effective. This appeared to some as a significant achievement (Carroll & Rounsaville 2007) and to others as disappointing and unsatisfactory, particularly in the light of the 'equivalence paradox' and the failure of matching research to establish robust matches (Orford 2008). Before discussing the epistemological and methodological assumptions upon which this body of research rests, in particular that interventions of this kind are technologies which if properly implemented should produce consistent and potentially explicable outcomes, and before describing the increasing criticism such assumptions have come under since the turn of the century, the review will return to the work of Finney, Moos and their collaborators, to related work by Morgenstern and colleagues, and to research by Simpson and colleagues at Texas Christian University. Finney, Moos and Morgenstern's work elaborated the earlier process studies, in particular by clarifying the concept of the 'proximal outcome' and continuing to explore mediators of outcome. Simpson's group, influenced by the work of Finney & Moos (Simpson et al. 1997), had researched treatment components that enhance retention and other desirable outcomes in large groups of treated drug dependent individuals, including participants in DATOS (Drug Abuse Treatment Outcome Studies), a set of large, federally funded treatment trials. By 2004 the group had elaborated a conceptual framework or treatment model which linked patient characteristics, treatment processes and post-treatment

outcomes (Simpson 2004). The contributions of this group are important to consider in this review.

2.5 Research at the Veterans Administration, Stanford and Rutgers from 1995

By the late 1980s and 1990s, Finney and Moos were creating complex conceptual models of treatment process. In 1995, Finney published a paper elaborating mediators and moderators of treatment. He identified two classes of mediator. The first class are those variables which have to do with treatment provision itself (for example the number of sessions, treatment activities, therapist characteristics) or with the patient's involvement (how much they contribute to group discussions for instance). The second class are 'proximal outcomes': changes that are intended to occur within the treatment period which are either theoretically derived from the programme model or are generic changes produced by participation, "whose attainment contributes to the desired end-states for clients or ultimate outcome variables" (Finney 1995).

The paper discusses moderators as well, generally patient characteristics or environmental variables which make a difference to outcome. Finney explains that a complete conceptual process model must consider the interactions between moderators and mediators. Since one of the conceptual issues he says may be examined by attention to moderation is "diagnosing why hypothesized interactions between patient characteristics and type of treatment did not obtain" (ibid. p.143), this paper explores similar territory to realistic evaluation, which considers which contextual factors constrain outcomes by inhibiting mechanisms.

Critical to subsequent studies described next are both the concept of the proximal outcome itself, and also the idea of specific and general mediators, that is mediators which belong specifically to the treatment model in question and ones which are generic across a range of treatments. Finney notes that:

"If the treatment implementation variable is a treatment provision or involvement variable, it specifies an "active ingredient" through which the more general treatment approach may exert its effects. If the mediating variable is a proximal

outcome (whether assessed during or after treatment), it identifies a possible mechanism of change in the treatment process.” (Finney 1995 p.138).

This is a helpful, muddle-reducing analysis, and posits a clear and comprehensible difference between a mediating variable and an underlying mechanism. Of course, the proximal outcome itself with its statistical association with subsequent desired outcomes is not identical with the mechanism, but it might well be an observable manifestation of it. Defining theory-based proximal outcomes which ought to be expected from contrasting treatment approaches formed the basis of the next studies to be considered. However, these important comparative studies by this research group at Palo Alto, California (Finney et al.1998, Moos et al. 1999, Finney, Moos & Humphreys 1999), and a process study with a similar focus by another group at Rutgers University, New Jersey (Morgenstern et al. 1996) which followed in the late 1990s were to throw up more puzzling findings.

Morgenstern’s group investigated theory-based processes in what they call ‘traditional chemical dependency treatment’. Since this model was apparently based on the disease model espoused by Alcoholics Anonymous, it was hypothesised that patients would start treatment in marked denial about their alcohol dependence and that treatment interventions would aim to reduce this. Treatment was also hypothesised to increase disease model beliefs, such as acceptance of ‘powerlessness’ over the dependency, commitment to attend AA, belief in a Higher Power and acceptance of the ‘alcoholic’ label. In addition, treatment was hypothesised to increase commitment to abstinence and intentions to avoid high-risk situations, processes regarded as general ones, commonly shared with other approaches. It was expected that increases in the desired beliefs would predict short-term outcomes.

However, the results did not support any of the hypotheses. Patients entered treatment with low, not high, levels of denial, and with high levels of endorsement of both the disease model and common processes. Treatment which consisted of group, individual and family therapy, didactic lectures and bibliotherapy, as well as exposure to in-house AA meetings, did indeed significantly but modestly increase disease model beliefs, but these increases

did not predict outcomes (even when ceiling effects were controlled for), and it failed to increase the common processes of commitment to abstinence and intention to avoid risky situations. High levels of these last did in fact predict better outcomes but they did not seem to be affected by the treatment process. The study did not support the theory that good outcomes are produced consequent on a 'radical realignment' of beliefs about one's own problem and reliance on a Higher Power, a 'conversion experience' as Cook (1998) describes it.

2.6 The VA studies

Finney and Moos, together with their colleagues, at around the same time conducted some large studies of Veterans' Administration (VA) treatment programmes for substance abuse, which Finney's 1995 paper was intended to introduce. These studies compared the outcomes of over 3,000 men treated in 15 programmes which were based either on cognitive-behavioural principles, or the more traditional 12 Step based principles. Some programmes were an eclectic mixture of the two. It was established that all these programmes were comparably effective in reducing substance use and related problems, with the 12 Step based programmes significantly more successful at producing abstinence, freedom from substance-related problems and employment at 1 year after treatment (Ouimette, Finney & Moos 1997, Moos et al. 1999). Further it was established regular and frequent attendance at 12 Step meetings and participation in outpatient care after treatment were associated with the best outcomes (Moos et al. 1999).

Several papers about proximal outcomes and mediation were produced from these studies. The first paper (Finney et al. 1998) compared cognitive-behavioural and 12 Step-based programmes. Proximal outcomes were posited based on what each type of programme was aiming to produce and patients were assessed at baseline and at the end of treatment to measure to what extent these proximal outcomes had been achieved. It was demonstrated that each type of programme succeeded in producing its own set of proximal outcomes.

Patients in 12 Step programmes tended to increase their disease model beliefs, become more accepting of a recovering alcoholic or addict identity, and were more committed to abstinence than at baseline. Behaviourally they attended more meetings, acquired sponsors, had more friends in the 12 Step programme and read more 12 Step materials. All of these outcomes increased significantly over the treatment period (except for commitment to abstinence, which, as in the Morgenstern study, was already high at entry), and they increased markedly more than in the cognitive-behavioural programmes.

Patients in the cognitive-behavioural programmes showed significant increases in self-efficacy, in a set of cognitive-behavioural change processes including stimulus control and self-reevaluation, and in a set of coping responses, such as problem-solving, positive re-appraisal, and cognitive avoidance. Their positive expectancies for substance use declined. All these outcomes are specifically targeted by the CBT programmes, so these results are not very surprising.

What perhaps was more unexpected was the result that the patients in the 12 Step programmes also significantly ($p < 0.001$) increased on all of the cognitive-behavioural outcomes (bar one), despite these processes not being explicitly targeted by this model of treatment. This seems a very interesting, and at the time, counter-intuitive finding. Somehow despite treatment programmes that did not contain any cognitive-behavioural skills training, and whose philosophy encouraged people to 'accept powerlessness', the participants in these programmes increased their self-efficacy and active coping to an extent comparable and in some cases to a greater extent than participants in cognitive-behavioural programmes. The received wisdom that predicted that the 12 Step philosophy would encourage helpless dependency, and erode self-efficacy, was radically challenged by these results. Other studies have continued to challenge it, for example Morgenstern and colleagues showed that affiliation with the 12 step programme of Alcoholics Anonymous after treatment predicted more active coping and higher self-efficacy, which in turn predicted better outcomes (Morgenstern et al. 1997). The mechanisms by which these processes occur are among those sought in the current research.

The search for such mechanisms is made more complex by further findings from the Veterans' Administration studies. A subsequent article by Finney, Moos and Humphreys (1999) showed that the relationship between the proximal outcomes at discharge (and at intake as well) and the ultimate outcomes of abstinence and freedom from substance related problems was weak, accounting for only around 2% of the variance in outcomes. 5 proximal outcome composites were created from the range of 12 Step and cognitive-behavioural (CB) outcomes. These were 12 Step cognitions, 12 Step behaviours, CB cognitions, general coping and substance specific coping. Of these 12 Step cognitions and CB cognitions at both intake and discharge were significantly but weakly associated with the abstinence at 12 months, and CB cognitions at intake and discharge, and general coping at discharge, were similarly significantly but weakly associated with freedom from problems at 12 months. The correlations ranged from 0.03 to 0.15, with most less than 0.1. Even when baseline measures were controlled for to test whether changes in the measures might be associated with 1 year outcomes, essentially similar results were obtained. However markedly stronger correlations were obtained between the proximal outcomes measured at follow-up and with abstinence and freedom from problems at the same point. All of these correlations were significant (except for 12 Step cognitions and problems) with a range of 0.25 to 0.39. Over a quarter (26%) of the variance in abstinence was accounted for by these associations. These results leave some unanswered questions about what exactly happens in treatment programmes and the relationship of these processes to people's recovery journeys afterwards. Are the changes that happen in treatment more or less irrelevant and all the important things occur afterwards? Is it possible to understand, in the light of these results, how the processes that occur in treatment set people up for a successful or less successful recovery?

These studies are examples of several that throw doubt on the theoretical underpinnings of treatment models, both the approach based on the ideas of Alcoholics Anonymous and its rival based on cognitive-behavioural methods and with a very different theoretical base. As with psychotherapy generally, comparative 'black box' outcome studies of different approaches very often, in

fact typically, result in 'no significant difference' results: the equivalence paradox or 'Dodo bird' verdict ("All have won, and all shall have prizes.") (e.g. Luborsky, Singer & Luborsky 1975, Stiles et al. 2008). As has been described, this led during the 1980s and 90s to an interest in treatment matching. Perhaps the equivalent outcomes were obscuring differential responses by identifiable subgroups of patients; certainly the idea that certain treatments might suit certain people better than others seems plausible. But as has been shown with the Project MATCH study and with other very large multi-site comparative trials, such as the Cocaine Collaborative Treatment Study (Crits-Christoph et al., 1999) and COMBINE (Anton et al. 2006), the treatments again tended to produce similar outcomes and a priori matching hypotheses turned out not to be supported.

However as this review will show, the enormous datasets from these studies, in particular Project MATCH, subjected to causal chain analysis, most recently with lagged mediational analysis over several time points by Kelly and his colleagues (Kelly 2011a, 2011c, 2013), have revealed some clues as to important change processes and predictors of longer term good outcomes. Some of these may contribute to the creation of better theories of change and will be considered during the phase of identifying potential mechanisms. First however, the contributions of researchers at Texas Christian University will be reviewed.

2.7 Simpson, Joe and colleagues

From 1991-93, a very large federally funded national drug abuse treatment outcome study (DATOS) was carried out in 11 cities across the United States, involving over 10,000 subjects. Patients received a range of treatments including long-term residential programmes, shorter in-patient programmes, drug-free out-patient programmes and methadone programmes. Throughout the following decade the data collected was analysed and published in a series of papers. Two research groups were involved, one at Texas Christian University and the other at National Development and Research Institutes, Raleigh, NC. Following on from earlier work, Simpson and colleagues established that in DATOS, as in earlier studies, there was a robust relationship between retention

in treatment and good outcomes (Simpson, Joe & Brown 1997). However, it was found that there was great diversity in the programmes within each modality in terms of who was treated, their success in engaging and retaining clients, and the services delivered. Simpson, Joe & Rowan-Szal (1997) showed that higher motivation at intake and early programme involvement predicted longer retention, and further, Simpson et al. (1997) added to this last paper by beginning to create a process model from their findings: they showed that counselling enhancements (in this case a collaborative problem solving mapping technique) improved the strength of the therapeutic relationship between client and counsellor, which in turn had a positive effect on patient engagement. The work of this group proceeded through a series of studies aimed at improving measurement of treatment processes (Joe et al. 2002) and identifying factors which were relevant to treatment improvement. Etheridge & Hubbard (2000) identified seven levels of process measurement which they believed were required to gain a comprehensive picture, including the client's external environment, client characteristics including cognitions and functioning, client outcomes such as cognitive and behaviour changes, treatment components, the range of services and the way the programme was delivered, the programme structure, the treatment system that recruited clients and provided ancillary and related services, and the external policy environment. It is clear that as a result of being involved in this very large national research study the researchers came to an appreciation of the complexity required to evaluate what was being delivered on the ground. Greener et al. (2007) from the same research group, studied the relationship of organizational functioning on client engagement and found that staff satisfaction with a range of organizational attributes, in particular adequate staffing levels (and institutional resources generally), staff influence on their colleagues and managers, and a group of factors describing the organisational climate, such as good communication, a clear sense of mission, relative autonomy for treatment staff in carrying out their jobs, a sense of team cohesion and lower perceived stress/work overload were all significantly correlated with better counsellor rapport and client satisfaction. This provides a clarification of the importance of the programme variables in Cronkite and Moos (1978) who hypothesised that the patient's experience and perceptions of treatment would be an important

influence on outcomes and gives some pointers as to what organisational context is likely to be conducive to better results.

Simpson (2004) brought the implications of this wide-ranging body of research together into a conceptual framework that attempted to map a sequential model of patient and programme attributes, evidence-based interventions that could be applied to a series of stages in treatment and recovery, that in concert with external support systems could produce a range of outcomes such as improved drug/alcohol use (preferably abstinence), reduced criminal activity and improved social relations. Working first to improve readiness, and providing access to an appropriately resourced treatment system, behavioural and cognitive interventions, social skills training and social support applied appropriately should enable early engagement, encourage programme participation and develop a therapeutic relationship. These in turn produce behavioural and psycho-social change, with sufficient client retention to result in stability and connection with post-treatment support systems. This conceptual development was accompanied by the production of a range of measurement instruments, manuals and toolkits designed to improve treatment process in line with this model.

There is no doubt that this process model is useful and that the resources that have been provided to the field have indeed contributed to the enhancement of treatment programmes in the United States and elsewhere. In fact the SHARP programmes researched here include workshops based on ITEP (International Treatment Effectiveness Programme) which includes a version of node-link mapping and is derived from the work of Simpson and his colleagues. This programme has been recommended by the British National Treatment Agency (2009) and training of agency workers has taken place with somewhat mixed results (Sondhi & Day 2015).

However, despite the development of this process model, and the careful elaborations and explanations of its components, it remains (perhaps by design, to encompass flexibility of application) rather broad-brush, and does not enable a close focus on mechanisms in the realist sense.

Its importance lies in its being the culmination of a body of work that was carried on from the 1970s which took seriously the need to understand and evaluate treatment process. It is argued here that the rise of evidence-based medicine and its adoption by policy makers whose chief consideration was to control expenditure resulted in an extraordinary privileging of efficacy trials, i.e. RCTs, as producing the only type of evidence worth considering, and that the effect was to obscure knowledge of process research and to attenuate its influence.

2.8 The rise of evidence-based medicine

During the 1980s and 1990s the idea that decision making in clinical care ought to be influenced by the best available evidence came to considerable prominence in the field of medicine. Even though the roots of this philosophy go back to the 19th century (Sackett et al., 1996), Cochrane reminds us that the effectiveness of medical procedures was extremely limited until the second quarter of the 20th century, and the first application of the experimental method in medicine, in the form of a randomised controlled trial (RCT) of streptomycin for tuberculosis, was not published until 1952 (Cochrane 1972, p.11). The increase in the number of pharmaceutical, surgical and other interventions which had genuine efficacy and which could be tested with properly designed RCTs led both to an enormous growth in applied medical research and to a much more robust knowledge base which could be accessed by practitioners. Sackett, one of the pioneers of evidence-based medicine (EBM), while he claims that EBM should integrate clinical expertise and the best available evidence (both being necessary for best practice), is critical of non-experimental approaches to knowledge, as he claims that these lead to false positive evaluations of efficacy, and maintains that the 'gold standard' of evidence is derived from RCTs and systematic reviews of these (Sackett et al. 1996).

This development in medicine led to a wide-spread and highly influential drive to make the field of addiction treatment 'evidence based'. In 1980 there was very little of this kind of evidence to be had, and most addiction treatment (both for alcohol and other drug dependence) was poorly evaluated. It is beyond the scope and purpose of this review even to sketch out the development of experimental research in the field, but in the next two decades a great deal of

efficacy research into pharmacological and psycho-social interventions was carried out, mostly in the United States, which was characterised by the careful specification of discriminable interventions, the training of practitioners to deliver these with fidelity, and the testing of these in controlled trials.

2.9 The technology model and its critics

One of the important corollaries of the rise to dominance of this approach was the assumption of a 'technology model'. As Carroll & Rounsaville explain, "This model attempts to specify the treatment variable – psychotherapy - in a manner analogous to specification of a drug's formulation in pharmacological trials, that is, definition of treatment techniques in manuals as well as precise specification of treatment dose, delivery of treatments, nature of the subject sample, and therapists' experience and training. Through this specification, a technology model for psychotherapy research seeks to control extraneous variability in clinical trials . . ." (Carroll & Rounsaville 1990, p.91). These authors describe in this chapter the various complex methodological problems involved in balancing internal and external validity in such trials and discuss to what extent the results may be generalised.

By 2005, when the same authors delivered the Society for the Study of Addiction's annual Society Lecture, they were hailing the fruits of this approach as a "brilliant success". Many well conducted trials had, they claimed, identified a range of evidence-supported interventions with "impressive empirical support" - the ones they cited were behavioural treatments, methadone treatment, couples therapy, motivational interviewing and relapse prevention (Carroll & Rounsaville 2007).

However, during the same period there was a rising tide of discontent from prominent researchers with the state of knowledge outlined by Carroll and Rounsaville. This review has already shown that outcomes from theoretically very different approaches yielded similar outcomes, something that Carroll & Rounsaville acknowledge. The promise of matching research had not come to fruition – there was virtually no evidence that assigning people to particular treatments on the basis of attributes such as length or severity of problem, co-

occurring mental health problems, preferred substance, or degree of motivation was of any benefit. There were predictors of outcome across treatments, such as readiness-to-change and self-efficacy in Project MATCH, but the general finding that interventions which supposedly worked via very different mechanisms produced more or less the same outcomes was a serious challenge to the technology model. It was established that (quite a wide) range of interventions were efficacious compared to a control condition, but there was little evidence for how these achieved their effects.

Morgenstern and Longabaugh showed that there was very little support for the idea that increased coping, one of the fundamental targets of cognitive-behavioural treatment, mediates the outcomes of this intervention, and comment that the absence of support might be due to methodological problems in the studies under consideration or perhaps that the underlying assumptions of the model needed revision. So although certain changes measured in patients were sometimes associated with better outcomes there was no evidence that CBT produced these outcomes more than the comparison treatment, and in other cases CBT produced intended changes, but these were not associated with better outcomes. These findings are in concordance with the Rutgers studies described above (Morgenstern & Longabaugh 2000).

By 2007 Morgenstern and McKay were suggesting that the technology model had reached its limits. They recognised that efficacy trials are important and have established several 'active treatments', but that evidence which might support the idea that these work through specific, theory-based active ingredients is hard to find. If this were the case, some treatments would most likely produce superior results due to having more potent specific ingredients, but as we have seen the treatments have broadly equivalent outcomes. Theory-based matching might also support the idea of specific effects but they note that evidence for this is not forthcoming. Thirdly they suggest that mediator studies in which links between theory-based processes and outcomes are tested could also provide evidence for specificity. The paper reviews a range of interventions (Motivational Interviewing, Behavioral Couples Treatment, Cognitive-behavioural Therapy, and 12 Step treatment) for efficacy, evidence for

moderators of effect and mediators of effect. The conclusion is again that effect sizes are very similar for all of these (although working with couples may be superior to individual therapy). Consistent client matching effects and mediation effects were not found across studies and the authors argue that this offers little support for the 'specific effects/active ingredients' technology model. The authors suggest that the effects of efficacious interventions could be explained by non-specific, generic factors, or a complex interaction between specific and non-specific factors.

This important paper goes on to assert the need for new models and conceptualisations which will take into account the heterogeneous response of clients to interventions and the interplay of specific and non-specific mechanisms. They suggest that research might focus on significant sessions which seem to stimulate sudden change (Tang & DeRubeis 1995, cited in Morgenstern & McKay 2007, p.1384), adapting to individual patient responses (Collins, Murphy & Bierman 2004, cited in Morgenstern & McKay 2007, p.1384), or on testing a generic process model of psychotherapy (Kolden et al. 2006, cited in Morgenstern & McKay 2007, p.1385). Kolden et al. (2006) found that both a bond between the therapist and the degree of openness or non-defensiveness of the client interacted with specific therapeutic factors in a path model to predict outcome (score on a mental health scale). It was suggested that the non-specific factors (bond and openness) provide a **context** for client change. This provides a conceptual link to a realist perspective.

Morgenstern & McKay end their paper by commenting that in their view the evidential problems with the technology model will require "a rethinking of assumptions and introduction of new methods, rather than incremental modifications of existing paradigms" (p.1385), and by stressing that understanding of how treatments work requires "understanding that they are embedded in a complex context of environmental, patient self-change and life-course factors" (p.1386).

This last comment references another key paper, published by Tucker and Roth in 2006. This article emphasises that the hierarchy established by the evidence-based movement with randomised controlled trials at the top, had effectively

made the latter the only evidence that counts, and they review the benefits and limitations of RCTs, suggesting that broadening the evidence hierarchy would improve the generalisation potential of research-derived knowledge and also improve what they call “science-to-practice linkages” (Tucker & Roth 2006, p.922). In particular they stress that contextual factors (including “a person’s values and life circumstances” (p.923)), deliberately excluded or controlled for in RCTs by randomisation to interventions, are essential to the understanding of their effects, to a significantly greater extent than is the case with medicines or other medical procedures. They make the point that the knowledge generated by the studies discussed above, which had established the context dependence of patterns of substance abuse and remission, had been to a great extent sidelined or ignored while randomised efficacy trials dominated the evidence base.

The authors reviewed in the last few paragraphs, while advancing trenchant and well-argued critiques, tend to pull their punches, retaining a marked degree of respect for the orthodoxy. They stress the idea that efficacy trials had in some ways produced an important body of knowledge, and suggest that the failure to find consistent moderators and mediators from specific treatments might have been the result of methodological problems rather than concluding that the technology model is not just limited but fundamentally flawed. This attitude seems to be a mixture of justified scientific tentativeness and academic diplomacy.

A rather more radical critique is provided by Orford, a British clinical psychologist and veteran researcher into addictions and problem drinking. He suggests frankly that in his view the general project of mainstream addictions treatment research, including efficacy trials and large matching or comparative studies, has been “asking the wrong questions in the wrong way” (Orford 2008, p.1). Rather than the ‘brilliant success’ hailed by Carroll and Rounsaville, Orford’s view is that the orthodox paradigm has reached a dead end. The paper is an opinion piece, inviting debate, but it makes some subtle and complex arguments. It is written by someone who has been deeply involved for several decades in some of the research projects he is criticising. It lays out what the

author thinks are significant failings of existing research, including the assumptions of the technology model, the failure to integrate knowledge about how people change without interventions, the ignoring of therapists' and patients' own theories, failure to take a systemic view, seeing change as the product of individual processes rather than embedded in a social context, and the insistence on a positivist, narrowly empiricist, epistemology. Many of these concerns are directly relevant to a realist research programme, and inform for example the choice of a 'theory-driven interview' method (Pawson 1996).

Orford suggests that research needs to shift in three ways in order to develop adequate understanding of how treatment helps people change and thereby to improve practice. First, he suggests that the emphasis on specific therapy techniques has not produced useful understanding and that this should be replaced with a focus on change processes. He suggests that these are 'common', non-specific processes, but does not consider in detail whether both specific and non-specific processes are dynamically related, as suggested by Morgenstern & McKay (2007) and Kolden et al. (2006). Second, he suggests that research needs to consider the "broader and longer-acting systems of which treatment is a part" (Orford 2008, p.6). He alludes to the work of Moos and colleagues, described above, as evidencing the importance of the context, for example the therapeutic climate of treatment settings, life circumstances, and social networks. Third, he emphasises the importance of a broader view of scientific knowledge production, in particular stressing the importance of taking seriously the tacit knowledge of practitioners and of including clients and patients as active participants in the generation of knowledge.

Orford conceded that at least some of these shifts will face considerable resistance from those entrenched in traditional disciplinary positions, and points out that western psychological and psychiatric traditions have been dominated by a focus on the individual rather than social systems. But since his article was written there has been a body of research published that does reflect a shift in perspective of which Orford might to some extent approve.

This research responds to some of Orford's concerns in two ways. First, the work of Kelly and his colleagues does indeed tend to take a longer-term view,

developing methods of analysing multiple mediators of change in an extended time series, and attempting to establish the relative importance of various mediators. This research also takes seriously and tests some of the 'lay' theories of change, in particular the ideas of Alcoholics Anonymous about how its programme 'works' to help people to stay abstinent. Second, there has been an increasing interest in mechanisms, and studies have been carried out, some designed to disaggregate named approaches into theoretically based components that are supposed to be implicated in change processes for clients, and to test these (e.g. Morgenstern et al. 2012) and others to identify effective 'behaviour change techniques' from a range of manualised approaches (e.g. Michie et al. 2012). The final part of this review will consider the contribution and limitations of these studies.

2.10 Kelly and colleagues

John Kelly and his colleagues have published a series of papers over the past seven years, which re-analyse the dataset from Project MATCH (Kelly et al. 2010, 2011b, 2011c, Kelly & Hoepfner 2012, Kelly & Greene 2014). Further to the interest in investigating mediators of outcome, Kelly used the fact that there were data at a number of time points, and a very large range of variables measured, to develop a hierarchical linear modelling analysis that was 'lagged' over time. Most previous mediation studies had attempted to model mediation with variables from a single time point, or from baseline and a single follow-up. These designs are inferior to one in which it is possible to measure a variable of interest, a potential mediator, and the change in the first variable in a temporal sequence (Nock 2007). Both static and time-changing co-variables are controlled for in this design. Kelly et al. (2011a) published a paper in which a range of mediators were studied simultaneously, in order to discover which were the most important pathways. All these studies concern recovery in Alcoholics Anonymous, which is clearly different from a formal short-term treatment programme, but its relevance for this review is that they provide quite strong clues as to what changes are robustly associated with enduring recovery over 15 months in AA (at least with this North American population), and since participants in the SHARP programmes are encouraged to use mutual aid

groups such as AA for long term recovery, it is plausible that, if the treatment programme is shown to initiate similar changes, these will be of benefit over the longer term. It is also the case that Kelly's findings reinforce findings of other outcome studies (e.g. Morgenstern et al. 1997). In addition, Kelly's group have investigated a wider range of factors and have been able to make comparisons across groups, for example between the rather more impaired 'aftercare' cohort, who had received residential treatment immediately before the Project MATCH intervention, and a less impaired 'out-patient' cohort, who were recruited directly from the community. Kelly & Hoepfner (2012) compared men and women, and found marked differences between them.

In summary, Kelly's group has established that for the whole group of subjects, the factors that are significantly predictive of good outcome are increased social self-efficacy (confidence to cope with social situations without drinking), and changes in the social network, both by reducing the number of drinkers associated with and by increasing the number of abstinent friends. For the more impaired aftercare cohort, reduction in negative affect and increased 'spiritual practices' were significant mediators of good outcome. When Kelly & Hoepfner (2012) compared the men and women in the sample they found that while social network changes were important mediators of abstinence outcome for both men and women, increase in negative affect self-efficacy (confidence to deal with painful feelings without drinking) was a strong mediator for women but hardly at all for men. In terms of the intensity of drinking outcome, it accounted for 33% of the mediation effect for women, but only 2.4% for men. Conversely social self-efficacy was a strong mediator for men (accounting for 35-39% of the effect of all the mediators together, which in turn accounted for 53% of the variance in outcome). However social self-efficacy turned out less important for women (0.2% of the mediation effect for intensity of drinking, 17% for frequency of drinking).

These are very valuable findings, but as has been mentioned, mediators are not mechanisms. It is clear that Kelly is aware of this limitation in explanation, for in a paper written with Greene about increase in spiritual practices as a mediator of recovery in AA, the authors point out that "a question that has lingered,

however, is how exactly does an increase in spiritual beliefs and practices translate into more abstinence and remission?" (Kelly & Greene 2014). They suggest 5 ways based on a range of psychological theories that could explain how increased spiritual practices could result in better recovery outcomes:

1. Spiritually-oriented, AA-specific, conditioned cues that activate recovery schemata and increase active coping.
2. Provision of a compassionate framework for self-forgiveness that decreases shame and guilt.
3. Positive cognitive re-framing of suffering and stressors.
4. Cognitive vigilance and memory exposure
5. Provision of a coherent (spiritual) framework that gives meaning and purpose to individuals' survival, suffering, and life experience.

These look very much more like mechanisms in the realist sense. However, they remain speculative. Kelly and Greene say that these require empirical testing, and suggest 'in-depth qualitative research' to "yield broader and, potentially enlightening, definitions that will inform measurement and future investigations." (ibid. p.311).

So as the interest in researching mechanisms advances, we begin to see researchers understanding that it is necessary to move beyond an empiricist framework to get at better explanations of change processes.

2.11. The resurgence of interest in mechanisms

It might have seemed that Morgenstern et al. (2012) were thinking along similar lines when they wrote that, "First, mechanisms research has largely been a secondary aim conducted in the context of efficacy studies and as such has suffered from flawed designs and limited methods. Second, at best, mechanisms studies offer support only for statistical association between active ingredients, mediators, and outcomes. To advance knowledge, causal tests of theories are needed." However it turns out that they were still focused on developing a design in "an experimental paradigm" (p.2), which would still rely on statistical analysis to test a hypothesised mechanism. Their design was methodologically more rigorous, with much better specified conditions and

clearer temporal chains, but it really takes us no further forward in explaining how mechanisms work.

Moyers et al. (2007) state some of the reasons for the burgeoning interest in mechanisms: "Knowledge of such causal mechanisms is highly desirable as they can be expected to focus research efforts, eliminate superstitious elements of treatments, and allow more efficient training of clinicians." In summarising the mechanisms research described in this review, it is fair to say that it has made significant contributions by identifying moderators and mediators of treatment effects, and in some cases linking these to hypothesised mechanisms of action. In terms of treatment interventions, as opposed to mutual aid-based recovery (e.g. Alcoholics Anonymous) the evidence is still quite equivocal. It is worth repeating the opinion of Longabaugh & Magill (2012) that "we are at the beginning of this research agenda, and all strategies and methods will be necessary to enhance this knowledge base."

From a realist point of view the findings of mediation studies are of great value in providing clues to possible mechanisms of action. Clearly characteristics and context are of great interest to the realist. If good recovery outcomes appear to be mediated by 'spiritual practices' such as private prayer, meditation and scripture reading, as was found by Krentzman, Cranford & Robinson (2013), the realist would want to discover the meaning of such behaviours in that particular cultural context, and the relationship to the person's intentions, priorities, commitments etc. It is also worth repeating that a realist maintains there is a way the world is (ontology) but that there are a range of valid perspectives on that reality (epistemology) which are socially constructed. The perspective of an individualist empiricist psychology is rather different to a sociological or realist social-psychological viewpoint. Blonigen, Timko & Moos (2013) found that reduced impulsivity is associated with better drinking outcomes, and this is described in their paper as a 'mechanism'. From the point of view of trait psychology, impulsivity is a measurable personality trait, internal to a person, perhaps influenced by genetics. However, it could also be understood as the behaviour of a person whose internal conversation is fragmented, whose identity project is undeveloped, who is at the mercy of first-order emotional

responses (Archer 2000, ch.6). It is not altogether clear what position these authors take, as although impulsivity is described in psychological terms, they also say, “although the idea of reduced impulsivity as a mechanism of change is novel . . . , it is consistent with contemporary definitions of recovery from substance use disorders that emphasize improved citizenship and global health, AA’s vision of recovery as a broad transformation of character, and efforts to explore individual differences in emotional and behavioral functioning as potential mechanisms of change (e.g., negative affect).” They also refer to social processes as possible explanations for reduction in impulsivity, for example the encouragement by others in recovery to be more structured and goal directed.

In summary, there is no disconnect between the findings of this body of mechanisms research and the realist project to identify mechanisms and contexts and to create an explanatory model. It does appear that the impetus towards understanding how people change in treatment was attenuated by the emphasis on efficacy research primarily driven by economic considerations. But interest in ‘how it works’ alive and increasingly vigorous, as is scepticism about the technology model of treatment.

The following chapter will describe the settings in which the present research was carried out, explore the complexity of these programmes and its implications, as well as providing an exploration of some central concepts such as addiction, recovery and recovery capital, and identity. The literature on identity as a factor in addiction and recovery is reviewed. The rationale for the treatment programme as described in the programme manual is outlined, some qualitative indications of change are presented and a realist approach to investigating change mechanisms is introduced.

Chapter 3: Situating the Research Settings

3.1 Treatment programmes as complex interventions

The settings where this research takes place are three treatment programmes, geographically separated but offering a similar experience to participants. They are all run by the charity Action on Addiction and are situated in Liverpool, in Bournemouth, Dorset, and in Braintree, Essex. They each deliver a structured day programme, requiring attendance from around 8.30 am to 4 or 5 pm, at least 5 days per week. Participants get referred, or refer themselves, to the programme in various ways, but the main criteria for entry are that they should have been identified as dependent on alcohol or another substance (or more than one), and that they should be aiming at resolving their problems through abstinence from substances. It is intended that participants attend the programme for 11 weeks (or 9 weeks in Essex, as it is a specially commissioned pilot and this duration was specified by the commissioner), and follow a pathway involving a collaboratively developed individual treatment plan, with identified issues worked on in individual counselling sessions, group therapy sessions, group-based workshops to explore and develop skills for recovery, and a range of communal activities such as meals, recreation (e.g. a game of rounders in the local park), and attending mutual aid support meetings in the evenings.

There are a number of ways in which the programmes can be considered complex interventions. Compared to a large regional or national intervention, for example the dissemination of needle exchange programmes as part of a national strategic response to the threat of HIV/AIDS, they are on a much smaller scale and have a local focus, taking referrals from the conurbation in which they are located, or in the case of Essex, from the county. However, compared to an individual intervention such as cognitive-behavioural therapy, in which a patient and a therapist work together in a specified way to achieve rather clearly defined outcomes, the SHARP programmes have considerably greater complexity. Pawson (2013) has delineated a series of dimensions of complexity, using the acronym **VICTORE** (volitions, implementation, contexts, time, outcomes, rivalry and emergence). It is worth considering how some of

these dimensions apply to the SHARP programmes. Pawson notes that questioning these dimensions is never-ending: each dimension will be considered here primarily for relevance to the research question, which is to explore what processes are taking place which produce a change in the internal conversation, and thus to a transformation of identity and lifestyle choice. The dimensions are related to one another and have a degree of overlap.

Volitions: Would-be participants have a series of choices before entering the programme and once they have entered they are also faced with choices. There will be variance in the keenness to enter the programme and the keenness will be driven by different reasons, for example being in trouble with the law and wishing to avoid or mitigate the consequences of this, or being desperate to salvage relationships with spouse or children, or having a strong desire to change from the person one feels one has become, an inability to tolerate oneself any more (McIntosh & McKeganey 2002). The choice to enter may be the person's alone or there may be pressure from family members, friends or employer. A particular individual may have a mixture of motives. There is a range of alternative interventions which might be accessible. The question of the acceptability of complete abstinence from all drugs and alcohol, as a goal for recovery and a condition of attendance, may play a part in the choice to enter the programme and to remain on it once begun. Once on the programme there are daily choices to be made as to whether to continue, whether to turn up on any particular morning, and to what level to participate in the activities of the day. Of course these volitions will be affected by the other dimensions of complexity, the implementation and contexts, perhaps most obviously the inter-personal context.

Implementation: It might seem as though this were a more straightforward dimension. The programmes take place in fixed locations, to a predictable timetable, with a reasonably clear philosophy and set of practices (the institutional context will be discussed in the next section). People get referred (via a range of routes), get offered an assessment meeting with programme staff on an agreed date, and if accepted are given a start date, on which they are invited to arrive at the programme premises in the morning. On arrival a set

of procedures takes place which are specified in the programme manual: assignment to an individual counsellor, introduction to a peer 'buddy' who will show the new participant to the daily group meetings and to the refreshment and informal association arrangements. The daily round and the progression through the programme milestones are reasonably predictable and consistent. However, there are factors in the implementation chain that appear to make a difference. An example is the situation when the SHARP programme began operating in Essex, when care managers and staff from other provider agencies who were in a position to refer clients were asked to consider who might be suitable for referral. This group of referrers were unfamiliar with this type of programme which was new to the area, and did not have a clear understanding of who might be suitable for it. As a result the recruitment for the first two cohorts was both limited in numbers and resulted in a poor completion rate of 40% (Elwell-Sutton 2014). The programme leader arranged a series of meetings with the referrers to discuss the problem leading to a greater number of referrals of more suitable participants. Suitability according to the leader (Unaka 2016, personal communication) consisted of a number of factors, but the most important of these was a commitment to the treatment goal of abstinence and a willingness to participate in a rather intense group-based programme for several weeks. Nevertheless it was expected that participants would have some level of ambivalence and complexity of problems. Subsequent cohorts were larger and had significantly better completion rates. An induction week was added immediately in front of the programme for the second cohort onwards, during which participants learned about the programme they were about to embark on and got to know their fellows and counselling staff. In addition "A zero-tolerance policy on substance use was added in cohort 3 which improved completion rates, with cohorts 3-12 having an average completion rate of 72%." (Essex CC Organisational Intelligence 2016).

Contexts: There are many contextual factors whose impact on the effectiveness of the programme is by no means determined. For example, there are times when a programme receives a large number of referrals and runs at capacity, at other times the number of participants may be low. A large group may contain a higher potential for identification and there might be a greater

accumulation of motivation and morale, leading to a more supportive and conducive environment; conversely a smaller group might seem more intimate and less threatening. The reduction in numbers might be due to a cluster of self-discharges or premature discharges by the staff because of drug or alcohol use. Such an event might seem frightening and reduce the remaining participants' trust and faith in the programme, or on the other hand it might increase their resolve. The relationship with the other drug and alcohol services, with the community of drug users and problem drinkers, and with the 'recovering community', the local network of ex-users (including graduates of the programme itself) will all be important contextual factors. The programme may have a strong reputation (e.g. for excellence, for toughness) and this reputation may vary among different groups. This reputation will likely affect decisions to apply and the hopefulness with which participants enter the programme. If, as is the case at SHARP Liverpool, some of the auxiliary staff are volunteer graduates, participants will routinely meet and converse with role-models for recovery. In the case of Essex, the programme was commissioned precisely because there was a gap in the provision of abstinence-based treatment and a lack of a strong local network of recovering people. So it might be that this lack of structural support would make recovery less easy, but on the other hand the early graduates of a specially commissioned, new and impressive type of treatment programme might well see themselves as pioneers and work hard both to maintain their own recoveries and to build new support structures for themselves.

The three geographically separated programmes also offer different opportunities to prospective and current participants. In Liverpool an alcohol free bar called the Brink offers a meeting place in the city for those who have been through SHARP or who have established recovery via other routes. This social space offers an opportunity to people considering applying to SHARP, or who have applied and are awaiting admission, to meet and obtain encouragement and information from, and to start to form bonds with, others who are maintaining abstinence after treatment. There is also a confidential counselling service there, the 'Brink of Change', which can be accessed for further advice and support. Attendance at the Brink is entirely informal and

without obligation, whereas in Bournemouth those who are waiting to enter the SHARP programme are expected to attend a series of preparatory days, professionally facilitated by counsellors, aiming at shoring up motivation and providing information about what to expect.

There are many other contextual variations which might be expected to make a difference to the way the programme is taken up by participants and what they get from the experience. Other critical contexts include what is happening in the home lives of participants. As a day programme requires participants to return home in the evenings, they may experience an environment of support, or stress and conflict, or loneliness, and crises may occur at any point. Events at home may act as disruptors or strengtheners of motivation.

Time: Several of the factors mentioned above are related to issues of time. How long a programme has been established will make a difference to its functioning: a mature programme may well be 'bedded in', with staff confident about their practice, referral routes clear and familiar, and with a local reputation. On the other hand a new programme can have a feeling of freshness and excitement, staff may be working harder to 'get it right' and may be paying closer attention to the manual, and the training and supervision provided to ensure fidelity to the programme specification. The timing of the programme for the participant may create variance in the experience. A person may be admitted soon after application, or there may be a long wait. This waiting period could enhance or erode motivation, depending on what happens during it. A person may be referred to treatment after a short or a long duration of addiction. There is evidence that intervention early in an addictive career may produce better outcomes; conversely, there is evidence that better outcomes may be predicted by a long period of problematic use, with an accumulation of negative consequences. Participants may feel too young, or too old, to change.

Outcomes: Although this study is not a 'realistic evaluation' of the SHARP programmes, but rather a study of change processes within them, some consideration of outcomes is essential, as some plausible link with the change processes and the desired outcomes. Traditionally, the outcome literature

concerning drug and alcohol treatment has focused on changes in drug and alcohol use: amounts, frequencies and patterns.

However there are two areas in the literature that argue for the consideration of other outcomes. One is typified by the work of Finney and his colleagues (reviewed in Chapter 2), who have proposed the operationalisation and measurement of what they term 'proximal outcomes', which are theoretically derived outcomes (from the underlying theory of the treatment model) which are intended to be achieved during the treatment period, and to the extent that the theory is correct, these proximal outcomes ought to predict the ultimate outcome of a sustained improvement in the drug and alcohol outcomes (e.g. Finney et al. 1998). In the case of the SHARP programme as we shall see below, the implicit theory is that improved interpersonal relationships, a sense of belonging to a mutually supportive group, and an increase in Recovery Capital should predict the achievement of sustained abstinent recovery. In fact an instrument called the Assessment of Recovery Capital (ARC) is used at the SHARP programme to measure various domains of Recovery Capital at entry to the programme and at the end of it. Consideration of the results of this measurement are discussed below in this chapter.

The second argument in the literature is typified by Tiffany et al. (2012). They argue that because of the impact of substance use disorders on human functioning, there is a strong rationale for including improvements in such functioning in outcome research. They point out that this has often been proposed but that there has been a lack of clear guidelines about which outcomes are most relevant. Their review suggests that level of cravings, social/network support, quality of life, self-efficacy for change and psycho-social functioning should be considered as key outcomes as there was evidence that these were robustly linked to good substance use outcomes or were clear benefits in themselves.

The consideration of a range of outcomes, which have either theoretical or evidential relevance, clearly adds complexity to the evaluation (or simply understanding) of the SHARP programmes. In actuality there are few outcomes which have both theoretical rationale and evidential support, and all of these

outcomes are contestable. Even the treatment goal of durable abstinence might not be the best measure of success, as someone who makes gains in the psychosocial outcomes while continuing to drink or use drugs might plausibly be considered more successful than someone who is miserably abstinent.

Rivalry: It is obvious that the SHARP programme is one among many initiatives or interventions that aim to help people with problematic substance use. Locally there are alternative programmes that people might access, with similar or highly contrasting philosophies and rationales. The concept of a 'rehab programme' that is not residential, but delivered on a day basis with comparable intensity, and with a range of advantages and disadvantages compared with traditional residential models, is rather new to this country, though it is better established in the United States. A 'day treatment programme' is often understood to mean something much less coherent and structured, perhaps a set of resources such as training (in using computers, job application etc.), counselling, advice, alternative therapies, offered on an elective, drop-in basis. The model exemplified by SHARP will have to fight for recognition if it is to be replicated successfully and serve as a template for an effective and more economical alternative to residential rehabilitation. A client interviewed for an independent evaluation of SHARP Essex, being unfamiliar with the day programme model, felt at first that he was being fobbed off with a cost-cutting version of what he felt he should have received. However having experienced the SHARP programme he told the researcher: *"At first I thought, they just want to save money, they don't want to run a hotel, but now I know it's not about that at all. I always thought rehab had to be residential, but it makes absolute sense to do it this way"* [Male Client Cohort 6] (Senker 2015)

Emergence: Pawson points out that that the existence of a programme will give rise to emergent effects, in other words in its interaction with pre-existing social structures novel effects will be produced with new causal powers. This can be illustrated clearly by contrasting the placing of a 'rehab' programme into the local community, taking local referrals, and whose graduates will remain living in the vicinity, with the traditional residential 'rehab'. In the latter case people with addiction problems are removed to a relatively distant institution, so that they

effectively disappear from view for a while. On leaving the programme, it is common for graduates to be resettled in a new area, sometimes in the town near the rehab, sometimes elsewhere. Non-responders will often return home to be reabsorbed into the drug using or drinking communities, restoring the status quo ante. However in the case of the SHARP programmes, graduates who establish ongoing recovery remain in the locality but in quite a different position: they join and strengthen the local recovering community (see section on recovery below). They are available as volunteers, supporters, companions for those in treatment, they participate in the organisation of resources (social spaces, recreational and other opportunities, support groups), and they spread the reputation of the programme to others, people still in trouble with addiction and their family members, as well as staff at drug and alcohol agencies. Those participants who fail to respond and relapse are of course also visible locally, but their reactivated addiction does not create significant new entities in the way the successful graduates do. The programme also produces a stronger mutual aid network, by hosting weekly meetings and strengthening those held elsewhere. Another aspect of emergence is the effect of the programme on the local commissioning system. Although the commissioning arrangements are different in the three areas, the establishment and implementation of SHARP in each case has moved the views of local commissioners and referring agencies from a position of scepticism (sometimes approaching hostility) to a position of admiration, more likely recommissioning, and in the case of Essex a proposal to support and fund replication of the programme elsewhere in the county. It is not implausible that these emergent effects will have an impact on the effectiveness of the programmes.

So many things have the potential to 'make a difference'. Complexity is an inevitable characteristic, and one which helps to explain why a 'black box' approach, asking the question 'does this programme work?' is very unlikely to produce a meaningful answer, especially if evaluation proceeds on the 'evidence-based medicine' derived randomised controlled trial model, as though the intervention were a technology which might be expected to 'work' almost independently of context. The question is, under what circumstances, in which contexts, will what kind of people respond or otherwise to what kind of

programme? In particular, what are the mechanisms by which the desired changes come about, and how can these be enabled? It is not necessary to demonstrate a fixed and unproblematically generalisable set of mechanisms that purportedly apply to everyone, but rather to show that a range of mechanisms which did appear to account for meaningful change in a set of typical programme participants could in principle be enabled in similar form in a broader range of potential beneficiaries. In other words, if we set the programme up in this way, if we emphasised these elements, if we recruited people with these characteristics, if we noticed these constraining factors in some participants and tackled them, we should be able to broaden the range of people for whom the programme would be a catalyst of significant and durable change.

3.2 What do these programmes intervene into?

The predicament of addiction

The people who enter the SHARP programmes have almost without exception highly problematic patterns of substance use of several years' duration. Typically, admission to an intensive programme whether residential or on a day basis results from a considerable accumulation of negative consequences and may well not represent the first attempt to address the problem. To the extent that a person embarks on the programme willingly, it represents an acknowledgment that one's own resources have been insufficient to deal with the problem, that one has lost control over it.

Various authors have pointed out the emancipatory potential of addictions, Giddens (1992 p.56) pointing out that the addict's 'intemperance' signals a refusal to "quietly accept one's lot", Bateson (1971) maintaining that the 'sober' alcoholic holds to a flawed epistemology which is subjectively corrected by intoxication, and Bernard Smith (a trustee of Alcoholics Anonymous in the 1950s) opining that "the [AA] member was never enslaved by alcohol. Alcohol simply served as an escape from personal enslavement to the false ideals of a materialistic society." (Alcoholics Anonymous 1957, p.279). However all these are agreed that addictions in actuality are unsuccessful, dysfunctional and damaging, mainly because of their disruptive effect on priorities, the

abandonment of reflexive concern for one's identity project, the pre-occupation with what Archer calls first-order commentaries, the immediate need for the 'fix', and because of the escalating nature of addiction and the perceived loss of control leading to feelings of despair, panic and self-destructiveness (Giddens 1992, p.55).

There are many different understandings of addiction: not only have ideas, theories and nomenclature concerning compulsive and problematic use of alcohol and other drugs changed over time, it is a currently contested concept. Recent opinion ranges from conceiving addiction as a socially constructed myth whose function is to explain and justify certain behaviours (Davies 1992) to claiming that addiction is a brain disease driven by changes in the structure and function of the brain (Leshner 1997, Volkow, Koob & McLellan 2016). May (2001), focusing on alcohol 'dependence', provides an insightful review of the medicalisation of addiction, claiming convincingly that over two centuries medicalisation has only been partly achieved, leaving certain dilemmas concerning, as May puts it, the relationship between susceptibility and culpability. The concern of medicalisation was to replace the idea of vice or deviance with morally neutral diagnostic categories. It has been proposed, for example by Peele (1989), that the medicalisation of addiction has relieved the addicted person from moral responsibility for their behaviour and for their recovery, but May convincingly argues this is not the case in actuality: there remains for many a distinctly moral aspect to recovery. May argues that while medicine has to some extent been able to establish a 'diagnosis' of addiction (and this problematically, as unlike other diseases, medical science has not been able to provide evidence for the organicity of addiction per se, as opposed to the biological effects of intoxication, toxicity and withdrawal) but has not been able to contribute to what might constitute recovery, as this remains a matter of volition and agency on the part of the sufferer.

In the absence of objective biological evidence for addiction (and the search for this has certainly not let up in the era of spectacular advances in brain science through new neuroimaging techniques) it is clear that the establishment of the presence of addiction is a matter of subjectivity. Giddens connects addiction to

the requirement in modern society for a continuous reflexive making of the self, due to the drastic weakening (as he sees it) of societal traditions that previously provided firm identities. He says “the fact that alcoholism was identified as a physical pathology for some while directed attention away from the connections between addiction, lifestyle choice and self-identity” (Giddens 1992, p.56). He describes addiction as an “inability to colonise the future” (ibid. p.57), an idea which will be considered more fully later.

Some of the cogent points which Giddens makes in his analysis of addiction are:

- that the experience of the ‘high’ starts as a highly rewarding experience of elation and/or triumph.
- that as addiction takes hold the pursuit of the ‘high’ “becomes translated into the need for a ‘fix’”. The need for relief from anxiety moves to the foreground.
- that the ‘high’ and the ‘fix’ are both a form of ‘time out’ from the conduct of ordinary life. The addiction is another world which separates one from the project of life, which is in stasis.
- that addiction is “a giving up of self, a temporary abandonment of that reflexive concern with the protection of self-identity generic to most circumstances of day-to-day life” (Giddens 1992, p.55)
- That the sense of the loss of self is followed by shame and remorse. Addictions escalate and the sense of loss of control leads to panic.

If this is accepted in general outline, it is plain to see how an extended pattern of addiction is likely to lead to an erosion of identity, an accumulating sense of dissatisfaction, possibly to the level of despair, and a wish to escape from the addiction. This wish may be suppressed for a number of reasons, the attachment to the addiction or the absence of hope for an alternative, but it is certainly the case that many addicted people make serious attempts to quit, sometimes successfully and enduringly, sometimes without success.

It is clear that very large numbers of people do manage to exit from their addictions, the majority without professional help (White 2005, 2007, Klingemann 2004) and there is a substantial literature about how this is achieved, and how the processes that result in unassisted or ‘natural’ recovery

relate to or may shed light on those that can be used in treatment. This literature focuses on two separate (but from the point of view of this thesis, related) areas: changes in identity and recovery capital.

3.3 Identity

A complication in the discussion of identity and its relevance to recovery from addiction is that there are a plethora of identity theories and identity is understood very differently in these. There are individual and social identity concepts, Cartesian concepts of identity as an entity such as the “soul”, reductionist concepts based on memory connections between psychological states and other life events, and social-psychological concepts, generally based on postulating “psychological continuants” that a person may have deriving from such things as beliefs, principles and commitments. Most of the literature concerning addiction conceives of identity in the last sense, but as a range of different theoretical traditions is made use of, care must be taken in comparing the accounts.

The pioneers of research into identity change were Biernacki, Waldorf and Stall, who researched the natural recovery of heroin users in the 1970s. According to these researchers’ theoretical framework people are deemed to belong to a number of ‘social worlds’ which each provide an identity based on the person’s internalisation of the norms of each ‘world’. Being a symbolic interactionist account, the commonality provided by each is a “common parlance”, common “modes of representation” and a shared perspective on the world (Biernacki 1986, p.22). The identities become salient in different social situations and are arranged hierarchically in terms of importance to the person for the sake of stability. Becoming a heroin addict involves the adoption of an ‘addict identity’, and the process of recovery from addiction “refers to the processes through which a new calculus or arrangement of identities and perspectives emerges and becomes relatively stabilized.” (ibid. p.25). Biernacki posits that the process of rejecting the addict identity begins when this identity becomes ‘spoiled’, that is, too much conflict arises between the stigmatised addict identity and the other identities of value to the person so that this can no longer be managed. The “process entails a different articulation of identities in which the identity as an

addict becomes deemphasized (symbolically and socially) relative to the other identities existing or emerging as part of the person's overall life arrangement." (ibid. p.25). Biernacki identifies three ways in which this can occur, *identity reversion* (return to an identity arrangement that existed prior to the addiction and which was separate from and thus unaffected by the period of addiction), *identity extension* (emphasising an identity which was co-existent with the addiction and bringing it to the fore in the identity hierarchy), and *identity emergence* (the creation of a new identity that did not exist prior to or during the addiction.) He proposes that which of these is chosen depends on the depth of involvement and salience of the addict identity, and on the quality of the prior identities available. Biernacki also provides us with, if not the mechanisms of identity formation, an account of the materials that may be made use of: "Identity materials are those features of social settings and relationships (e.g., vocabularies, social roles) that people can use. . . . People selectively incorporate these aspects of their social relationships into a coherent arrangement of identities and thereby create a new sense of self" (ibid. p.144). This underlines the social nature of identity formation. In the following Chapter presenting the conceptual framework of this research, it will be strongly argued that identity, of both the personal and social kinds, is thoroughly socially constituted.

Kellogg builds on the work of Biernacki and colleagues, in particular by considering how the 12 Step fellowships of Alcoholics Anonymous and Narcotics Anonymous provide identity materials to form a new identity as a recovering alcoholic or addict. The paradox by which members commit to self-labelling as an alcoholic or addict, which might seem to run contrary to the formation of an identity away from the 'addict' one, is explained as a strategy that not only serves to create bonds with a group that is practising recovery but also serves to develop vigilant awareness. The old 'addict identity' is likely to have been very prominent in the old identity hierarchy and is unlikely just to melt away. Squarely facing and admitting the power of the old identity both creates a powerful sense of shared experience, and an acknowledgement of the identity conflict that needs to be managed to avoid relapse (Kellogg 1993, p.241).

Koski-Jännes (2002), using Rom Harré's theory of identity formation, which distinguishes between personal and social identities and the formation and maintenance of these by means of identity projects, presents the possibility that emergence from addiction may or may not entail new identity projects. Her research with 79 quitters of various addictions suggests that if the addiction has interfered problematically with one's relation to oneself then a new personal identity project is required, and if it has impacted on one's relation to the social and moral order then a social identity project is needed. If both are affected then recovery will entail a combined identity project. For those whose addiction has had no or minimal impact on their identity, then identity work is not required to exit from the addiction. This differentiation has relevance for the discussion of recovery capital in the following section.

McIntosh & McKeganey interviewed 70 recovering (i.e. no longer drug using) addicts to discover how they had created a narrative of their recovery, as part of the construction of a new identity (pace Giddens 1991). They found that these narratives very often had versions of similar components, in particular a re-appraisal of the drug use itself, which was now felt to have lost its rewarding, enjoyable and exciting character and was being continued in the latter stages of the addiction as an attempt simply to 'feel normal'. Likewise, relationships with other drug users and with the drug using life style were appraised as repetitive, empty, inauthentic and a painful struggle. An intolerable conflict was often reported between the person one had become as a user, and the person one had been before becoming a user, and the person one aspired to be. The loss of self-respect due to failure in other areas of life, or as a result of humiliating or degrading activities such as stealing or prostitution, was felt to be incompatible with the person they felt themselves to be 'at heart' (McIntosh & McKeganey 2000, p.1509). They point out how these narratives are not constructed just by oneself alone, but rather they are influenced by others including counsellors and drug agency staff. An interesting example is given of how a comment by a drugs counsellor about whether a drug user was wanting to quit for the sake of her daughter or for herself caused her to "reformulate" both her own reasons for wanting to quit drugs and also to explain her previous failures as due to her not having been doing it for herself.

Recently Best and his colleagues have presented what they term the Social Identity Model of Recovery (SIMOR). They state, “This model frames the mechanism of recovery as a process of social identity change in which a person’s most salient identity shifts from being defined by membership of a group whose norms and values revolve around substance abuse to being defined by membership of a group whose norms and values encourage recovery.” (Best et al. 2016, p.113). In fact, despite a mistaken critique of Biernacki and McIntosh & McKeganey, this paper is really a continuation of those researchers’ work. Best et al. claim that Biernacki and McIntosh & McKeganey “ignore other identities that the person may hold, the wider social context of groups they may belong to and the impact of their social network on substance-related behaviour”, whereas the former explicitly refers to the rearrangement of a hierarchy of social identities, and the latter also give clear examples of the ‘addict identity’ conflicting with other identities such as family member, father-to-be etc., often leading to the ‘existential crises’ that in the narratives of recovery become crucial turning points (McIntosh & McKeganey 2000 p.1507). What Best and colleagues do add to these accounts is a focus particularly on membership of a social group explicitly committed to recovery from addiction and its values, norms and practices. The example they give to illustrate their conceptual framework is the 12 Step fellowship of Alcoholics Anonymous, in which the practical way of life which sustains enduring recovery is most likely to be achieved by those who have a strong sense of belonging and commitment to the group, those for whom regular exposure to the group norms and values foster an identity as a ‘recovering person’. Furthermore, committed membership of the group produces a sense of solidarity that acts a bulwark against stigma. Membership of a ‘recovery group’ promotes a sense of difference with ‘groups of users’, but by no means precludes committed membership of other social groups which do not involve drug or alcohol use. In fact, in Best and colleagues’ model, maintained recovery involves membership of such groups alongside the recovery group, so that the combined commitment to these strongly outweighs the pull of the ‘using group’. They point out that it may take some time for the membership of the non-using groups to become mutually supportive and compatible with membership of the recovery group, resulting in a coherent ‘recovery-focused’ social identity.

This brief review of literature relating to identity and recovery shows that for the most part the viewpoint is somewhat more distal than that of the present research. The journey of recovery is usually described by those with several years since their active addiction, and the actual processes by which these changes are put into motion are not emphasised, apart from McIntosh & McKeganey's comment about the influence of drug workers and some speculative suggestions by Biernacki about the process of identity rearrangement in Therapeutic Communities (Biernacki 1986, p.193). Even in the latter case the Therapeutic Communities he was referring to had a length of stay of at least one and up to two years, and there is no explanation of the mechanisms of change.

Notions of personal and social identity are central to the conceptual framework of this study, deriving from the theoretical work of John Greenwood and Margaret Archer in the realist tradition, but rather than looking at the identity processes which lead up to the decision to quit addiction, or the processes of identity evolution and maintenance that take place in longer term recovery, this study aims to focus on the mechanisms which are activated in the comparatively short period of the SHARP programme, which is entered into shortly (usually within days or weeks) after the attainment of abstinence, and to explicate the contexts that facilitate or constrain these mechanisms.

3.4 Recovery and Recovery Capital

Inevitably, there have already been many references to 'recovery' from addiction, but what recovery consists of, and whether it is a suitable term for life after addiction, is contested. There have been various recent attempts to define recovery, or at least to come up with a 'consensus statement' about what it is (e.g. Betty Ford Institute Consensus Panel 2007, UKDPC Recovery Consensus Group 2008). These examples were produced by expert groups, and like others they stress that a definition of recovery requires three components. First there is some kind of cessation of problematic/uncontrolled use (possibly requiring abstinence but perhaps accepting of some level of moderate controlled use). In the Betty Ford statement this is referred to as 'sobriety', in the UKDPC statement it is 'voluntarily-sustained control over substance use'. However, an

improvement in the substance use is by no means constitutive of recovery on its own. Both of the statements include in recovery an increase in health and well-being, and, perhaps more surprisingly, social involvement. The Betty Ford statement calls this 'citizenship', UKDPC call it 'participation in the rights, roles and responsibilities of society'. Other literature has solicited the opinions of those who define themselves as being in recovery (e.g. Laudet 2007). Laudet's survey found that most (but not all) American people who defined themselves as 'in recovery' believed that abstinence was a necessary foundation, but they tended to see recovery as much broader than simply quitting drugs: commonly cited benefits included "having a new life", "self-improvement", "having direction, achieving goals", "improved/more positive attitude", "improved finances/living conditions", "improved physical and/or mental health", "improved family life", and "having friends/a support network" (Laudet 2007 p.251). Interestingly these respondents did not stress the social involvement/citizenship aspect of recovery.

In terms of what makes recovery more likely or easier to achieve, the work of Granfield and Cloud in particular has contributed a concept that quickly gained currency and influence: that is to say, recovery capital. In the 1990s these social work researchers began to study people who had been addicted but who had given up alcohol or drugs for a period of years with no (or minimal) exposure to treatment or self-help groups (Cloud & Granfield 1994). After a series of further studies they began to formulate the concept of recovery capital, which derives from the idea of social capital as outlined by Bourdieu as "the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition." (Bourdieu & Wacquant 1992).

Granfield & Cloud (2001a) show how this relational capital, which is distributed unequally, for example by neighbourhood, ethnicity and class (Granovetter & Tilly 1988), and gives differential opportunities for self-actualisation, is used to support a successful life after drug use. They identify a range of factors that contribute to the social capital useful for recovery. Stability in employment, ideology that stresses a sense of obligations to others, and the maintenance of

relationships with both family members and non-family friends appeared to be the most important resources in the development of a durable recovery.

Recovery capital is an evolving concept. In 2008 Cloud & Granfield expanded the concept they had presented. As well as the social capital consisting of resources deriving from a network of relationships, they included physical capital, by which they meant financial and other tangible assets, human capital, by which they meant assets possessed by a person such as knowledge, skills, credentials and qualifications, as well as physical and mental health. They also included cultural capital, meaning the capacity, by way of beliefs values and attitudes, to fit into a socio-cultural group. As they say, "Those who misuse substances, who accept conventional norms, and have a stake in societal conformity have a distinct advantage over those who have been socialized to reject them." (Cloud & Granfield 2008, p.1974). Their research found that quitters often 'converted' to pro-social attitudes and values. They point out that drug users often belong to a 'street culture' with values of not losing face, street reputation and violence, which make recovery more difficult, and they also claim that disadvantaged sectors of society develop codes of behaviour that enable survival but hamper "their ability to function effectively in conventional society and employ the necessary strategies to overcome problems like substance misuse" (ibid. p.1975).

Valuing such a code is now seen by Cloud & Granfield as a form of 'negative recovery capital' in which they also include certain circumstances to do with age and gender as well as mental and physical health problems, and a history of criminal justice involvement/imprisonment, all of which may be hindering factors in the achievement of recovery.

Despite the authors insisting on the limitations and need for development of the concept, its plausibility has caused it to have quite an influence on thinking in the field, and the implication that the business of treatment is to activate recovery capital and to build it in those who have little, and to mitigate as far as possible the effects of negative recovery capital, has been taken up in various quarters including in the SHARP programmes, in whose therapeutic framework treatment activities are justified by their potential to build recovery capital.

The question of whether the possession of recovery capital is the main determinant of the likelihood of exiting from addiction, or whether the severity of the addiction problem is also relevant, has been taken up by White & Cloud (2008), who present a matrix with high and low problem severity on one axis and high and low recovery capital on the other, as a guide to treatment planning, suggesting that someone with high recovery capital and low severity is likely to require minimal intervention, particularly compared with a person with high severity and low capital who may need intensive and extensive help. Kelly & Hoepfner (2015) also present a 'biaxial formulation of the recovery construct' with the degree of remission of the addiction on one axis and recovery capital on the other, with the two in reciprocal relationship with one another (linked by a stress/coping model).

3.5. The 'Recovering Community'

In recent years there has been, both in the United States and elsewhere including the U.K., a significant increase in the visibility of a group of people who declare themselves to be in recovery and who have certain communal aims and aspirations, in particular to destigmatise the condition of addiction and of recovery. Public marches and conventions, sometimes attracting the attention of the President of the United States, websites facilitating communication and sharing resources, local 'club houses' and other facilities, and films and videos (e.g. *The Anonymous People* 2013), are examples of phenomena that are increasing in frequency and impact in the U.S., and similar activities, on a somewhat smaller scale are taking place in the U.K. (Leighton 2015). The relevance of this to the SHARP programmes is that they are located in the local community and are in reciprocal relationship with the local 'recovering community', which many graduates of the programmes join, as members of mutual aid groups, volunteers at the agencies, staff of 'recovery cafés', recreational interest groups (Livingstone et al. 2011), as do family members, some of whom organise similar networks of support. Conversely the community makes recommendations for treatment and shares experiences of it amongst those who are seeking help, and they also cultivate the reputation of the programmes. It will not be possible to properly explain the effectiveness of the SHARP programmes without reference to the local recovering community,

as it is highly likely that it plays a major part in providing both social and cultural recovery capital.

3.6 Treatment rationales – how does the treatment manual explain how “treatment works”?

Treatment staff at the SHARP programmes are guided in the implementation of the programme by a detailed programme manual. This document deals with the various components of the programme and provides a rationale for each of these. The first section sets out what it calls the ‘spirit’ of SHARP, by which is meant not anything transcendent but the ethos, the set of principles by which the programme is conducted. There are some rather clear statements about the therapeutic milieu. The manual emphasises that the treatment takes an interpersonal approach, and the opening sentence is as follows:

“The Self Help Structured Day Treatment Programme (SHARP) is designed to bring about a safe and containing environment in which to facilitate the development of clients’ interpersonal relationships, with the goal of achieving abstinence-based recovery. The programme gives people a chance to come to terms with their addiction, to help them gain insight into how they (and the people around them) have been affected, and to acquire the skills and support they need to make lasting change.” (Action on Addiction, n.d.)

Addiction is characterised “by a consuming relationship with a substance or behaviour that is driven by a conscious or unconscious desire to feel something different, which results in a range of harmful consequences.” Although it is not made explicit it is implied that the programme is designed as an antidote or escape from the “consuming relationship” and a mitigation/repair of the harmful consequences.

Three interlinking central principles are proposed: the philosophy of mutual aid, a focus on developing interpersonal relationships, and building recovery capital. Treatment is seen as a collective and collaborative process, and it is intended that participants should be integrated into and see themselves as belonging to a “dynamic community of people helping each other to achieve recovery”. The focus on interpersonal relationships is so that “clients can develop healthier ways of relating, remove obstacles to recovery and enhance their ability to build productive lives.” Various aspects of recovery capital are identified and it is

clear that the components of the programme are designed to build recovery capital, in particular a new social network, which will offer support but also a sense of belonging. Increased self-efficacy and self-esteem, emotional resilience, and the development of social skills are identified as aspects of recovery capital that the programme can build.

The clarity and predictability of the daily and weekly schedule, and the expectation that participants attend regularly and on time is also identified as an important characteristic as this quotation from the manual shows:

“An organised and meaningful timetable is a therapeutic intervention in itself - people coming from the chaos of active addiction have often lost, or may never have fully known, a sense of commitment and self-discipline. This is yet another way of restoring and enhancing self-esteem. The routine of the weekly timetable helps individuals develop consistency and responsibility – the foundation on which change can be built.” (Action on Addiction, n.d.)

A section on interpersonal group therapy states that it is the “central feature of the programme”. The manual maintains that it is through exploring, understanding and developing interpersonal relationships that the foundation for long term recovery is laid. Two mentions are made that in this process a person can “find out who they are”.

So it seems that integration, belonging, self-knowledge, and structure are what the programme aims to foster.

3.7 Quantitative measurement of change in the SHARP programmes

Research into the links between recovery capital in its various forms and the durability and quality of recovery is quite sparse as yet, and there is great scope for valuable study in this area. However, the plausibility and relevance of the recovery capital concept to provide a rationale for the psycho-social treatment offered at SHARP programmes caused the Action on Addiction leadership team to require the use of the Assessment of Recovery Capital (ARC) measure, for each participant at the start, mid-point and end of the programme. The ARC is one of the first instruments designed to measure recovery capital and it has been shown to have acceptable test-retest reliability and concurrent validity (Groshkova, Best & White 2011). The ARC produces scores on a number of

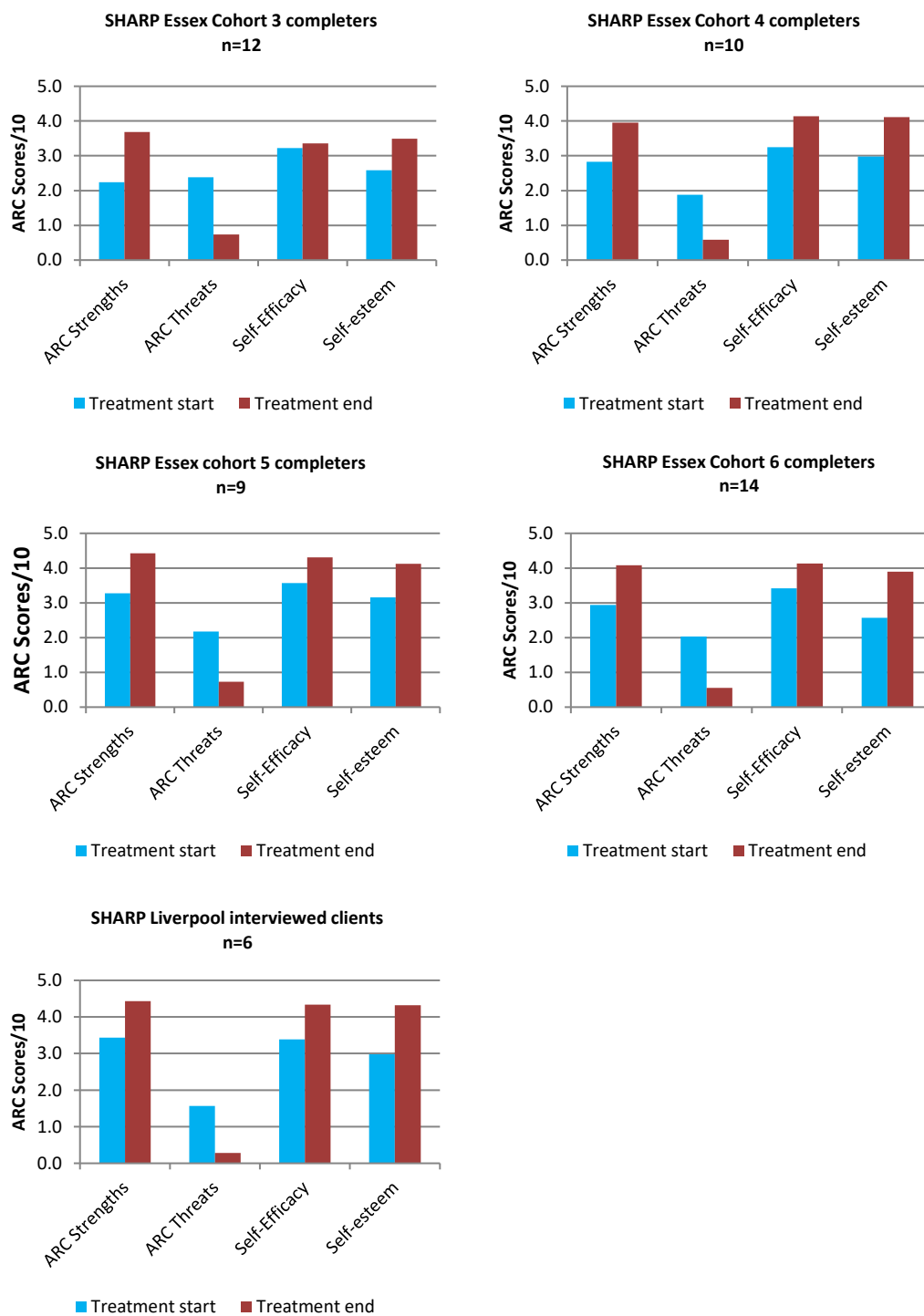
scales, viz. Substance use and sobriety, Global psychological health, Global physical health, Community involvement, Social support, Meaningful activities, Housing and safety, Risk-taking, Coping and life functioning, and Recovery experience. The original version of the ARC consisted of 100 items, with 50 measuring strengths on the 10 scales, and 50 measuring threats. The latter could be seen as tapping into the concept of negative recovery capital. In recent research (e.g. Best et al. 2011, Best et al. 2012) a 50 item version measuring just the strengths was used. The 100 item version has been used by Action on Addiction to audit its programmes and also by a number of undergraduate students on the University of Bath BSc. in Addictions Counselling degree programme. In each case the scores for threats showed at least as much and usually more change than the strengths scores. The reduction of negative recovery capital seems as important to understand as the accrual of positive capital, so for the SHARP evaluations the 100 item version was used. In addition the self-efficacy and self-esteem scales from the Texas Christian University CEST (Client Evaluation of Self and Treatment) (Joe et al. 2002) were also used at the same time points.

Data collection was most consistently done at SHARP Essex, and an external evaluation of the first two cohorts was conducted by Elwell-Sutton (2014). He was able to show that the ARC strengths scores for these cohorts increased significantly over the period spent in treatment, even for those who did not complete the programme. Using a paired sample t-test, probability for mean difference (in strengths scores only) was highly significant at 0.007 with a 95% confidence level. This is despite these first two cohorts being characterised by much higher levels of premature drop-out.

I collated and analysed ARC data from cohorts 3-6 in SHARP Essex and for the 6 participants in this study from SHARP Liverpool who had complete scores recorded. Using the same paired sample t-test for mean difference, in every case highly significant ($p < 0.002$) differences were found for increased strengths, diminished threats, increased self-efficacy and increased self-esteem. The changes in scores were remarkably consistent across cohorts (see

figure 3.1 below). In addition, every one of the individual strength and threat scales show a significant change in the direction of improvement.

Figure 3.1: ARC and CEST Scores at the start and end of treatment



To the extent that the ARC and CEST have reliability and validity, the measurements indicate that over the period of the programme, clients who complete are reporting consistent changes in the all domains. It is possible that the process of completion itself produces a feeling of achievement and a tendency to view oneself more positively, but this interpretation is not supported by the fact that the mid-point test scores practically all show a step-wise improvement throughout the programme, i.e. they stand between the starting scores and the end-point scores, or in a few cases they are equal to or slightly above the end-point scores, indicating that the latter cannot be put down to end of treatment euphoria.

These results give reason to suppose that something is changing in a positive direction in the outlook of programme clients, most strongly in those who complete the programme and graduate. Again assuming that the measures have some construct validity, participants have an improved self-image, feel more confident in their ability to remain drug or alcohol free, and experience particular improvement in mental and physical health, meaningful activities and social support.

In a study of people in recovery from heroin addiction in Glasgow, Best et al. (2012) found that “greater engagement in meaningful activities (*as measured by the ARC*) was associated with better functioning, and was associated with quality of life, followed by number of peers in recovery in the social network.”

3.8 A realist approach: introduction

At SHARP some of the changes which other research has shown to be associated with successful recovery seem to be making an appearance with some consistency. The purpose of the present research is not to determine how these changes predict longer term outcomes, but to identify mechanisms by which these changes come about, and the contexts which facilitate or constrain them. The research is conceived and analysed from a realist position. The conceptual framework will be laid out in detail in the next chapter. Whether it is appropriate to describe the position as *critical* realism is open to question: the approach was chosen partly in order to critique received knowledge in the addictions field, practically all of which derives from a positivist, hypothetico-

deductive body of research. Even the current, very marked, interest in the 'mechanisms' of psycho-social interventions has tended to produce research in which more sophisticated models of statistical analysis (for example, lagged mediational analysis) have shown that certain variables mediate or moderate outcomes. This is interesting and important work, but from a realist point of view, mediating variables do not constitute mechanisms (though they may be important empirical pointers), and moderating variables likewise do not constitute contexts.

Two simple illustrations may be given: there is a clear and robust relationship between 'retention', i.e. staying in an intervention for a sufficient length of time, preferably to completion, and positive outcomes at follow-up (e.g. Simpson, Joe & Brown 1997). It is not difficult to imagine various reasons for this finding. However, the retention itself, no matter how strong the statistical association with the outcome is, cannot be taken for the mechanism: if this mistake is made, as has indeed happened, inducements may be made to encourage clients to continue in treatment when they would not have done without these, or clients who for example have shown failure to respond, perhaps using drugs on the unit, would not be discharged as they would have been normally, in order to increase the retention rates. And yet the outcomes may turn out to worsen, as the mechanisms which are responsible for the association are not activated in these cases, and indeed the continued presence of these clients on the unit might have a deleterious effect on morale and thus on the effectiveness of treatment for the other clients.

Kelly et al. (2011) found that for a large group (the "more impaired, aftercare" group) of alcohol dependent patients in a large research study known as Project MATCH, spirituality/religiosity was a significant predictor of good drinking outcomes in Alcoholics Anonymous. Once again however the "religious status" and "spiritual practices" that were measured cannot in themselves be taken for the mechanism, as the cultural context of religious belief and practices to this set of people in North America in the late 20th century, and what these attitudes and behaviours mean in terms of personal agency has to be taken into account.

The following chapter will attempt to justify a realist approach, in particular to defend the proposal that causality is real, that there are causal mechanisms at work which cause the outcomes of a psychosocial treatment, and that those mechanisms are best understood as changes in the 'internal conversation'. I will argue that the internal conversation is also 'real' and has causal powers. The conceptual framework that guides the research will be laid out.

Chapter 4: The conceptual framework

4.1. What is realism?

The term realism has been used to refer to a wide range of philosophical positions. In fact there are so many disagreements amongst 'realists' that despite it being perhaps the dominant approach in contemporary science (Baert 1998), Leplin (1984) has commented that "scientific realism is a majority position whose advocates are so divided as to appear a minority". In recent decades a particular form of scientific realism has come to be taken much more seriously in philosophy, for example in the work of W.C. Salmon and Hilary Putnam (see Boyd 2007). The main tenet of realism in this sense is that there is a real world made up of entities whose ontology is independent of our understanding of them. A corollary of this is that scientific theories are referential: they refer to real things which exist independently of the theories and their concepts. Realism in the social sciences claims that not only are physical objects real, but also social and cultural entities are as well. Mentation (taken to include meanings and intentions) is also a real phenomenon. The ways in which the mind-body problem is dealt with varies among philosophers: Putnam (1999) rejects both physicalism and dualism, upholding both the reality of mental processes and the reality of physical entities but proposing that different conceptual perspectives and vocabularies are required to understand them.

Realism of this kind restores the importance of ontological questions and rejects the 'epistemic fallacy' of constructivism that conflates ontology and epistemology. It defends the coherence of combining ontological realism with a constructivist epistemology. Realism is not objectivism, it does not hold that there is any objective certain knowledge, one single correct way of knowing about what exists, it is possible to construct more than one 'scientifically correct' way of understanding reality (Lakoff 1987). As Putnam (1975) says, the best scientific theories are (at least) approximately true, and this approximate truth is an adequate explanation of a theory's predictive success. Putnam's point is that without a realist ontology and theories that refer to real things, the blatant success of science would be a miracle (Chakravartty 2015).

4.2. A realist research programme

The main implications of a realist position for this research are ontological, epistemological and methodological.

1. That there are real processes going on which cause the changes that occur in treatment, and that causality is legitimately understood as being produced by generative mechanisms that are activated in certain circumstances. These mechanisms are not usually directly observable and entities (including social structures, cultures and agents) possess causal powers independently of whether they are actualised. These mechanisms may be described and understood. This ontology is in contrast to the “successionist” understanding of causality, by which all we can know of causes is the observation of constant conjunction, and which underlies quantitative, statistical research in the positivist paradigm.
2. That it is possible to create a (fallible but approximately true) explanatory model of how these processes operate using a conceptual framework, for example by supposing that the changes result from the interplay between the culturally emergent properties of the treatment programme and the personal emergent property of the participant’s internal conversation, and using the research method to focus on the local, contextual mechanisms.
3. That culture and meanings are real (Maxwell 2012, Chapter 2) and diversity is real (Maxwell 2012, Chapter 4). Maxwell argues persuasively that culture (which he and Archer understand as ideational, i.e. consisting of beliefs, values, conceptions) is not something that is shared equally across members, but rather has ubiquitous, marked diversity: culture is a “distributive” knowledge system. This is an important point for realist research as it points away from expecting a simple unifying mechanism or set of mechanisms and from assuming that all members of a treatment or recovery community ‘think the same way’. A related consideration is whether solidarity is based on similarity or contiguity (or both), in other words does solidarity emerge from people recognising and

stressing similarities rather than differences, or from the development of interaction between people through which they come to know and care about each other independently of similarity. Maxwell reviews the history of these contrasting ideas about solidarity, and argues that although similarity and contiguity are both sources of solidarity, contiguity “in conjunction with difference, can create complementarity and thereby generate solidarity that is compatible with heterogeneity” (Maxwell 2012 p.60). Since previous research (into social networks), theory (identity, group cohesiveness), and the SHARP programme handbook (belonging, developing interpersonal relationships) all suggest that solidarity in some form will be implicated in the mechanisms of change, it is crucial not to foreclose on the idea that this may be compatible with diversity.

4. My own positioning vis-à-vis the research crucially needs to be included and the effects of my professional knowledge and status in relation to access to participants (clients and staff), to the interviews and field observations, and to the analysis of material, requires careful handling. However rather than seeing researcher subjectivity as solely a source of bias, and something to be rigorously eliminated from the research design, from a realist perspective researcher knowledge, beliefs and dispositions may be considered valuable resources, which can add skill and subtlety to the research activity and add to the validity of the conclusions. Of course, subjectivity is not entirely ‘virtuous’ (Glesne & Peshkin 1992, p.104), and great care must be taken that the researcher’s prior motives and commitments (which inevitably play a large part in shaping the research programme) do not distort the research process or pre-determine conclusions.
5. The analysis of the qualitative material gathered needs to be able to describe connections and relationships as well as themes and categories. It is likely that this ‘connecting’ analysis (Miller & Maxwell 2012) will run alongside a ‘thematic’ analysis. Miller describes (op. cit.) how in her own research into adolescent friendships her analysis became a series of iterative moves from categorising to contextualising

strategies as her first coding and construction of categorical matrices did not capture what was critical in the temporal, narrative accounts she was collecting. Likewise, the description of mechanisms in this research cannot avoid the temporal and contextual aspect of change.

4.3. Mechanisms of behaviour change

The realist idea of the causal mechanism goes beyond a Humean perspective on causality, or at least the perspective attributed to the “Old Hume” as the recent Humean debates have it. Hume makes very clear in the *Treatise on Human Nature*, Book I, Part III, Section II, that there are causes connecting events, but in the traditional reading of his position on causality he is taken to hold that not only is it impossible to know about causal connection other than through the subjective impression of repeated conjunctions of events, but that it is incoherent to make any kind of statement about necessary causation beyond regularity of conjunction. In recent decades certain philosophers have proposed a “New Hume” who is supposed to have entertained the possibility of “thick” causal connection, that is to say an acceptance that there are real causal powers connecting events. This reading of Hume makes him into a species of realist, but since his arguments are taken to imply that humans cannot grasp such real causal powers by means of an idea, the label of ‘sceptical realist’ has been applied to him (Wright 1983). The debates about how to read him are complex (e.g. Blackburn 1990, Millican 2009) but the issue at hand is not what Hume held, but whether theoretical terms and concepts “carry with them any ontology” (McMullin 1983).

The position of this thesis is that there is a fact of the matter as to whether X caused Y, and that this applies to social as well as to physical causation. Moreover, it is regarded as coherent that the process by which X caused Y may be described, even though it may not be observable, and that such a process may be referred to as a social causal mechanism. The description is such that the way the mechanism operates is (partially) understood and that it provides an explanation for the occurrence of Y and some predictive power that if X occurs within a comparable context such that the causal mechanism is activated, then it is likely, or at any rate possible, that Y will ensue as a result of

X. A description of the context must add explanatory power, that is, it specifies why the mechanism was activated or not.

Jon Elster defines mechanisms as “frequently occurring and easily recognizable causal patterns that are triggered under generally unknown conditions or with indeterminate consequences.” The reason why he defines them in this way is to contrast them with scientific laws, whose conditions and consequences are clearly determined. In his view there are few or no such laws in the social sciences, but he sees mechanisms as intermediate between laws and descriptions or narratives (Elster 1998, p.45). Elster’s definition is relevant to this research as he is committed to the programme of methodological individualism, that is to say that social phenomena are explained essentially by the behaviour of individual agents (Elster 2007, *passim*). The search to identify and explain social mechanisms therefore legitimately starts with an attempt to explain individual action. The realist position is somewhat different: while it is committed to the idea that human agency is the only efficient cause of social phenomena, this does not by any means imply what Archer refers to as upward conflation, that is to say, the claim that social phenomena *reduce* to individual actions, that individuals are all that count, that “there is no such thing as society”. The agents that this thesis wishes to recognise and whose sense of self is “ontologically inviolable” (Archer 2000, p.2) are neither “Modernity’s Man”, the rational *homo economicus* whose relations with the world and whose normativity and emotionality are unaccounted for, nor “Society’s Being”, the social constructionist person *as site*, whose human qualities are simply the gift of society and whose selfhood reduces to a “theory of self which is appropriated from society” (Archer 2000, p.4). The frame of this research, and the one within which the concept of causal mechanism is intended to be understood, is essentially Archerian.

In particular, the predicament of the addicted person might well be illuminated by Archer’s insistence that personal and social identity are vitally informed by our ultimate concerns and commitments: many people entering treatment are aware that their identity has been in some way undermined and that in particular the things that they used to care about and the commitments they

might have once had have seem to have evaporated. They have had a tendency to dismiss care, concern and their associated emotions as unimportant and transitory. And Archer claims that such a repudiation is destructive both of solidarity of self and solidarity with others. This helps to clarify both the isolation and the passivity of the addicted person prior to the initiation of change and recovery. We can see the process of recovery initiation as developing enough care and commitment to be active in making things happen. As Archer says:

“The reflexive turn towards inconstancy would effectively make us passive: our instant gratification may give the illusion of hyperactivity, but we would not care enough, or long enough, about anything to see it through. There is a default setting on the human being: if we do not care enough about making things happen, then we become passive beings to whom things happen.” (Archer 2000, pp.2-3)

In the case of a highly stigmatised and destructive dependence to alcohol or illicit drugs, simple desistance is not an adequate outcome for success: a new way of living involving an adjustment, or transformation, often radical, in relationships with others and with oneself is required to produce recovery from the devastating effects of the addiction. So what this research is attempting to investigate is the causal role of an intervention based on individual counselling and group therapy in producing these types of outcome.

And, although it is beyond this programme of research to demonstrate, the process is properly morphogenetic. That people are agents capable of transforming themselves is a condition of the morphogenetic process, and they do so in the context of an evolving and transforming social reality, on which their own transformations are dependent and to which they are creatively contributory. As addicted people recover (in the sense of transformation) they also create the community of recovery, a community of practice that changes the conditions both for their own transformation and those of others following on.

Pawson and Tilley claim that in general the mechanism of behaviour change that accounts for the degree of success or failure of an intervention is a change in the reasoning of the participant. Many examples are given in Pawson & Tilley

(1997), Pawson (2002) and Pawson (2013). The idea is that the behavioural choices of the participants follow largely from their reasoning about such choices for example in terms of desirability, function, position among alternatives and so on. There are various important factors which impinge upon such reasoning, some of which are social or cultural in origin and some derive from the individual's biological and psychological situation. Both of these are expected to be of importance in an adequate explanatory model of change in an addiction treatment programme. An illustration of a cultural factor might be that certain reference group rules might constrain choice: for example, if it is important not to lose face or to conceal one's vulnerability this will affect behavioural choices. If 'being addicted' implies to some extent that a person has unconscious attention bias to cues for drug use, as a body of research evidence indicates, then this bias will impinge on behavioural choice as well, and indeed can be shown to subvert 'rationality' and conscious decision making. However it is clear that under certain conditions a person may reliably persevere with a new behavioural choice despite such constraining factors being active. The constraints are not deterministic of outcome, and neither are facilitating factors. The ability of people to desist from chemical dependence (whether to nicotine, alcohol, heroin or any other drug of dependence) despite adverse social circumstances and despite the persistence of craving, attentional bias or other psychological or biological concomitants is attested to by myriad examples, and conversely the failure to emerge from addiction despite superficially favourable conditions is also extensively evidenced.

4.4. What are mechanisms exactly?

Although I have so far mentioned the kind of thing a mechanism in this research might be, that is, a change in a person's reasoning in a stable enough fashion to produce a reliably different pattern of behaviour, and have hinted that in order to do this the change in reasoning might have to imply or produce a change in a person's ultimate concerns and commitments, to explain exactly how this might occur or what it might mean for such a thing to occur it is necessary to explicate a more precise and elaborated concept of a mechanism. It will also be necessary to justify the level of analysis required for a useful explanation, and to show that the level of analysis possible using the methods of this study reaches

such a criterion. The aim of the study is add some quantum of explanatory power to what is already known of mechanisms of change in recovery from addiction.

It is clear that, for instance, analysis of such mechanisms at the level of the neuronal changes that might occur in the brain of a person in treatment concomitant with the changes in their reasoning is a long way beyond the scope of this study. And indeed it is not clear that such an analysis would be actually useful in explaining the process. It might be useful in understanding how biologically based craving, attentional triggers or other neuropsychological processes might be implicated in producing a context which makes such changes in reasoning more or less resilient, and commitment to behaviour change more or less certain, but for present purposes such understanding will perforce be bracketed off and remain in the hypothetical realm. That is to say, such factors may be included in the explanatory model as hypothetical contributors but their precise role and quantity of their contribution will remain unknown. To what extent access to mechanisms like these is possible through subjective report will be considered in more detail in the chapter on method.

Conversely, analysis at the level of broad social or psychological concepts such the social network or self-efficacy, to name two of the most consistently observed mediators of recovery outcomes, is inadequate to explain how change occurs in an individual or in a group of individuals. Even a measurable increase in such an apparently individualistic characteristic as 'self-efficacy' leaves unanswered exactly what such a change involves, how it comes about and how it exercises its effects. Part of the problem here is that what are referred to as mechanisms are really a kind of measured input that is correlated with an output and as Bunge (2004, p.201) comments, "observable inputs and outputs . . . explain nothing." So if we know that a change in social network predicts more abstinence, we are left with the task of conjecturing the mechanism by which such a change produces such an outcome. In all such cases there is a range of possibilities, for example associating with other people who present themselves as committed to abstinence (as is the case when attending Narcotics Anonymous or Alcoholics Anonymous) might build and strengthen commitment

in the person. The goal of remaining abstinent takes on a value based on one's identity as a 'recovering' person. Alternatively, the mechanism might be one of 'role modelling', or of providing alternative activities during the periods when drugs or alcohol were previously consumed. There are of course various other possible and plausible mechanisms. Bygstad and Munkvold explain that the aim of realist research is to identify a key mechanism which has the strongest explanatory power, but because, as Maxwell cogently argues, "diversity is real" (Maxwell 2012, Chapter 4), it may be that a number of 'key mechanisms' will have to play their part in an adequate explanatory model.

It might be asked what level of grain is required to provide a useful explanation. So, for example, if the mechanism under consideration is the evolution of identity and commitment as a result of group membership, would it not require a certain attitude of trust and respect towards the group to bring this into effect? It certainly might be hoped to specify the conditions under which this might occur and perhaps those which might prevent it or inhibit it. The question then arises: is this trust building part of the context or part of the mechanism? It is proposed here that those components which make up the process of change in reasoning (that is processes that are internal to or relational to the person who is changing) are part of the mechanism. There may be mechanisms which are countervailing and also internal or relational to the person, as well as those that impinge on the person's behavioural choices in other ways, and these are considered part of the context.

Illustrations of these provide clarification: the internal process is characterised by reflexivity or the internal conversation, as Archer calls it. So a person might, as a result of feeling accepted into a group and feeling a sense of belonging to the group, be more committed to acting in accordance with a particular set of values. The trust and belonging shore up the person's resolution. The way this works is via a change in the internal conversation, and what brings this trust and sense of belonging into being is the attitudes and behaviours of the group members and the person's response to these. All of this constitutes the content of (this particular) mechanism that results in robust behaviour change. Examples of countervailing mechanisms which provide context are loyalty to the

old crowd (of drinkers/drug users), craving conditioned by places and situations, restricted opportunities compared to one's peers by virtue of having, say, a long criminal record or concomitant mental health problems. There is a wide range of these possible contextual mechanisms and they will have a varying effect on the change mechanism depending on their strength and salience. Some of them are constraining but some are facilitative. All of these have their effects as processes not as entities: it is not the criminal record per se that is the constraining mechanism, it is the effect of the record when a person applies for a job or wants to volunteer, as his or her friends are doing, and the result is a rejection. Again this mechanism acts as a constraint on the change mechanism by means of the internal conversation: "I am damaged goods, what is the point of remaining sober? I am going to go and use!" And this particular mechanism (because it works through the person's reasoning) may be active in actualisation or in anticipation, in other words a person may assess themselves as disadvantaged or even hopeless and pre-empt failure by discharging themselves from treatment.

These paragraphs point up what Bunge wishes to make clear: that mechanisms are processes in systems (Bunge 2004, p.183). Mechanisms are not made up of "entities and activities" (Machamer, Darden & Craver, 2000) but are processes that go on "in material complex things not in their individual components" (Bunge 2004, p.183). Archer's internal conversation is indeed an internal and private process, but it is that which mediates the relationship between the social and the person, and I hope it is clear that the changes outlined above all involve systemic processes. Society is an open system, not in the positivist sense of having a host of uncontrollable variables, but because it is "necessarily peopled" (Archer 1998, p.195). People as creative agents are capable of "resisting, repudiating, suspending or circumventing" (ibid.) society's tendencies. Archer's point is that the relationship between societal forms and the agents that people it is mediated, and that this mediation is bidirectional.

On the one hand society's structures have power in the sense that they shape the situations in which people find themselves. These structures emerge from the prior interaction of agents and "the results of the results of that

interaction” as Archer says, pointing out that as such they are dependent on (past tense) activity but not reducible to current (present tense) practice. This is crucial in maintaining the ontological independence of structures and agency.

On the other hand, according to Archer these structural powers do not have causal efficacy directly in relation to human agency. They exert causal power in relation to human projects (a crucial Archerian concept). So as human agents formulate through their power of imagination how they would like things to be, these projects, which can be anything from arranging one’s personal physical comfort to transforming society, are enabled and constrained by the social and cultural structures they encounter. The process of the internal conversation is an interior dialogical reflection, emerging from a person’s concerns, as she encounters the social powers that shape her environment. Archer claims, and I agree, that this reflexivity has causal powers “for the delineation of our concerns, the definitions of our projects, the diagnosis of our circumstances, and ultimately the determination of our practices in society.” (Archer 2003, p.130)

This is consistent with Pawson and Tilley’s claim that what explains the response of people to social interventions is how it affects their ‘reasoning’. Reasoning here is not to be understood in terms of ‘rational choice’ but is rather to be identified with Archerian reflexivity which fundamentally includes a person’s emotions. Emotions are conceptualised as ‘commentaries on our ultimate concerns’, in other words we feel an emotion when we are faced with something that we care about, that matters to us. The position taken here is that emotions are central and indispensable to human experience and that as Elster says (cited in Archer 2000, p.194), a human being without emotions would have no reason for living “nor, for that matter, for committing suicide.”

Emotionally informed interior life, which Archer describes as an emergent property which creates personal identity, is of particular importance for any study of addiction, addiction treatment and recovery from addiction, as one of the most generally accepted ideas about drugs and behaviours implicated in addiction is that they are “mood-altering”, and moreover they are commonly believed to alter, usually by attenuation, emotional experience. If this can be

sustained as a theoretically valid claim, then it will help explain why people with a history of addiction frequently feel themselves alienated from their values and their emotional life (this needs to be conceptually separated from whether as a consequence of addiction people have or have not committed acts contrary to their own or society's values such as stealing or violence). There is a need for problematisation here, including defending a distinction between addiction as a human predicament and addiction produced as a neurological condition consequent upon exposure to drugs in, for instance, laboratory animals. A distinction should be made between mechanisms of in-the-moment resistance to temptations and mechanisms that work by building commitment to a particular identity, and both may be important in the explanatory model, and there is a relationship between the two: a person who is not engaged in the latter may well have less motivation to use the 'drug refusal skills' they have been taught.

4.5. Emotion, Identity and Commitment

It is clear that the experiencing and handling of emotion is of central importance in the modes of therapy characteristic of group-based intensive programmes such as SHARP. This is a tradition that runs very consistently through the historical precursors of such programmes. The founder of Alcoholics Anonymous, Bill Wilson, wrote in what was to become the main text of the AA movement that anger, particularly when held as resentment, was "the 'number one' offender . . . from it stem all forms of spiritual disease, for we have been not only mentally and physically ill, we have been spiritually sick" (Wilson 1971, p.64). A few pages further on (ibid. p.67), he claims that fear "touches about every aspect of our lives. It was an evil and corroding thread; the fabric of our existence was shot through with it." Vernon Johnson, founder of an influential alcoholism clinic in Minnesota, maintains that "the condition (alcoholism) could be accurately described in terms of a special kind of emotional distress that is found to be present in all of them (alcoholics)" (Johnson 1980, p.9). He characterises the goal of the group therapy at his clinic as "to discover ourselves and others as feeling persons" (ibid p.132).

Yet there is no developed theory of emotion and its role in human agency to be found in this literature, which is not aimed at an academic readership, but at those affected by alcoholism and those involved in helping them. Johnson, while explicitly claiming to be pragmatic and not theoretical (ibid. p.8), nevertheless sketches out a process by which the regular manipulation of mood with alcohol or other 'mood-altering' drugs is followed by an 'emotional cost' (ibid. pp.9-21). This entails not only the return of the addicted person to a painful feeling state, by means of a combination of something like an opponent process (Solomon 1980) and remorse at the undesired behaviour while intoxicated, but also the progressive erosion of self-worth and the increasing domination of self-hatred and shame.

Not only do Johnson's clinical observations and patient surveys support the idea that prior to many serious decisions to quit an addiction there is a cumulative build-up of crises whose combined impact rather suddenly breaks in upon the addicted person's consciousness (the so-called "rock-bottom"), but a variety of qualitative studies into the initiation of recovery from addiction reveal in the participants' narratives a point at which feelings of self-disgust or alienation became intolerable (McIntosh & McKeganey 2000, Koski-Jännes 2002). Participants often describe a process of emotional rediscovery linked to a transforming or emerging identity (Koski-Jännes 2002).

The issue of the relationship between emotions and identity, and their implication in personal and social identity projects will be discussed later. Before that it is necessary to propose an understanding of what emotions are and to link this theoretically to the remarkable emphasis on recognising, differentiating and expressing emotions in the therapeutic practice of treatment centres and counselling for addiction recovery. The realist understanding of emotions in this thesis derives from the theoretical work of Margaret Archer (2000), and John Greenwood (1994). It is worth explicating Archer's theory of emotions and the internal conversation in some detail, as it will be the central framework for analysing the data and for explaining mechanisms (i.e. not just giving them a descriptive label but showing the process by which they work). Archer defines human emotion as 'commentary on our ultimate concerns' (Archer 2000,

Chapter 6). As she says, this definition presumes that emotions are intentional, that is to say they are about something in the world. They emerge in the relationship of our concerns and the real world situation. The modification of emotion by the use of addictive behaviour is not an exception to this, but demonstrates how in addiction the concerns of a person become narrowed as do the situations that are of import to an addicted person. The philosopher Charles Taylor (1985, pp.48/9) remarks that emotions are “affective modes of awareness of our situation” and also speaks of the “import” of emotional responses – in other words emotions are not things that simply occur in a certain situation, but they arise out of aspects of the situation that “give grounds or basis for our feelings” (ibid. p.49). This is crucial for a realist, as opposed to a cognitivist, understanding of emotions as they do not simply arise from a set of established beliefs or appraisals, but they arise from a relationship between a person and an (ontologically) real situation. According to this account a person cannot simply choose how they feel independently of how things really are. Archer describes part of the inner dialogue as “about the relationship between our epistemology and our ontology” (Archer 2000, p.196). Additionally, the realist account recognises the active folding back of the emergent emotional commentary onto the constituents of the situation. In other words, emotions change things, they have emergent causal power.

Archer points out that we are all aware of an ‘internal conversation’ and that this internal commentary is ineluctably interwoven with our activity, it is not just descriptive but has a monitoring and regulating role as well. As she puts it “Life is always a predicament and never a spectacle, because we cannot shed our status as participants.” (ibid. Ch.6 p.193). And it is this internal conversation, according to Archer, that generates *personal* identity. In her analytical dualism, the internal conversation is a personal emergent property, in relationship with cultural and social emergent properties, which generate *social* identity. Neither reduces to the other. Emotion in this account is a critical constituent of the internal conversation, indeed its ‘fuel’, as emotions express what matters to us and without them nothing would matter.

If it is generally true that addicted people are altering their emotional response, then they are disrupting the internal commentary, perhaps by silencing or diverting part of the dialogue, which in turn becomes disconnected from the feedback from reality, which in Archer's account of non-addicted persons, shapes the emotional commentary, which causes changes to, for example, a person's goals and behaviour. The drug may work at the neuronal level, for example inhibiting arousal and thus reducing anxiety (a first-order emotional response), but as a consequence the second-order emotional processing (that is to say emotions as commentaries on our concerns, the human aspect of emotions) is also attenuated. The addiction experience itself produces concerns of its own, arising from real situations, not just withdrawal effects, but from effects on performance and social relations. The combination of emerging addiction-related concerns, which are amplified by the resort to addictive behaviours in response to the second-order emotional commentary as well as to first-order affect, with an attenuation of emotional response in life situations where it is required and the resultant dissolution or fragmentation of a person's concerns, could provide an explanation for the blatantly dysfunctional re-ordering of priorities, so typically and bafflingly observed in addiction. The end point of this is that nothing *matters* but the drug, which in one form or another is often remarked upon by addicted people or previously addicted people reflecting on their past experience.

So the habitual use of 'mood-altering' chemicals and behaviours is likely to disrupt both the emotional component of the internal conversation and the maintenance of personal identity. The various ways in which this occurs need to be explicated in order to present a coherent analytical frame with which to understand how a reverse process of transformation takes place.

This present study is aiming to identify mechanisms for this process (or the start of it), and in order to do this the steps suggested by Bygstad & Munkvold (2011) will be worked through. Steps 2 to 4 consist of identifying key components, theoretical redescription, and identifying candidate mechanisms. The next step is an analysis of the mechanisms in the context-mechanism-outcome form.

4.6. The relationship between emotion and identity

Theoretical redescription requires clear theoretical assumptions and this section, following Archer, will lay these out. First it is assumed that emotion emerges in the relationship between a person's concerns and the import of a real situation. These situations are in three orders: the natural order (body-environment relations), the practical order (subject/object relations), and the discursive order (subject/subject relations). Moreover emergent emotion can be classified as first-order and second-order: first-order emotions emerge from the person's encounter with ineluctable situations in the natural, practical and discursive/social realms, which are to a great extent givens (although we may be mistaken about them), second-order emotions emerge from our reflections in the internal conversation, which allow for re-ordering and re-prioritising or even remaking of our concerns, thus allowing a transformation of our emotional experience and permitting the maintenance, elaboration or transformation of our identity.

It is important to recognise that there is nothing automatic or entirely predictable about which emotions emerge, as they do so through the relationship between the situation and the person's concerns. So if we take social normativity as something we all encounter, it is possible to be differentially emotionally responsive according to one's particular concerns. One person may be ashamed of, say, failure to gain qualifications at school, where another may be indifferent, despite both being aware of society's standards in this area. Crucially the emergence of emotion in a person in the social realm depends on that person's commitments, and the extent to which a person comes to feel they belong to a social group, that they care about the members of that group, and become party to what Greenwood calls "certain arrangements, conventions and agreements" (Greenwood 1994 p.149). This is what Greenwood means by the intrinsically social nature of 'social emotions'. This is not a social constructionist account, as what are in relation are realities with causal powers, independent of our understanding of them, i.e. the arrangements, conventions and agreements are emergent properties that exist prior to the subject meeting them and which exercise causal efficacy over them (Archer 2000 p.217), although indeed causal

power may be exerted in the opposite direction as individual persons confront these pre-existing properties.

So a treatment programme, with its philosophy and practices, embodied in the actions of both the treatment staff and the group of clients, past and present, presents a micro form of what Archer calls a Corporate Agent, a local manifestation of broader based Corporate Agents, for instance in this case the charitable organisation which runs the programme, whose original creation 30 years ago was inspired by an international recovery movement. In the activity of the programme its causal powers emerge, and the aspect we are interested in is the power to transform clients' personal identity and to allow the emergence of a new social identity.

As was described in Chapter 3, Koski-Jännes (2002) points out that there are a range of possibilities in the way social and personal recovery projects are implicated in the move from problematic substance user to non-user. She postulates the idea that to the extent that one's relationship with oneself is problematic, recovery will involve a personal identity project, and to the extent that one's relationship to the social and moral order is problematic, recovery will involve a social identity project. Although there is some difference in the way Archer conceptualises personal and social identities, this is a useful framework for considering the predicaments of clients in the treatment programme. Archer insists that the development of personal identity (which is not the 'gift of society' but is based on the ordering of our ultimate concerns in the natural and practical as well as the social realm) is prior to the development of social identity, although social identity does affect the person in a dialectical fashion (Archer 2000, p.294). Koski-Jännes also cites Biernacki (1986) who, while claiming that identity issues are central to the attainment of recovery from addiction, says that resolution may occur by re-adopting an earlier identity, extending a current identity or by developing a new identity.

The observation by Granfield and Cloud (2001) that people with high levels of social capital who exited from addictions without treatment tended to base their identities on their current social role and to exclude the fact of their addiction or their exit from it in their self-definition, may be contrasted with the emphasis (to

at least some extent public) on being a 'person in recovery' that was previously characteristic of members of the 12 Step mutual aid societies, but is now extending to a wider 'recovery movement' exemplified by online communities such as 'Faces and Voices of Recovery', films such as 'The Anonymous People' (2013), and manifestations such as recovery rallies and organised walks. The purpose of these includes the promotion of a destigmatised, respectable identity for those in recovery, and at the same time offering the possibility of a role as a recovering person, a practice which may be adopted, a social group which may be committed to. Many of the members and participants of such manifestations have been through treatment programmes, and/or been members of mutual aid societies, so that there is a dialectical interplay between the personal transformation which might begin in a programme such as the one being studied, and the cultural manifestations whose emergent properties facilitate recovery at what Archer calls the level of Corporate Agency in her description of the acquisition of social identity:

"The 'We' represents the collective action in which the self engaged as part of Corporate Agency's attempt to bring about social transformation, which simultaneously transformed society's extant role array as well as transforming Corporate Agency itself. This then created the positions which the 'You' could acquire, accept and personify, thus becoming the Actor possessing strict social identity."
(Archer 2000, p.294-5)

This scope of this research does not allow for close examination of the history of identity development during a client's life, nor of how the transformed identity proceeds in its development during the years of recovery. Much of the literature on identity and recovery relies on interviews with people with a considerable period of time in recovery (in Koski-Jännes' case, at least three years and with a mean duration of 9.3 years). This research focuses on the transformations that occur during a three month treatment programme, attempting to identify the mechanisms that cause the transformation and the context in which these mechanisms are activated. In particular, how the internal conversation is altered by the experience of treatment, and how that is related to the development of a new identity.

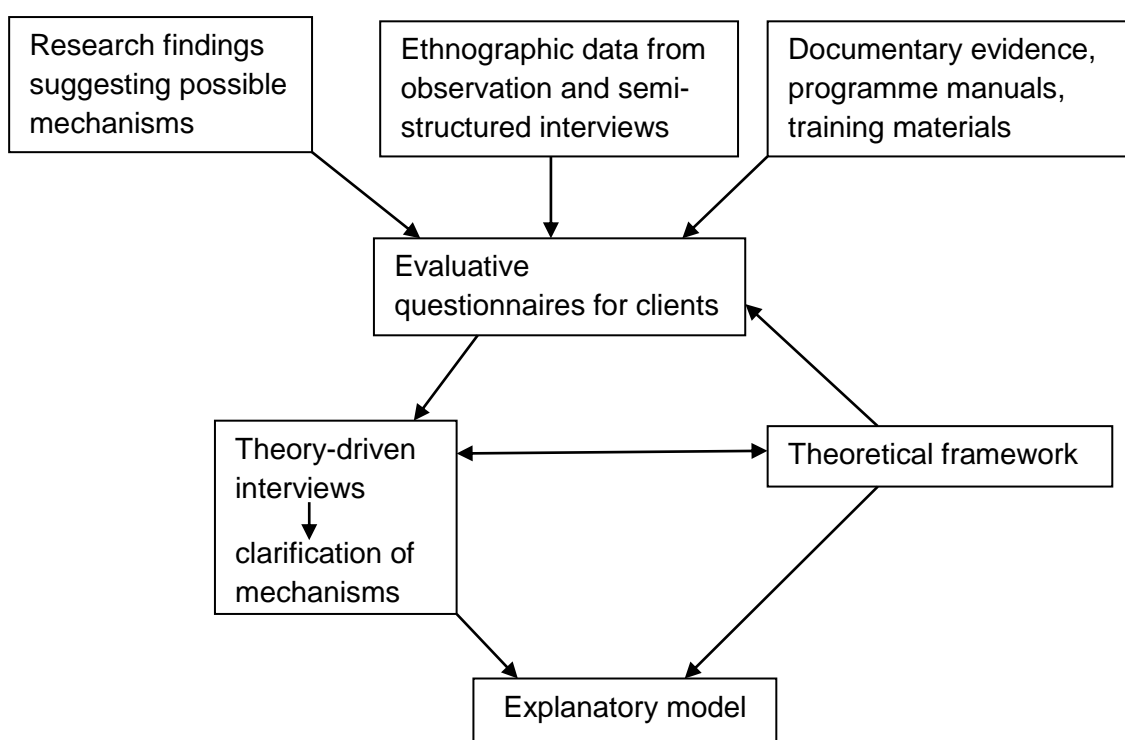
The next chapter will describe the proposed method and make an attempt to justify a close look at a small, specially chosen sample of people engaged in three related treatment programmes.

Chapter 5: Methodology

The aim of this research is to identify mechanisms underlying change for participants in a group based treatment programme for alcohol and drug dependent people. I will then attempt to create an explanatory model by synthesising what has been learned about the relationship between contexts, mechanisms and outcomes. Explanatory modelling in a realist paradigm is problematic: I will discuss some of the problems in this chapter and return to this issue when critiquing what the model achieves and its limitations.

Following a section on validity as it is understood in this research, the chapter will discuss my own positioning and consider how this affects the validity of the study, it will review the choice of settings, and the selection of research participants. Then the first phase field work and interview design and the material that these produce, will be considered, followed by the preparation for and implementation of the second phase 'theory-driven' interviews. A general outline of the study and the steps in the research process has already been given in Chapter 1, pages 24-26. I reproduce the diagram again here, together with the steps in the process:

Figure 5.1 Outline of research process (reproduced from Chapter 1)



5.1. Steps in the method:

1. Review literature on treatment process.
2. Conduct field observations and first wave interviews with clients and counsellors.
3. Review programme manuals and related materials.
4. Provisionally identify key processes, and categorise as contexts, mechanisms and outcomes.
5. Theoretical redescription of key processes.
6. Construct questionnaire and conduct theory-driven interviews.
7. Analyse the second wave interviews and clarify contexts, mechanisms and outcomes.
8. Create an explanatory model using the theoretical framework.
9. Present explanatory model in contexts-mechanisms-outcomes form.
10. Compare with alternative models.

5.2. Validity

"An account is valid or true if it represents accurately those features of the phenomena, that it is intended to describe, explain or theorise." (Hammersley 1987)

With Maxwell, I think there is reason to retain the concept of validity in qualitative research, particularly from a realist point of view. I have followed rather closely his views on the relationship between understanding and validity, and the issue of generalisability, laid out in Chapter 8 of his book (Maxwell 2012, pp.127-148). Realism of the kind espoused here certainly rejects a single correct version of the understanding of reality, accepting that our knowledge of reality always depends on theory and concepts: there is no possibility of an 'observer-independent' account of what we experience. However what Maxwell is arguing for is that there are "ways of assessing accounts that do not depend entirely on features of the account itself, or the methods used to produce it, but in some way relate to those things the account claims to be about." (Maxwell 2012, p.133). The words "in some way" are important here: he does not claim

that there is going to be a 'correspondence' based on similarity or mapping to an 'absolute reality' but there will be a relationship of contiguity, analogous to his distinction between similarity (themes) and contiguity (relationships, connections) when discussing qualitative data analysis. This, as Maxwell points out, is close to pragmatism: the validity of an account depends on the "implications and consequences of adopting and acting on a particular account" (ibid. p.133), i.e. it will in some way impact on reality.

Another important point is that validity does not inhere in methods. In positivist quantitative research, using the correct method is supposed to ensure internal validity, and this focus on methods and procedures allegedly to support validity has been taken into some influential texts on qualitative research (e.g. Lincoln & Guba 1985). However, it has been repeatedly pointed out (Brinberg & McGrath 1985, Philips 1987, cited in Maxwell 2012) that no method in itself can ensure true or valid conclusions. Shadish, Cook & Campbell (2002, p.34) state: "Validity is a property of inferences, it is *not* a property of designs or methods, for the same design may contribute to more or less valid inferences under different circumstances".

This does not of course mean that methods are irrelevant, but that the methods used to collect and analyse data must be of a kind that enables valid inferences to be drawn, valid accounts to be made, in the light of the context and purpose of the research. In the process of collection and analysis threats to validity must be identified and if possible mitigated against. In the following sections, each stage of the research process will be described, and in each case issues of descriptive, interpretive and theoretical validity will be considered (Maxwell 2012, Ch.8), as well as generalisability. As Maxwell says, "Generalization in qualitative research usually takes place through the development of a theory that not only makes sense of the particular persons or situations studied, but also shows how the same processes, in different situations, can lead to different results." (Maxwell 2012, p.141).

5.3. My own positioning and its use in the research process

This section will review my professional experience, the evolution of my research interests, my relationship with the organisation, treatment staff and programme participants. The implications of my positioning for the validity of this study will then be discussed.

For 30 years I have worked for a charity whose current instantiation runs both the treatment programmes I have chosen to study and the educational centre which I developed and of which I was director for over a decade. I have worked in a range of roles: counsellor and group therapist, trainer of counsellors, counselling team supervisor, leadership team member, developer of an undergraduate degree programme, undergraduate research supervisor, programme consultant, and research co-ordinator. Outside of the organisation, in the early 1990s I trained as a psychotherapist, worked part-time as an honorary therapist in the National Health Service in London, and contributed to the development of a model of psychotherapy. I have contributed book chapters and articles on psychotherapy, addiction and its treatment, and have peer-reviewed articles for journals in the field.

During this period I have maintained both an enthusiasm for the project of helping people deal with and emerge from addiction and emotional distress, and a perennial scepticism, puzzlement and inquisitiveness about the body of knowledge that informs the practice of addiction treatment and psychotherapy. The complexity and context dependence of approaches to the problem struck me immediately I started to work as a counsellor in a residential treatment centre, as did the dogmatic, and contradictory beliefs held about addiction and ways to respond to it by policy makers, commissioners and providers of treatment, workers in the field at every level, and people who use drugs/want to stop using drugs/have stopped using drugs.

The centre I worked in had recently opened and was one of the first of its kind in the U.K. Within a couple of years of entering the field as a counsellor, partly as a response to a perception that there was a lack of training and supervisory structures governing the work at the centre, I began to focus my own work on

the professional education of counsellors. The professional knowledge that was used to shape the work at the centre came from one counsellor who had completed a one year training programme in the United States at Hazelden, the famous archetypal Minnesota Model treatment organisation. His training had equipped him with competence in the 'core functions' of an addictions counsellor in the Hazelden mould, and he transferred this knowledge to the rest of us on an apprentice model. Most of the counselling team were members of Alcoholics or Narcotics Anonymous and several had themselves been through similar treatment programmes as patients. What was not included in our professional development was any knowledge of the historical or socio-political context of this kind of work, nor how it related to other approaches, nor anything about research. However, there was (fortunately) quite a pronounced emphasis on ethical practice, which was the source of the team's willingness to examine and modify the work in the direction of increased respect and humaneness. During a career spent attempting to build and encourage more formal professional structures to support more effective, consistent and thoughtful practitioners I have never ceased to be deeply interested in the relationship between contextual, improvised, spontaneous counselling activity, and formalised models of counselling which may prescribe and proscribe certain counsellor behaviours and utterances.

Currently I am a member of the leadership team of the charity Action on Addiction, and my main role on this team is to act as a strategic advisor to the team, particularly in regard to how research should inform practice and how we should evaluate our programmes.

As to how this background bears on the validity of this study, I will claim that my extensive experience allows me to make quicker and surer judgments about what is going on in treatment environments and activities. I also claim that my experience as a counsellor and psychotherapist coupled with my commitment to ethical practice enables me to build a relationship when interviewing a participant that is friendly, encouraging and focused (I will elaborate on this in the section below on interviews). Of course, my positioning brings potential threats to validity: as a senior executive of the charity which employs the

counsellors I will interview, I might be seen as an authority figure and participants might be cautious about what to reveal to me, but my reputation among the staff of Action on Addiction is as someone trustworthy, respecting of confidentiality and impartial, thus someone safe to confide in. Clients of the agencies tend to find me easy to talk to, unthreatening, interested in hearing about their experience and opinions. If my theoretical commitments engendered a desire that the research should turn out a particular way, that would also constitute a threat to validity. I would characterise my attitude as one of constructive scepticism, and in the research process, both while interviewing and observing and while immersing myself in and analysing the data, I will monitor my own interpretations and conjectures, willing to elaborate and revise my understanding as this process unfolds.

5.4. Power relations and validity/reliability of interview data

Despite the claims made in the last paragraph, it is clear that there is a large power differential between myself and my interviewees. I am a white, educated male with a high status position in the organisation that runs the treatment programmes. Many of the interviewees are vulnerable in that they are in crisis as a result of their addiction problem and most lack social capital in the form of education, social status and self-confidence. Both men and women find themselves facing a male interviewer.

Is there any evidence that my claims are justified and that effects of this power differential were in fact mitigated? Did clients feel free to express themselves and to collaborate with me in making sense of their experience? My own personal identity includes a strong commitment to egalitarianism, to equal opportunity and to gender equality. I believe that this comes across to the people I meet fairly quickly, but how can I sustain this claim?

I presented myself in fairly informal dress (open necked shirt, chinos) and made an effort to appear friendly, engaging in informal chats with participants, but avoiding detailed discussion of my research outside of the interviews. It was certainly my impression that people were not intimidated and were ready to speak freely to me, but this could be a result of placation. Several of the

interviewees commented at the end of the interview that they had indeed felt that I was easy to talk to and that they felt I was both trustworthy and appeared genuinely interested in them as individual people. Perhaps the most concrete evidence was provided by an email I received later. It happened that I was visiting SHARP Liverpool about a year after the interviews and I recognised one of the interviewees, Kirsten, who was working as a volunteer at the agency. I said hello and said that I would meet her later for a chat about how she was doing. I actually missed her and decided to leave a card apologising and wishing her well. A couple of days later I received an email that read:

“Thank you so much for the beautiful card and kind words, it was really nice to see you again, couldn’t believe that you remembered me, but really touched that you did, thank you so much for being part of my journey, I remember being really nervous just before our interview, you helped me feel at ease, safe and comfortable, can’t thank you enough.”

This message was reassuring to me, in that she remembered feeling safe. Our only meeting at the time of the research was the interview of around 30 minutes. It is certainly true that my own self-reflection during the interviews was concerned with creating an alliance and a feeling of trust and safety. I cannot demonstrate so clearly that the other interviewees felt the same, but all of them gave me a similar impression. The richness of the interviews also supports this intuition.

5.5. Ethical approval

Ethical approval for the research was obtained from the University Department of Education and from the executive team of Action on Addiction, the charity running the SHARP programmes. The research plan was evaluated for compliance with the Economic and Social Research Council (ESRC) principles of ethical research (ESRC 2010). Particular attention was paid to ensuring transparency, by fully informing participants of the purpose, methods and any possible uses of the study, using plain comprehensible English explanations. The fact that participation was voluntary and entirely confidential was made clear at several time points to prospective and actual participants and to counselling and administrative staff who helped co-ordinate the research. The design ensured that participants’ interview material would not be disclosed to

staff and that agreement to participate or not would not in any way affect the treatment that anyone received. Data collection, for instance audio recording of interviews, was transparent, with the recording equipment shown and demonstrated to each participant and the secure and confidential storage of recordings and notes explained. The interview and observation process was considered to offer low risk of harm to participants, but the researcher was in a position, as an experienced psychotherapist, to detect and handle sensitively any distress that might arise from the research process. Likewise the staff teams involved were all trained and experienced in ethical working, and are bound by codes of ethical practice, including the protection of confidentiality, treating people with sensitivity and without discrimination.

5.6. Data collection: Interviews

In the first phase of this research, field trips were made to the treatment programmes, and current and past participants were interviewed individually, as well as counselling staff. The purpose of this first phase is to collect material from which possible mechanisms can be suggested, in preparation for a second round of 'theory-driven interviews' in which the evolving theory of change may be elaborated.

Since the conceptual framework posits that a programme 'works' by influencing the client's reasoning (including emotions, and not to be confused with 'rational choice'), and in Archerian terms, modifying the 'internal conversation', which includes emotions, described by Archer as a commentary on our concerns, the interviews are the main source of data, being conversations designed to encourage and elicit reflexivity, and in which there is an opportunity to explore the client's emotional life as it unfolds in the treatment process. Field observations are useful a) in fleshing out the accounts of the interviewees (as they are observed interacting in groups and other activities, and b) perhaps more importantly, to provide examples of clients not doing so well in treatment, perhaps not being able to cope and possibly discharging themselves or being discharged prematurely. Observation of the events leading up to such a situation, hearing the client speaking in a group or hearing the counselling team discuss their views about them will allow some tentative analysis of why the

client was unable to respond to the programme constructively. Interviews with counsellors will also be used to elicit their views on why treatment is not successful for some clients.

5.7. What kind of data can interviews produce?

In chapter 10 of his book 'Realism, Identity and Emotion', John Greenwood makes a claim that was perhaps controversial in 1994 but is more widely accepted today. He says, and my agreement with him is critical to the validity of this study, that "one potentially very powerfully exploratory resource in the theoretical analysis of human psychology is the ability of human agents to provide accounts of their emotions, motives, beliefs and other psychological states" (Greenwood 1994, p.178.) He does not claim that such agents are "epistemic authorities on the causal explanation of their actions or modes of cognitive processing", else social psychological research into such matters would be redundant. He points out that people do "err regularly when advancing causal explanations of their actions" but this is not inconsistent with their ability to give reasonably accurate and reliable accounts of their psychological states (ibid. p.178.) Importantly, he thinks this ability derives not necessarily from any belief in the authority of introspection, is "not grounded in any form of 'direct access' to 'internal states' but derives from the intrinsically social nature of our self-knowledge". The working out of this claim in his chapter is an important underpinning of the current study.

Recently, Smith and Elger (2013) published a useful paper about the use of interviews from a realist perspective. They review a number of important theorists and methodologists both within and outside a realist tradition, including Holstein & Gubrium (1995, 1997) and Hammersley & Atkinson (2007). Their paper presents and synthesises a number of arguments about the role of interviews in knowledge production. The place of interviews in my research is critical to justify as they are a major source of data at two stages of the design. The early interviews with counsellors and clients will be mined for possible clues to mechanisms of change and the ways these are activated (or believed to be activated) by participation in the treatment programme. The second stage interviews are intended to be collaborative "theory-driven" interviews in which

participants will be invited to refine and elaborate the theoretical model being developed.

Holstein and Gubrium come from a constructionist tradition, but a great deal of what they have to say about interviewing is relevant to a realist approach, as realism accepts the socially constructed nature of knowledge, and most realists would agree that participants in an interview are involved in meaning making, and that interviews are a vital research tool to collect information about the experience of participants. Realism of course posits the existence of social structures which shape social action, and the analytical dualism of Archer requires an analysis of the acting subject as well as the structural powers facilitating or constraining such action. In Archer's theory the mechanism that mediates between structure and agency is reflexivity: "The subjective powers of reflexivity mediate the role that objective structural or cultural powers play in influencing social action and are thus indispensable to explaining social outcomes." (Archer 2007, p.5).

What this implies for the research process using interviews is that the interactivity of interview conversations produces reflexivity, or at least makes it manifest. The relationship between the internal conversation and an external one with another person is key here, for a person's internal conversation is also shaped by a layered ontology: our reflections are our own but they are not entirely free. The social structures bearing on the situation most proximally are those connected to the practice of academic research, and the practice of addiction treatment. So various forms of reflexivity are generated by researcher and participant in both private and shared forms: "I am carrying out a research interview not a counselling session, moreover it's for a PhD thesis, so what kind of conversation should I be having? How do I keep the interview focused? How can I introduce my perspective and at the same time not lead the interviewee?" The interviewee may well be thinking, "Here is someone who has come to talk to me as part of their research – what does that mean for me? How do I respond?"

Holstein & Gubrium (1995, 1997), writing from a social constructionist perspective, have useful things to say about the "active interview". They stress

that an interview (other than a structured one) is interactive, that it involves active drawing out, not passive recording: “Our active conception of the interview, however, invests the subject with a substantial repertoire of interpretive methods and stock of experiential materials. The active view eschews the image of the vessel waiting to be tapped in favour of the notion that the subject’s interpretive capabilities must be activated, stimulated and cultivated.” (Holstein & Gubrium 1997, p.122). In their opinion an interview is a particularly effective method for inciting “the production of meanings that address issues relating to particular [substantive] research concerns” (ibid. p.123). A skilled interviewer is able to help the interviewee focus on the research agenda and to articulate meanings without forcing interpretations on the respondent: “The objective is not to dictate interpretation, but to provide an environment conducive to the production of the range and complexity of meanings that address relevant issues, and not be confined to predetermined agendas” (ibid. p.123).

As realists, Hammersley & Atkinson (2007) consider the interview capable of generating both meanings *and* knowledge, albeit the partial, fallible knowledge of realism. These authors see interviews as the gathering of insider accounts giving access to information which would be hard to gather in other ways, and also producing “evidence about the perspectives, concerns, and discursive practices of the people who produce them.” (2007, p.99).

5.8. The first phase interviews

The procedure for setting up, carrying out, and analysing interviews was as follows:

The counselling team leaders at Bournemouth and Liverpool were contacted by email and telephone to discuss a convenient time for my visit. I had visited both agencies for short field observational visits on several occasions previously and had discussed with the counselling team the research I was conducting and inviting them to participate both as interviewees and as facilitators of client interviews. A “plain English description” of my study and a consent form was sent for the counsellors to read and to be given to the client group as well. I

requested that during my visit (five days at Liverpool and three days at Bournemouth) interviews would be arranged with clients who had been in the programme for at least three weeks and who would be willing to be interviewed, and with counsellors. During my visit I also asked to attend group therapy and other group activities and to sit in on team discussions about the client group.

In both agencies all clients and counsellors who were available during the week volunteered. This number at each agency was reduced by who was actually available on the interview days, as some had appointments or were absent for various reasons. Some volunteers had not been on the programme for long enough and thus did not meet the criteria. Within the time available, I was able to carry out six interviews with SHARP Liverpool clients currently on the programme, six with current SHARP Bournemouth clients, three with Liverpool counsellors, and three with Bournemouth counsellors. These were in fact all of those able to attend for interview on the days in question. In addition I was able to interview an ex-client from each agency, who had each completed the programme approximately two years previously. Each interview was preceded by a short conversation, checking that the interviewee had read the plain English summary and had signed the consent form. I ensured they understood the confidentiality of the interview and that they were free to participate or not without consequences to them or their treatment. I reminded them that I would like to hear about how they thought they were changing and how they believed the programme was helping them to change. I stressed the point that it was their honest perspective I was interested in, not an account they thought would meet with approval or would paint them in a good light. If they were struggling or thought the programme was failing to help them I wanted to hear about that. The interview would not need to continue for a fixed length of time, but I estimated that it might take between 20 and 40 minutes. All interviews were recorded on an Apple iPhone 4s using the Fire 2 recording application, with consent of each interviewee. The phone was placed in clear sight between us, and the interviewee could see me activate and switch off the recording. I explained that the recordings would be stored securely and confidentially and when no longer needed, they would be erased.

The interviews actually took an average of 26 minutes for clients (range 21-35 minutes) and 37 minutes for counsellors (range 27-52 minutes). The recorded interviews with clients began with me thanking them for agreeing to talk to me and reminding them that I would like to hear how they thought they were changing in treatment, and that I would ask them how they accounted for these changes. I encouraged the interviewee to continue speaking by making brief summaries to check understanding and to convey that I was paying attention to the interviewee, and further, I made it clear if the material they were giving me was useful ("That's the kind of thing I'm interested in! That's a vivid and clear example. Can you tell me a bit more about how that came about?") Also I made enquiries into what part individuals (fellow programme participants, counsellors) and groups (the client group, the counselling team) had played in the process of change. I encouraged the interviewee to elaborate as specifically as possible on changes of attitude, patterns of thinking and on their emotions, and how these produced new behaviours. On occasion I made reformulations or summaries in as accessible English as I could produce of the processes that I had heard them describe and offered them for confirmation or correction. I transcribed the interviews myself, and retained the recordings for repeated listening, for it is by attending to the pace, inflections and tone of voice, and the conversational dynamic (how I responded to what I had just heard and how the client responded to my contributions) that I intend to make an assessment of the 'authenticity' of the material.

In terms of descriptive validity, listening repeatedly to the recordings allowed me to check what had actually been said, taking into account that, particularly in Liverpool, the interviewees used a fair amount of local idiom in expressing themselves. The process of transcribing also required very careful and repeated listening. Having been part of the conversation, I was able to recreate indistinct phrases with confidence in a way that I believe a professional transcriber would not have been able to.

Interpretive validity is more problematic. In Maxwell's terms interpretive validity is to do with how well the researcher is able to understand the interviewees' meanings and frames of reference. In this situation at least three things

mitigated the threats to validity: my own experience in these settings and as a therapist has provided me with a sensitivity to a respondent's meaning, and the ability to discern when a person is speaking in their own voice as opposed to programme jargon or slogans (of course 'their own voice' is profoundly shaped by the person's cultural and social history, but the existence of individual, reflexive persons with personal identity and their own internal conversation is strongly defended here). The use of counselling skills in the interview, such as empathic responding, summarising, and paraphrasing, in order to check out my understanding also aims at increasing interpretive validity. Third, the proper preparation of respondents for the interview and the provision of a comfortable and private space for conversation maximised the likelihood that they would speak freely and openly. The interactivity and collaborative style of the interview and the transparency of the idea that we were making sense of things together also aided the production of a valid account.

The most difficult aspect of interpretive validity is to determine whether the same kind of expression (in terms of words used) from different respondents carries the same meaning, for example statements of intention to change or assertions that aspects of the programme are being beneficial. It may be possible to intuit from tone of voice or the way a person expresses something whether they are being more or less 'honest' or 'authentic' than another, but as far as possible such intuitions will not be relied upon on their own, but more substantive evidence will be adduced to support such contentions.

Consideration of theoretical validity will be discussed in the analysis section.

5.9. Data collection: Field observations

During each visit to the research sites I made observations of informal interactions, for example of clients arriving and meeting the staff in reception, making coffee in the dining area, smoking and talking outside, as well as observing group therapy sessions, life story sessions and skills workshops. In addition I observed staff meetings in which clients were discussed. When observing the informal interactions I often joined in the conversations, asking

clients how it was for them being on the programme, what had brought them here, or what was going on that day.

Each period of observation was followed by note taking in private (I did not take notes during the sessions themselves). These observations had two main purposes. First, to obtain triangulating or enriching data which can be combined with interview data. For example, an experience or significant event for a client might be described in a morning staff meeting, it might be part of the material brought into a group session, I might hear about it from the client's perspective in the interview with her or him, and I might hear the counsellor's perspective in a separate interview with them. Second, it was my main source of data concerning people who were not responding well to the programme. Such people, who are likely to drop out or be discharged, are less likely to volunteer to be interviewed. However, observing their behaviour in relation to their peer group and staff team, and hearing the counselling staff discuss the client's difficulties and proffer their opinions as to why this person is struggling, makes it possible to infer the context that is constraining the change mechanisms or is facilitating the mechanisms which sustain the problem (see Pawson & Tilley 1997 p.75). For in order to explain why a change mechanism is or is not effective we need to understand how its effect overcomes the 'sustain' mechanisms of addiction and its associated behaviours. Further evidence to help with this issue emerges from the interviews with counsellors who consider why some clients are not able to use the programme beneficially.

5.10. Analysis of first phase data

The analysis of the first phase data is designed to identify what Bystad & Munkvold (2011, p.5-6) call "the real objects of the case", and to redescribe the material within a theoretical frame. The data produced by these methods is very rich and 'thick' in Geertz's (1973) sense. Moreover conventional 'thematic' analysis is inadequate to produce what is required to identify the "key components", to subject these to theoretical redescription and to generate some 'candidate mechanisms'. What I am listening for are descriptions, inevitably partial, of processes involving relations. There is no necessity to analyse each interview in the same way, as each person has an individual account,

developed in conversation with me, and there will be a variation in the way change processes are described in terms of detail, clarity and coherence. Therefore a few key interviews are likely to yield more in the way of thick data than others. However, all of the interviews were subjected to the same process of analysis.

The first stage of analysis was preceded by listening several times to each interview and transcribing them. Most of the analytical process was conducted listening to the recordings of the interviews playing on a computer using the VLC audio/video playback software. This allowed easy re-listening to passages, the bookmarking of significant statements, and attention to the tone of voice, and the timing, phrasing and emphasis of responses. On several occasions this permitted clarification or correction of phrases that had not been clearly heard at transcription. Sections of transcript were annotated and a file of notes on each interviewee was compiled. Referring to these notes, I listened to each interview again, writing a summary of the passages which appeared to speak of contexts, mechanisms and outcomes, at this point refraining from labelling or categorising these. A considerable amount of the interviewees' transcribed words were included in these summaries.

These summaries appear in the following chapter (Chapter 6). The next stage was to consider how to categorise these accounts, and, having re-read them, I inserted brief tentative descriptions of the processes I was discerning. These appear in *italics* within the sections on each interviewee. These were conceived of as 'process components' in the proposed model of change.

These were tabulated in three columns for each interviewee (Table 7.1), further condensing them and assigning them provisionally as contexts, mechanisms or outcomes. Then a consideration was made about what kind of things these contexts, mechanisms and outcomes seemed to be. This was the point at which the phase 2 questionnaire was constructed (see below).

The notes on my field observations were analysed for examples supporting or augmenting the emerging change processes, and also for examples where

clients had met difficulties which led to them leaving the programme prematurely and where change mechanisms failed to be activated.

The interviews with the counsellors were subjected to a similar process of transcription, repeated listening and annotation, which resulted in summaries of what each counsellor said concerning their own theory of how treatment produces change. Three counsellors also gave their opinions as to why the programme is unsuccessful for some clients.

A process of theoretical redescription followed. The tentative key components were redescribed using the theoretical framework provided by Archer and Greenwood. This abductive process was intended to show how the evidence supported or failed to support a theoretical model of change.

The category of theoretical validity advanced by Maxwell (2012, pp.139-141) may be considered here. According to Maxwell theoretical validity has two elements: the validity of the theoretical concepts used as building blocks in the model, and the validity of the relationships between these concepts. Whether or not the relationships posited are coherent, are supported by the data, and do not involve large uncountenanced leaps which are not bridged by evidence or convincing argument, is discussed as the explanatory model is presented in Chapters 8 and 9. Further elaboration and clarification, using a new set of data, was sought in phase 2.

5.11. Phase 2

During phase 1 of the study, guiding the interviewees towards particular topics was deliberately and consistently minimised, and while I was making observations of the treatment programme I suspended to the greatest extent possible any theoretical preconceptions. While this allowed the phenomena under study to show themselves and to be described by the participants, it was not possible to focus sufficiently on the emerging tentative key components.

Following Pawson (1996) a number of 'theory-driven' interviews were conducted with six volunteer clients currently in the treatment programme at SHARP Essex, as well as three graduates of the programme. The procedure for

recruiting these was similar to that in Phase 1: consent forms and a revised plain English description of the study were circulated by the staff to all the people currently in the programme and to several graduates, resulting in 14 of the clients in treatment (out of 15) volunteering to participate, and three graduates also wished to participate and were willing to come to the centre to meet me.

All volunteers were asked to complete the questionnaire shortly to be described. They were provided with an envelope in which to seal their responses so that the staff were not privy to these. From the 14 clients in treatment, 6 were selected at random for interview (names drawn from a hat), and the three graduate volunteers were also interviewed. This selection was made for logistical reasons: there was limited time to conduct the interviews and conversations with six current clients and three graduates were predicted to produce sufficient material for analysis.

5.12. The questionnaire and phase 2 theory driven interviews

A questionnaire was created, again following Pawson (1996), from the process components identified in Phase 1. These component processes were encapsulated in item statements intended to be as clear and accurate as possible. They were arranged in three sections, corresponding to contexts, mechanisms and outcomes, and these sections were titled as such, except that instead of 'mechanisms', the phrase 'what creates the change process' was used. In response to comments from another researcher and from the treatment staff, the questionnaire was minimally revised before being circulated to participants. A copy of the revised questionnaire is presented in Appendix 3.

Participants were asked to score each item on a seven point Likert scale, and then to select their top three choices (independently of the scoring) in each of the three sections. An important point here is that the purpose of the questionnaire is to evaluate the degree of endorsement of the emerging theory, and to serve as a tool to develop a conversation with each participant about this theory. The theory-driven interview as described by Pawson is a collaborative endeavour designed so that participants can help the researcher elaborate an

emerging theory: “On the theory-driven model *the researcher's theory is the subject matter of the interview, and the subject is there to confirm or falsify and, above all, to refine that theory.*” (Pawson 1996, p.299, italics in original).

The 17 questionnaires received were analysed in a simple fashion to produce average scores for each item, to rank order these in each section, and to record which of the items were chosen most frequently as the top three. This latter procedure was not used in the Pawson study, but it was found useful as a cross-check on the consistency of responses, and to structure the interviews.

The nine interviews began with a review of consent and confidentiality, with a brief recapitulation of the description of the study, and a general inquiry into what the respondent thought about the questionnaire, how clear and how relevant were the items, and how easy had it been to respond to it. This was followed by an exploration of the top three items chosen by the interviewee in each section. In particular the interviewee was asked to explain how each of these items had ‘worked’ in their own case, with an emphasis, both in the instructions to the questionnaire and repeated in the interview, that what I was interested in was not whether each item was true, but to what extent it had contributed to the person engaging with, persevering with, and changing in response to, the programme. The interview concluded with an inquiry as to whether anything important had been missed. Although the questionnaire and interviews deliberately direct the attention of the respondent to components of the theory, and are thus inescapably ‘forced choice’, it would be useful to know if any of the participants had significant additions to contribute to the theory. Methodologically this is problematic and asking the interviewees if they had anything to add is the weakest aspect of the interview, as it is likely that after an intense discussion of the endorsed items, a participant might either to be unable to think of anything to add, or (perhaps less likely) to improvise something to say, just in response to being asked.

5.13. Phase 2 analysis and the development of an explanatory model

The analysis of the scores and of the interview material is presented in Chapter 8. The contribution of the interviews to the endorsement and elaboration of the

emerging theory was presented before a return to the underlying theoretical framework. Archer's concept of the internal conversation and the formation of identity projects was revisited, focusing on her description of a reiterating process of personal morphogenesis or morphostasis (Archer 2003, p.124). Her criticism of Vygotsky was rebutted and a modification of her process was suggested using a concept derived from Vygotsky (Leighton 2004, pp.92-93).

An explanatory model of change is presented, derived from the analysis described above, first in terms of the morphogenetic cycle proposed by Archer, and then in the Contexts-Mechanisms-Outcomes form recommended by Pawson & Tilley (1997, p.77) and Bygstad & Munkvold (2011, p.5).

The strengths and limitations of the model are discussed and its relationship to alternative models of addiction and recovery considered.

Finally, the contribution of this study to knowledge in the field of addiction treatment is discussed, together with implications for the training of counsellors and the improvement of programmes.

The following chapter presents the relevant data from the first phase interviews and observations, together with the preliminary analysis. It is important to note that the interviews have not been trawled for evidence supporting any particular theory of change: all data from the conversations pertaining to the process of change have been included in the analysis.

Chapter 6: Presentation and initial process analysis of the client interviews, triangulation with field observations, counsellors' theories of change

6.1. Introduction to Chapters 6 and 7

This chapter (**Chapter 6**) will present a considerable portion of the interview material. It is presented in some detail to ensure the richness and relevance of the interviews is conveyed. It seems very important that these respondents should be vividly presented as people. What has been selected in these presentations is any material in which there is reasonably explicit description of what might constitute contexts, mechanisms or outcomes. In these extracts, preliminary ideas about what might constitute mechanisms of change will be briefly included in *italics*. These were formulated after the extracts were selected. I have labelled these *process components*, bearing in mind Bunge's (2004) point that mechanisms are not entities or activities, they are "processes in systems". **An abbreviated sample of interview analysis is provided in Appendix 1b**

In addition, problematic or 'sustain' mechanisms will be tentatively identified, either from description of mechanisms that blocked change or facilitated relapse given by interviewees from their past history, or from interviews with respondents who seem to be using the programme less fruitfully, or from field observations of clients who are clearly struggling and discharge themselves from the programme. Field observations will be adduced to support, elaborate or challenge these descriptions.

In the following chapter (**Chapter 7**) a more structured presentation of the key components will be given, with examples from each of the interviews. These components will then be theoretically redescribed. The way in which the components are related to one another will be analysed in order to form sequential processes.

The chapter will describe how this analysis leads on to further retroductive work in Phase 2, including a questionnaire in preparation for a set of 'theory-driven interviews' at SHARP Essex (Pawson 1996).

The following table, **6.1**, provides a list of all the clients interviewed in the study. Phase 2 clients are included, although they are not presented until Chapter 8, as the table shows that the third group of interviewees diversified the sample by including more women and younger clients. Liverpool and Bournemouth are rolling programmes, Essex runs a cohort model, starting together.

Table 6.1: The Phase 1 and Phase 2 client interviewees (anonymised)

Name	Age	Gen	Problem substance	Time in Tx
Bournemouth clients (Phase 1)				
Robert	38	M	Alcohol	8 weeks
Anne	34	F	Alcohol	5 weeks
Philip	40	M	Alcohol, heroin	8 weeks
Keith	44	M	Heroin, cocaine, alcohol	6 weeks
Michael	36	M	Alcohol	10 weeks
Julian	38	M	Heroin, alcohol	3 weeks
Richard	36	M	Heroin, alcohol	1.5 years post
Liverpool clients (Phase 1)				
Jason	56	M	Alcohol	6 weeks
Charlotte	42	F	Alcohol	5 weeks
Francis	44	M	Alcohol	6 weeks
Simon	46	M	Alcohol	7 weeks
Saul	45	M	Alcohol, prev. heroin	8 weeks
Kirsten	42	F	Alcohol	3 weeks
John	50	M	Alcohol, cannabis	2 years post
Essex clients (Phase 2)				
Derek	52	M	Cocaine, alcohol	6 weeks
Libby	31	F	Alcohol	6 weeks
Molly	21	F	Cannabis, cocaine	6 weeks
Lucy	22	F	Alcohol	6 weeks
Martin	30	M	Cocaine, alcohol	6 weeks
Malcolm	45	M	Alcohol	6 weeks
Melvyn	47	M	Alcohol	7 weeks post
Laura	48	F	Cocaine	8 months post
Abbie	51	F	Cocaine, heroin, alcohol	2.5 years post

All interviewees are of White British ethnicity. This was true of all programme participants at the time of the research. The sample represents the age range and gender mix of participants.

6.2. Phase 1 interviews with clients: examples 1-7 from SHARP Bournemouth

(All names and potential identifying material have been changed. All extracts from the interviews are presented in the temporal order in which they occurred.)

Example 1: Robert (Bournemouth) aged 38, alcohol

Robert is a 38 year old man, who says he has been an alcoholic since the age of 17. He says he began to drink in a heavy binge pattern from the age of 14, and thinks he was an alcohol addict from 17. He describes his mother as an alcoholic, and says he recognised that he had a problem emotionally from the age of 8 or 9. During the last 20 years he says he has held down jobs while drinking but gradually lost relationships, contact with his family, housing, jobs, “I lost everything. I had nothing left; I had the clothes I stood up in and that was it”. He found this situation “very, very painful.”

Despite a lack of contact over the years, Robert was taken in by his family for detox: he felt gratitude and elation to be alive, leading to “a deep desire to change” and readiness to seek help. He felt ready for commitment (“I really wanted to make an effort”, “For the first time I really desperately felt I had to apply myself.”). He responded to the care he received from his family with “deep appreciation, love”. He had strong feelings of failure and unworthiness.

The interview with Robert provides a good example of a plausible account of ‘treatment working’. It also illustrates some of what Cartwright and Hardie call ‘support factors’, that is, other components of the set of causal factors that are required to set change in motion. I will argue that the mediator ‘negative affect self-efficacy’ (NASE) (Kelly & Hoepfner 2012) is relevant to this case and that the client’s account gives an explanation about how NASE is being developed and the reasons why it is necessary to develop it. This is discovered in a way very different (and complementary to) measuring NASE at baseline, making an intervention to teach coping skills, and then demonstrating by further

measurement any difference in scores. I will also argue that this case can be seen as an example of 'treatment working' as it is implicated in the development of a viable and relevant identity project, and that the changes described by the client both immediately before entering the programme and during the programme itself can plausibly be construed as part of the process of developing this identity project.

When asked to explain how he was changing in treatment he said he was moving away from "objectifying things", making an intellectual analysis (which he says is "a coping strategy for me"). He said, "I used to intellectualise everything: there wasn't any emotional connection". "I wasn't emotionally involved with people." "I am now slowly becoming more emotionally sensitive to other people", "I do get a reaction from other people and from myself, it's a slow process and uncomfortable at times".

Asked "how does this change occur?" he explained that he received consistent feedback from others in his treatment group that he did not open up to people.

Process component: Challenge from peers

He felt this was true, and he recognised that if he did not open up to others, they could not help him. He knew had to build trust in other people to do this. Robert was able to describe this process too: his disclosure of emotionally sensitive personal material when he read his life story to the group was responded to with identification. This produces "an emotional connection or bond" which "allows you to have the trust to open up more, I find." More opening up leads to more connection, more bonding.

Process component: trust built on an emotional bond, which is built on identification or recognition of their caring.

This also applied to his relationship with counsellor. Feeling her 'humaneness' (as a result of some self-disclosure on her part) increased his trust in her.

Process component: Trust/bond increased by recognition of the other caring.

Robert contrasts his ability to give astute feedback to his peers deriving from his intellectual analysis (“it could have come from a psychology textbook, but there wasn’t much of me in there”), and the genuinely caring communication that arises when there is an emotional bond (“It meant much more”). My interpretation of this is that it fits with the development of a personal identity as he begins to care deeply for others and feels their care for him. He feels more authentic.

Process component: Reciprocal care leads to feeling of authenticity.

As far as treatment activities that he thought were helpful, he mentioned that the drama group had built his self-confidence. As a self-conscious, under-confident person he had “let go” of his inhibitions and joined in, which he felt risked ridicule (“making a fool out of yourself”), but ridicule did not ensue, and he found a sense of fun, and increased confidence.

Process component: increased confidence.

Developing ‘negative affect self-efficacy’

Robert said “It is very uncomfortable for me to be with my emotions (as it is for a lot of people)”. “It feels raw, naked, vulnerable to expose my emotions to others. I have been hurt . . . and so it’s difficult to open up and make yourself vulnerable again.” He was able to describe the two ways he reacted to hurt feelings: he would withdraw and isolate, or put on a passive aggressive, sarcastic mask. Both of these states were associated with heavy drinking.

So, the ability developed in treatment to risk feeling emotions, risk showing these to others, and finding reward in emotional connection. This led to an increased confidence that emotions can be experienced and managed without resorting to drinking.

Process component: increased confidence.

I asked Robert if he attended the 12 Step meetings of Alcoholics Anonymous which are recommended (but not insisted upon). He responded quite forcefully that he did not. AA is not attractive to him. He doesn’t believe in a ‘Higher

Power' or in the existence of God. So he feels unable to adopt the belief system. He then said that he was exposed to AA as a child, as he grew up with his mother's addiction and involvement in AA, which he did not like as it seemed that his mother used the AA philosophy to dodge responsibility for the hurt he experienced as a result of her addiction. Robert did acknowledge that connection and social support were very important for him currently, but he got that from SMART mutual aid meetings, rather than AA, and from renewed family relationships and friendships in the local community. So it is clear that despite his aversion to AA, changing and developing his social network is happening for Robert. Although he was not explicit about this, I inferred that the change mechanism here was that as a result of attending SMART meetings and interacting with his friends and family, he felt increased acceptance in these relationships, and more like a useful participant.

Process component: change in social network: acceptance & belonging, active participation

This conversation led to me saying that "in a way we have reached the deepest part of the interview, as I would like to ask you what your deepest concerns are right now, what you care about the most."

Identity Project

Robert was able to respond to the question about deepest concerns with a minimal pause: "My immediate family who I care for, having received support, being able to provide that kind of support to other people, hoping to nurture both myself and other people, to try and gain the skills to enable me to live a long term, healthy, positive life, to somehow to get the potential talents in me out there, because I have a lot . . . I could give a lot to a lot of people. I am very bright and I'm very caring but I never had the emotional coping skills, yet, to express that." This statement confirmed the inference I mentioned in the last paragraph, and shows that Robert is thinking clearly about his future and the kind of person he would like to be. This project is modest and realistic: he does not have grandiose aspirations, nor is it drawn out too clearly and definitively. There seems room for surprise in the way his project will unfold.

Process component: Aspiration to support others, to be contributory, to be useful

I asked if he had a vision of himself in 2 or 3 years, and he said that he would like to “complete my Open University degree, to come back to that. I would like relationships, I do have some material ambitions . . . I’d like to have a flat again, to be able to pay the mortgage again, to provide for a family, to have a family.” These things are not yet actualised but they seem clear, meaningful and realistic.

Robert said that he feels like he is starting completely again “from scratch”. But if he maintains the changes he is making every day and applies what he is learning, “I am aware that I could have quite a good life”. This consciously connects the processes of change in treatment with his developing identity project.

Returning to the subject of emotions, I asked “Do you know what you are feeling? Is that something you are learning here? How does that work?” He replied, “It’s difficult for me because I do have disconnect from my emotions – over the years I’ve kind of become more and more disconnected from them, I’ve denied them, rejected them, not accepted them, buried them, suppressed them. And it is now trying to connect with them again, and yes I do find it difficult sometimes to know the emotions I am feeling.” “I get help with that here, and it is something I try to express more here.”

Process component: discovering what he cares about.

The remaining Phase 1 client interviews will be presented more selectively (a fully transcribed example is given in Appendix 1, together with a section showing the analysis). What is selected is intended to present what each person said about the specific change processes that were going on for them.

Example 2: Anne (Bournemouth) aged 34, alcohol

Anne has had previous treatment for her alcoholism but feels she is making more changes in the current episode at SHARP. The changes involve becoming

more patient and more open; she reveals her feelings and concerns to others rather than keeping them hidden behind a “happy face”. When asked why she is making these changes now, she attributes this to the fact that, “for the first time in my life there is something I really, really want – I would really like to become a paramedic and I can’t keep being a drunk all the time.” This provides a context for change that contrasts with those expressed in most other interviews, in which the predicament seems so dire that there is no alternative but to change, but where concrete career aspirations are not yet formed.

Process component: the development of a specific life aspiration.

Process component: becomes willing to reveal her feelings and concerns to others.

When asked how the changes are being produced, she described a dilemma concerning expressing things that concern or bother her. Either she bottles things up or she expresses things too aggressively. She feels that the anxiety engendered by both of these causes her to drink. She has been learning about these patterns in workshops on communication, and is practising new ways of expressing herself. However she speaks about this issue in the context of her relationship with her peer group in treatment: “we all identify with each other – we have group therapy which is very helpful.” She now talks about her concerns in group (unlike in previous treatments where she was quiet) and gets feedback in the form of the group members telling her “what they hear me saying, maybe how I’m coming across”, and also suggesting how she could communicate with someone she has an issue with “in a non-aggressive way but in a non-passive way as well.” Processing feedback involves listening to things that are “hard to hear, hard to take in”, but because some of the feedback is written down, she can reflect on it later and begin to accept its validity and usefulness. She said she has become more assertive and confident about expressing herself. This is reminiscent of John (Liverpool, Example 9) being “riled” at feedback from counsellor or peers, and coming to accept it later.

Process component: identification leads to a feeling of commonality/ belonging.

Process component: she receives challenging feedback from the group, she finds it hard to accept, but she reflects on it and begins to accept it.

Process component: she becomes more confident and assertive.

Example 3: Philip (Bournemouth) aged 40, alcohol, heroin

Philip came from a family of heavy drinkers. He remembers a crucial event in his emotional life when he was 10 years old: his mother abandoned the family, and Philip, watching his elder brother crying but not showing his own distress, thought to himself, "Nobody will ever do this to me again." He says, "This was a precipice and it became how I conducted my life." He suppressed his feelings with alcohol and later with heroin. His life became chaotic, with periods of unstable volatile relationships with women, homelessness and time spent in prison. He had completed a treatment programme some 10 years before this current one, and he contrasts the two programmes. In the earlier one he had become emotionally attached to his group, and had valued the cathartic experience of being emotionally open with others. But he had not addressed his conflicted feelings about his family, particularly his children.

He came to SHARP from a night shelter driven to seek change by desperation, having lost everything materially and in terms of family relationships. He says SHARP was different in its emphasis on examining the 'here and now' rather than the past. He gives a very clear account of the process that was helping him:

"At first I didn't see that, I constantly wanted to relate to things that were in the past." The groups concentrated on the here and now, challenging behaviours, but Philip commented he thought even more challenge was needed. "The way I deal with it is I bring my stuff in. I say what I think is going on. Some of my group members were quite aware, I was lucky. I wanted closure on something."

When asked what that was he says: "My self-pity, because I'd lost everything. I felt I deserved what I'd got. It was pointed out this was an excuse or justification for using. 'Woe is me and stuff'. I also talked about my children and got told how inconsistent I was. I didn't realise how profound that was (*it is clear Philip*

means the process of sharing and getting feedback). The two aware group members understood the treatment process and gave me feedback. My counsellor helped articulate the pattern, which was self-pity leading to using. It fitted for me.”

“I realised a lot of the thinking I had was not really true, was not conducive to a healthy way of living.”

Process component: revealing his feelings and concerns, he participates in the ‘here and now’ of the group and becomes aware of the benefit of that.

Process component: receives challenging feedback from the group (two of whom he particularly respects) and clarification from counsellor.

I asked Philip “How is that changing?” He said, “I’m in the art group, I see my art as integrally therapeutic. It was my outlet. It helped me move on from what I was doing. I liked it. The process here, how it works in here: I could see the dynamics, how difficult it can be – helping people to get back into a place in the here and now. With the creative stuff and finding an active role in society, whatever that’s supposed to be. I think I got that from here. It’s a therapeutic environment: group work is pretty integral, for me.”

Philip explains that the benefit of treatment for him was more about interaction, relationships and connection than learning behavioural skills, although he had derived some benefit from the cognitive-behavioural work. Philip stresses the assumption of responsibility. He says of his previous identity as a relapsing drug user who was sent to prison and became homeless, “I was negating my responsibility as a human being.” He says he is building a new identity based on taking responsibility. When asked what was needed in addition to the emotional work he did in the previous treatment he replies: “Self-belief, self-esteem. I get it from the art-room” (he emphasises *active contribution* not the emotional expressivity of his art work).

Process component: interaction, connection and active contribution leads to increased self-esteem.

Example 4: Michael (Bournemouth) aged 36, alcohol

Michael had been living an isolated life in a bedsit in Bournemouth, drinking, suffering from anxiety, avoiding people and with failing health due to his alcohol consumption. This led to a crisis (“I crashed very badly”) and he was admitted to hospital for detoxification and from there was referred to SHARP. His interview took place soon after he had completed the main SHARP programme but was still attending the Working Recovery programme regularly. He had some difficulty motivating himself to attend SHARP each day, but said that his mother had instilled in him a battling “don’t give up” attitude, which he used to combat his hopelessness and inertia.

Process component: encouraging internal dialogue challenges his tendency to give up on himself.

He had a difficult passage through the programme, involving some lapses back to alcohol use. Michael says that when he returned from these lapses, he was “accepted every time.” It was this acceptance that he says “made the difference, being believed in.”

Process component: experience of consistent acceptance

This is the principal transformative element for Michael as he sees it. It not only produced a recommitment to the programme that resulted in him completing it, but also produced an increase in his confidence. An example he gives is that he was trusted by the staff at Working Recovery to research and purchase printers for the photography lab. He felt that the staff believed in his ability to do this and he was further encouraged by the successful implementation of the printers.

Process component: experience of being trusted leads to increased self-worth.

Michael also said that he had quit previous treatment attempts after experiencing being bullied (psychologically) by other peers. This time he did meet someone he experienced as a bully, and felt an urge to leave in order to avoid them, but instead he was encouraged by his group and his counsellor to confront this person assertively. The feared outcome (being attacked) did not

occur, and this resulted in increased confidence and self-esteem. This incident was also reported by counsellor Joan in her interview.

Process component: encouraged by others to be more assertive and less avoidant, his confidence and self-esteem increase.

Example 5: Keith (Bournemouth) aged 44, heroin, cocaine, alcohol.

Keith has had quite extensive periods of being drug free in the last 10 years but has relapsed several times into active addiction and crime, leading him to serve his last prison sentence. He was released 2 months before starting SHARP.

“I came from prison. Doing treatment was part of my probation, so it was partly duress at first, in a way. But I have done quite a few bits of treatment anyway, and I think treatment ain’t going to work for you if you ain’t willing to be open-minded, and like, change and that. I think it just gives me the environment, er, and the setting, to er, explore, you know, what my make-up is, how I think and how I react, in those everyday situations, everyday emotional situations as well, and how I cope with that.

Process component: exploration and recognition of emotional responses to situations.

It’s taken me a couple of weeks to get involved, not so much with the process but to get to that transition, coming out of prison and starting in a treatment centre. It’s quite scary coming in where you don’t know anyone, there’s a process of, er, getting familiar so to speak.”

Process component: time to settle, and feel familiar with the treatment situation.

Keith finds the SHARP programme more flexible than others he has been on, particularly because of its day delivery (“you’re in and out all the time.”) which he finds unsettling, but Keith makes it clear that he is committed to staying clean, which helps him stay steady.

“I think most of the time I tried before, I always had some form of resistance, I’ve tended to challenge, kind of doing my own thinking around it, rather than

stop thinking about it, come in sort of like an empty basket, don't know nothing, and see what transpires out of that. However obviously your own personal experiences, your own logic and tendencies will always interfere, within the process, but I'm not trying to dictate that process." Keith had made a decision before entering the programme that he was going to get involved.

Process component: Prior decision to get involved, not to resist or argue with the process.

I asked him what he was getting clean for. "I don't want to use any more, the fun has gone out of it. It's painful for me and obviously I've got a daughter as well. And I have responsibilities. You know prison isn't a life. And when I had my daughter I wasn't using, I was clean and I never thought, at the time, that I would ever use again. But I've been using drugs for 30 years or thereabouts, and the way I lived my life you can't really do that socially, really."

Tim: "Who were you when you were using, what were you like?"

Keith: "I was lawless, I mean just lawless, I just did what I wanted to do to go and get my drugs, if it meant committing crimes or whatever."

Tim: "When you reflect on that person what are your emotions? What do you feel about that?"

Keith: "Well it's sad isn't it, really – (long pause) – I suppose, guilt and remorse, a bit of shame about that person because I know that I never had those values except in active addiction. It's not really me, I am the one who commits crimes and behaves quite anti-social, however I also have values and morals but I lose that when I use. I mean you have to or you're not going to be very successful."

Tim: "What's helpful here? What's working?"

Keith: "The structure. Don't get me wrong I have a lot of opinions about how it could be better and what I think is a load of nonsense! That's my reality I suppose. They also introduce you to the fellowships, like, you know, the Anonymous fellowships, and I go to Cocaine Anonymous and I have a sponsor and I work the 12 Steps you know, and I try to apply that. Which I suppose most

people in life have those values but because I've been using I have lost sight of those values and you have to be re-taught, don't you? I mean most people are kind and considerate and, you know, honest. Maybe I'm selfish to a degree, but not totally self-centred. And it's just about reversing that, I mean, being in an environment where you can do that, because, you know, you've got people with varying degrees of maturity."

Process component: re-establishing values

Tim: "You've been here six weeks. How do you think you will change in the next six weeks?"

Keith: "Not much I don't think. Because at the end of the day I've come to that place you know . . . In the last six weeks I've changed, so to speak. You know, my self-esteem was low, it wasn't great, but by going through this process I've kind of built my self-esteem up, by being honest and sharing how I'm feeling. I've always known . . . I live my life . . . I mean I've always had that kind of make-up where I'm not going to struggle trying to find a job or whatever – I kind of create my own job, I paint doors and stuff like that, it's just that at the stage where I was when I first came in here, that weren't going to happen, because I was too self-obsessed, because I wasn't feeling too good about myself. I've learned that if you feel ok about yourself, if you take care of yourself and if you try to be supportive of other people then your self-esteem kind of rises quite quickly.

Process component: Taking care of himself and supporting others in the programme leads to increased self-esteem.

So yeah my next four weeks is going to be about planning what I'm going to do next. I'm excited about that because I have things I want to do, but I can't do them now because I'm doing this and this is more important, more important than anything, more important than my daughter even at this minute, as if I'm not right . . . (*implying he wouldn't be able to be a good father if he didn't have a secure recovery*)

Process component: re-ordering of priorities in accordance with his 'ultimate concerns'.

“As far as where I’m going to live, I’m in supportive housing at the moment, and where I live is kind of dependent on how much responsibility I’m going to have to take for my daughter, so it has to be left kind of open at the moment. I’m going to have to really reflect. But being in a dry house, supportive housing, right now is good for me, because of my situation and because I’m on probation, there’s a lot more resources for me to draw on, so I’m lucky in that sense.

I met my probation officer yesterday, and we were talking about taking responsibility for my recovery as this programme is less structured and intense than some others, and I suppose I should be proud of myself, because I leave home every day and come here and then go home, whereas other people just can’t cope with that.”

Example 6: Richard (Bournemouth) aged 36, heroin and alcohol

The interview with Richard produced a consistent theme of developing self-knowledge. He had had a 15 year drug using career and was primarily motivated to change through his realisation that his interests were radically limited to drugs and money, that he had not developed as a person since his teens (he said he still had the same taste in music, and still dressed similarly; he had not had any kind of conventional career and compared himself in this regard to his successful younger siblings). He felt “empty, I was a husk really, that’s how I see it.” He went on: “Well, my rock bottom wasn’t when I was homeless or anything like that, my rock bottom was just looking at myself in the mirror, and actually looking at myself and saw, you know you were talking about identity, that identity thing, what I saw in the mirror wasn’t who I thought I was.”

Process component: commitment to change after recognition that his identity was seriously attenuated.

He describes a very limited emotional life. He said he always avoided feeling anything if he could. The main change in treatment was the rediscovery and

development of his emotional life. He learned to identify his feelings; he said the first feeling that he had in treatment was anxiety, and then anger. Later his repertoire of feelings widened to include affection and caring for himself and others. He said of his aspirations, "I just wanted to be a kind honest person, that didn't have ulterior motives, and, you know, wanted to help."

Process component: aspiration to have values and to contribute.

Richard made it clear that the changes came about as a result of his counsellor helping him to identify feelings and his peer group offering feedback and affirmation.

Process component: Experiencing and identifying emotions in group and receiving affirmation.

Example 7: Julian (Bournemouth) aged 38, heroin and alcohol.

Julian had been in the programme for three weeks when interviewed. He described how from the age of 11 to 37 "using drugs and alcohol suppressed my sexuality." He had a bad relapse after a period of abstinence, and lost everything materially. Feeling desperate he asked for help.

Before he relapsed he was able to build himself up when he came out of prison "with just a carrier bag". He started to do jobs for people, built a business and a family. "It felt amazing, fantastic". He has now lost it all, but says "it's a relief I lost it all, because now I can start sorting myself out."

He came into treatment "full of fear about meeting people", especially men. He is bisexual, and fears judgment or misunderstanding from others. He said, "I've got two ex-wives and four kids but my last partner was a bloke."

He is still anxious around new people but says "I feel safe here. . . it's like an air bubble, if you get what I mean." As a result of this feeling of safety he is beginning to trust but said "It's still early days and I still don't trust people completely but it's getting better".

Process component: increasing trust.

He said “Coming here and doing what I’m doing is giving me a bit more confidence back, which was smashed to bits after being on a relapse.” But it seemed too early in his treatment process for him to be specific about how changes were occurring.

Process component: regaining confidence (but not clear about change mechanisms).

6.3. Phase 1 interviews with clients: examples 8-14 from SHARP Liverpool

Example 8: Jason (Liverpool) aged 56, alcohol

Jason has a conflicted relationship with his wife, who also has a drinking problem. He has had a previous attempt to maintain abstinence from alcohol but found he could not while living with her, as the conflict (in his attribution) led to him resuming drinking: “I stayed three and a half months clean. Inevitably, I relapsed, thinking . . . - I mean I felt as though I’d got stronger, but obviously not strong enough not to relapse!”

So when he came into the SHARP programme on the advice of the staff, he had arranged to live in a flat separately from his wife:

“I brought it into SHARP and we had a chat and they said you need to put boundaries in place. So that’s what I did – I explained to her – I said ‘Look, I can’t do this while we’re living together and you’re carrying on drinking. I can’t do this.’ We both have a home – I have a flat and she has a flat. So she moved back to her flat.”

During the treatment period, Jason had some testing interactions with his wife. She came to his flat in the evening intoxicated, “ranting and raving” and making a disturbance in public. Jason’s customary emotional response in the past was to become angry in his turn and conflict would ensue:

“And normally, I mean – she took her coat off and she was like swearing at me you know, and I never made any . . . normally I would have . . . it would have led to violence, we would have ended up fighting.”

“If you look at past history, it was a very volatile relationship.”

So, one first order emotional reaction would have been anger, provoked by indignation at her aggressive behaviour. Jason still has first-order emotional reactions to this situation: he is embarrassed due to the public altercation, worried as he is not sure how she will behave or how he should react, and concerned, due to his affection and feelings of responsibility for her. However, he is able to rein in his usual response, eventually deciding to back away when she runs out in the road in a dangerous fashion, risking being hit by cars. He was able to be consistent in his communication that he would not respond to her provocation, which included being taunted by her that she had met someone else (a new lover). He was physically hit by her but would not fight back. Furthermore, the following day his wife had become drunk and thrown herself in the River Mersey, had broken her arm and been taken to hospital by the police. Jason felt obliged to visit her, only to receive more aggressive and accusatory communication from her. Once again he did not react angrily, and suggested that as he was tired he would cut the visit short and leave the hospital. His first order emotional reaction to this was sadness:

“And I must admit, well, it’s about a ten minute walk from the bus stop to the station you know, and walking to the station I felt a bit sad, because of the way . . . probably because of the way she’d spoken to me. But then again I’m thinking, well, I thought about myself, and what I was like, and I thought . . .”

Process component: explicit evidence of reflexivity.

There is a good deal of second-order emotion emerging from these situations, both in the immediate aftermath of his success in restraining himself and in his reflections afterwards. “I just felt stronger as a person, to step back from that . . .” In his reflections in the interview, he feels proud and happy about the changes he is making: “I am absolutely over the moon, no, because I can feel the changes in myself, I can, I really can.”

Process component: develops second order emotional appraisal of a difficult situation, he feels different, proud of himself.

Jason also makes it clear that his ability to modify his second-order emotion, and thus in turn his first-order responses (as the import of the situation changes for him), derive from experiences in the programme. In particular, he has learned to modify his inner conversation by being able to reformulate emotionally arousing statements from others. He describes this as having happened in the treatment programme:

“You know sometimes when we go into a conversation – a confrontation, y’know - and somebody says something and you think, you know ‘That’s landed!’ And the other thing is, ‘Hang on, whoah! that’s not mine, that’s yours!’ That’s not mine, but in the past you’d deal with it in the old way. You’d just take it as said, and you know you would just take it from there and react, and you’re off. It lands and it seems to stick with you.”

Jason recognises that this situation has occurred with his wife and with others:

“Yeah, ‘That’s not mine! You own that!’ I’m learning a lot from that and not just with my partner, my wife, you know. I’ve been in other conversations and situations and I’ve thought ‘hey that’s not mine – and I’m not even going to rise to that – that’s just going straight over’, but in the past it could have landed, it could have got to me. And then, do you know, I’m taking a drink!”

Jason explains that his ability to revise his emotional reactions derives in part from an image given to him by his counsellor, that of an ‘internal committee’. This represents an internal conversation in which Jason is critically appraised by a judgemental inner ‘panel’. He says that he has learned instead to listen to his peer group instead of the ‘internal committee’:

“And I think it is all thoughts, I mean if you listen to people – I mean listening’s a big thing isn’t it? – how many times have you, er, - I mean I’ve always liked to think that I’m a good listener anyway, but how many times do we not listen properly, and we act out on what we thought we’ve heard? You know, and even arguments, I’ve even thought about that an’ all: being told “you fuckin’ said . . . ! blah blah” “But I never fuckin’ said that, what I said was . . .” But if you were listening in the first place you’d avoid that confrontation. You know if you just sit down and listen, not just to the counsellors, listen to what the group are saying,

and take on board and if, you know, you look and you listen hard, you can see, see the way people are feeling, you know. But I think this stuff that lands on you and ouches you, and the way you react to that, I think that's a big one for me. And again, instead of running it through your own (*internal*) committee run it past the committee here (*the group*), and instead think, think logically – think that's helped me an awful lot.”

Process component: he takes up the image offered by the counsellor, and uses feedback from others to modify his internal conversation.

His ability to use this mechanism to change the outcome has depended on the building of trust, which had developed over the first few weeks of the programme. The first glimmerings of trust emerged as he experienced the SHARP programme, as well the immediately preceding environments of the Brink of Change and Genie in the Gutter, as warm and accepting. His rawness and vulnerability in the early days produced feelings of wanting to run away, due to the intensity of what he observed in the group therapy, but he experienced encouragement from his fellow group members and staff to persevere.

Process component: trust emerging from feeling accepted and welcomed.

Countervailing mechanism: intensity of the programme creates an urge to run away.

Trust allows him to use the encouragement instead of running away.

He began to admire the honesty and openness of some of his peer group and found that he responded emotionally:

“I can feel, I can feel for other people. I mean I have heard other people's life stories, but even interacting in group therapy I find that I can relate to people. I mean if somebody shares something that I can relate to I can relate back. I find that helps, I find it uplifting, I find it helpful, as well.”

Process component: he develops care for others, as a result of identification, which uplifts him.

Jason also explicitly refers to his identity. His opening statement began: “When I first came into the programme, erm, I felt quite lost – within meself – I felt I’d lost . . . some of my . . . some of my identity, erm, I felt vulnerable, although as a precursor to SHARP I’d been at the Brink for I think it was 6 or 7 weeks, which initially gave me, some sort of, a little bit of value, before I came in here.”

Later on in the interview I ask him about what he meant by his identity:

Tim: “That’s sounds important. I know it’s sometimes difficult to explain, but I would just like to go back and pick up on something you said earlier. You mentioned that you thought that in a way your identity was under some kind of threat, that you were kind of losing that identity. What was it? What was your identity do you think?”

Jason: “I lost me sense of worth, I lost me sense of values, in addiction. I lost me goals, me values and me morals, without a shadow of a doubt, and since I’ve been here, er, I’m listening to the counsellors, and sometimes they put things in a different perspective, although I can relate to it exactly what they mean, in a different light maybe, and I can say ‘whooh’ and I can see the old me.”

Tim: “‘This is a person who *did* have values.’ Is that what you are saying?”

Jason: “Yeah, yeah. And I find them coming back as well. I find a lot of me values are coming back. I am most definitely changing . . .”

Example 9: John (Liverpool) aged 50, alcohol, cannabis, cocaine

A similar perspective is given by John, aged 50, who is looking back at his treatment two years later. He remembered how helpful it had been to have his perspective challenged by the group and by the counsellors, and yet at first he resisted angrily, as his ‘reality’ was so persuasive and familiar to him that when it was challenged he simply felt misunderstood. But at the same time he had developed a trust that maybe these challenges could help him change. When I asked how this trust had been developed he said:

“I remember a particular peer – he was a nice lad but he was strong you know – he was a strong lad and he came across very well, but firm, he knew where he was coming from, and he opened up in group once about being sexually abused, when he was a kid, and that just blew me away! His fuckin’ honesty, the way he just brought it. You know it was the gender group – the way he just brought it – and you know it fuckin’ riled me, I thought ‘fuckin’ hell’ and it opened the door for me to step into. And it wasn’t just that particular . . . I mean people’s honesty in there; it just opened the door, to step in and do it as well.”

Process component: trust developing from admiration of others’ honesty.

So as with Jason, trust came from admiring others’ honesty, relating to what he heard from others, and being freed up to risk more honest sharing of himself. The challenges which John describes remained a struggle to accept (for example that a great deal of his anger and hatred was misdirected as he had denied to himself that he had been mistreated as a young person). However when he had thought about and accepted this challenge it changed his emotional experience.

Process component: Reflexive process following challenge from counsellor and group. Trust required to accept challenge and modify internal conversation.

John also spoke of a return to the values of his family. He said his family had “good values, I never felt right as a criminal”; he was excited by the criminal lifestyle but never comfortable with it. He has discovered that when he is living more honestly, he feels good, connected, proud. When ideas of unworthiness intrude, as they still can two years into abstinent recovery, John says he can have an “emotional crash”, but this is “brief these days, as I can check myself.” He added that he stays connected to people and communicates his feelings: “So these doubts and fears, I just run it past them and share me feelings. It works.”

Example 10: Charlotte (Liverpool) aged 42, alcohol

Charlotte, aged 42, had described herself as being protected from responsibility by her father in childhood and by her husband over a 26 year marriage. She

developed a drinking problem when her husband's work took them to China and she became isolated. She returned after a year to England but remained bored and lonely. He divorced her ("from the other side of the world") and she was left alone with her children. "Now I have to deal with life." She describes an attenuated emotional life: "and that was all I knew: angry or happy; those were the only two." Her family had not encouraged emotional expression but rather the expectation was "don't feel, just get on with it".

Her personality on entry to treatment, she described as "hyper, a bit scatty". She was restless, uncomfortable with feelings, tended to do everything in a fairly extreme way: "I mean I go the gym five days a week for three hours or I don't go at all. It's all or nothing with me." A few weeks before entering the treatment programme, she had taken a deliberate overdose and been hospitalised, which she described as a "cry for help".

She was able to describe her transformation as a discovery of her feelings, and was able to give an account of how this was taking place. As with others, for the first two weeks in SHARP she was very quiet, didn't say a word. She listened, heard other people talking about themselves and related ("Oh yeah, that's like me! I thought I'm not the only one." The reading of her life story was a watershed:

"I cried when I did my life story – when I wrote it I didn't feel it much but when I read it out I put myself back there. I thought 'Why am I crying?' I thought these things didn't affect me. But obviously they must have as I had no control over my tears. I realised I was feeling something about what had happened to me. At the time I wasn't allowed feelings I just was told to get on with it."

A major change for her is the discovery of what is important to her emotionally. Not so much the sudden teenage pregnancy and motherhood at 16, but the divorce, her feelings of abandonment by her husband. The process of this recognition is described by Charlotte:

"I heard things in group from other people, 'things that would 'ouch' me' (*cause an emotional reaction*). Also I would make sarcastic or flippant comments in group which I didn't think meant anything and someone, maybe a counsellor,

would say ‘So obviously it bothers you – that comment that you just made obviously means . . .’, whereas to me I was just saying it: it was coming out my mouth.”

“I’ve done that all my life, keep the shutters closed, but it’s ok to feel things, it’s ok to feel angry. When you accept your feelings what does it feel like? It feels like I’ve lost about four stone doesn’t it?” “I never expressed anger directly to my husband because it didn’t feel right; I didn’t want to express it to my children as it didn’t seem fair and I didn’t want them taking sides.” “I’m discovering my own feelings and wants.”

So the mechanism of change can be tentatively described as a process of identification with others, a recognition of what they are describing. She gets an emotional reaction, realises ‘That is how I am actually feeling!’ This builds a sense of trust with her group and with the counsellors. Another important process is the acceptance of challenge or reframing by the counsellors, in this case of her flippant or sarcastic remarks.

Example 11: Francis (Liverpool) aged 44, alcohol

Francis said that when he entered the programme he was “very erratic, very shaky, I didn’t know where I was, couldn’t communicate very well. I was a scared person.”

He had spent 4 years going to AA meetings, could stop drinking but not stay stopped. He managed a maximum of 2 months without drinking. On the most recent occasion he “made an excuse go out for a 4 week binge that would nearly kill me.” He ended up in hospital, with his mental and physical health deteriorating: he was diagnosed with pancreatitis and diabetes, both consequent on his drinking.

Francis says that before SHARP, “I couldn’t open up to people – little things would happen and I couldn’t speak about them they would build up they would kind of blurt out and I would go and drink on them.”

'Sustain mechanism': feelings about others not expressed, build up and blurt out, drink to deal with the consequent feelings (embarrassment/confusion/shame?)

Several of his friends had been through SHARP and some had 2 years sober. He decided he needed the same kind of process and got himself referred.

He was quiet and watchful for the first two weeks. He witnessed very emotional and intense groups on his first day, and 2 graduations. He saw people crying and expressing emotion, and thought "What's this? I didn't come here for this!" He considered not returning but did. He arrived on the second morning "more chilled." I was still confused as to what was going on, but people said just stick with it, you'll be ok."

Countervailing mechanism: difficulty with the emotional expression of others, reflexivity about his discomfort, feeling of wanting to run.

Over the weekend Francis had a good long think about it. "What's the alternative?" Carrying on the way he had been did not seem an option ("I didn't have it in me").

More considered reflexivity.

I can't really put in to words what happened. I could see people taking a step back and taking a serious look at themselves – being scared to do it but doing it anyway. I could see that they were scared like me. I thought 'I'll give it a go. Fuck it, let's go for it!'

Process component: using fellow participants as role models, recognising they were as scared as he was, admitting their courage, deciding to do it himself.

After the life story I felt more acceptance from the group. They knew more about me That was important, I wasn't keeping it all back. I left things out, but when the group asked me questions and paid attention to my story I felt relief. I felt closer to the group."

Process component: feeling of more closeness through experiencing acceptance, recognition of others' interest in him.

“My counsellor Erin told me I was fixing others, focusing on others not on myself, not looking at myself, blaming others: ‘She done this and he done that, and if only he would do that it would be all right and you know!’ Erin leapt on that. It was not easy to hear at first, but I had a think about it. I could see I was doing that and she wanted me to look at my part in it.”

When asked how he got help in group therapy Francis said, “I got a text from my partner, I wanted to react, but Krissy (*counsellor*) shut me down from focusing on her (*my partner*) and asked what was my part in it? ‘What do you mean? It’s her!’ But I thought about it and could see she was right. I would be wanting to fire off stupid texts back . . .”

Process component: challenge from personal counsellor, then a similar challenge from a counsellor in group therapy. Challenges not easy to accept but he reflects on them and decides they are accurate.

“This has changed me a lot. I’m still judgmental of people and I have ego stuff and that, but thinking about my part in it. Acceptance that I’m playing a part in it. So someone’s doing my head in and they probably don’t even know they’re doing it but I’m stuffing myself with all this anger I’m doing it to meself. I try to calm myself down.”

Process component: modification of internal conversation.

“I am using it (*what I’m learning*). Several times here I have stepped back, apologising for my actions and things, which I’ve never done. I see the difference in people when I do that.

I also write things down (*advised by counsellor as an outlet*) things that are doing me head in, upsetting me. Also sitting with other people’s feelings, just letting them be. Not trying to control everything all the time.”

Another example Francis gave was, “My dad has just been diagnosed with cancer and is getting radiotherapy I went to visit and he burst out crying. He’s a

dead proud man and I didn't want him to be crying in front of me so I jumped up and legged it out of there, and it was put to me that I could have just stayed and sat with him, just let him be upset, and . . ." (pause) "It's a game changer this!"

"Gary said to me in group 'Do you think it's anything to do with you?' (Legging it from the hospital). I have realised I have a tendency to run away from things. Never finishing anything."

A live example of Francis's tendency to run away from emotionally charged situations. He did in fact run, but was challenged and he was able to reflect on this and take responsibility for his actions rather than attribute his flight to others ("he's a dead proud man.") He feels this is indicative of an important change for him ("it's a game changer, this!")

Example 12: Simon (Liverpool) aged 46, alcohol

A few months before admission, Simon says "I was totally closed off to life, to people. I had lost my job." (as a bus driver). There was serious concern from family members (his sister and mother) "Something had to change, I was dying anyway." He was withdrawn, incommunicative, not wanting interaction. He decided at one point deliberately to "drink myself to death". Simon went to the Brink (recovery café) sporadically, still drinking (4 litres of strong cider per day). When tried to stop on his own he had near fatal seizure and was hospitalised.

When he came into SHARP he couldn't face people, avoided them. He was still reclusive and hid away to avoid interaction at the start.

Tim: "What was the turning point?"

"I don't know. I had to sit in group, but for the first two weeks I didn't speak." Simon was invited to contribute his thoughts and feelings about what was going on in group but didn't feel he had any. "They chip away at you. I didn't leave because I committed myself to complete the course. The way people were speaking openly about the way they were feeling - I couldn't do that . . . I felt 'The world's against me so it's me that has to combat the world and I combat it

by isolating'. He added, "Alcohol was a part of me: I couldn't see my life without alcohol."

Process component: commitment to the course allowed him to persevere despite not being able to contribute at first.

When I asked about his values, Simon said he was "a completer, perfectionist; I have to see it through . . . I'd see myself as a failure if I didn't complete the programme."

When he came in he felt worthless, self-loathing, a failure. However he recently decided to change last name to his grandparent's because he admired this person's values.

As far as change in the programme is concerned Simon said that after his life story session he felt listened to and taken seriously. He said "There's been a very gradual change – in the last four weeks I've come out of myself . . . I now have people in my group who are only a phone call away if I need help." (*Simon names four people*).

Process component: Feeling listened to led to a feeling of trust which allowed him to risk revealing his feeling and concerns.

Process component: he begins to create a network of mutual support.

Example 13: Saul (Liverpool) aged 45, alcohol, previous heroin dependence and problematic cannabis use.

Saul had completed the programme at Phoenix House 22 years previously, having been addicted to heroin. He says he is a gay man whose stepfather strongly disapproved of and was disappointed in Saul's sexual orientation. At Phoenix House he describes having had an inspirational counsellor, also gay, who helped him to be proud of his sexuality. He did not use heroin after this time, and felt more acceptance of being gay, but he continued up to the point of interview to expect disapproval and judgement from others.

His stepfather was described as a Ghanaian-born professional criminal who had tried to raise his stepson, who is of white ethnicity, as a tough fighter, whereas Saul felt himself to be a sensitive and non-violent person. He has three older sisters who are black, the children of his stepfather's previous marriage. He feels love towards them and feels loved in turn. His father was murdered when Saul was 20, and he feels that he has always carried a very conflicted emotional burden concerning him. He says he loved him and hated him at the same time; he felt a great sense of relief and freedom when he was killed, but also a sense of guilt and loss. He says that at Phoenix House the issues he felt about his step-father were not dealt with. Two years before coming to SHARP, he went to a residential treatment centre for his alcohol dependence, which had a traditional 12 Step based programme. He was introduced to the 12 Step fellowships of Alcoholics and Narcotics Anonymous, which he attended after he left, but he says he "got no therapy. I needed therapy about my step-father." He relapsed several months later and was drinking heavily until he was hospitalised. He went to the Brink recovery café and was referred from there to SHARP.

As far as changes that were happening at SHARP, he specified three things, in relation to his group, his counsellor and the treatment philosophy. The group, he felt, were encouraging him to be more trusting and open. He still expected covert judgement about his sexual orientation, but this was improving as a result of the group members challenging his sullenness and reluctance to reveal himself. He recognises that he can be "a child, self-destructive, stubborn, self-piteous and lonely" and that when he is like this he wants to take drugs or drink. He feels as a result of engaging in group therapy he has "grown up. As a grown-up I can let go of the drugs."

Process component: encouragement from others and increasing trust leads to a new openness and a change of attitude.

With his counsellor, he had devised a ritual to "let go of my conflict with my stepfather". He had written a letter to his father expressing his conflicted emotions and how it had affected his life, and set up a Buddhist shrine ("I am a very spiritual person"), before which he burned the letter and then meditated.

He told me that he thought this was a very effective ritual for him, after which he had felt a definite sense of freedom and autonomy.

Process component: an issue he considers crucial is addressed creatively with the help of his counsellor.

Third, he said he had understood and accepted the programme's philosophy about total abstinence. Saul was the only one of the interviewees who mentioned his attitude to abstinence. His counsellor at Phoenix House 22 years ago had suggested that he should consider complete abstinence from alcohol and other drugs, but Saul had not accepted this. He has reflected while at SHARP about his history of poly-drug use and his move from dependence on heroin to heavy cannabis use and then dependence on alcohol. He has recognised that his reluctance to accept complete abstinence before was do with his stubbornness, and that with his developing identity as a 'grown-up' he was able to accept and commit to being alcohol and drug free.

Process component: reflection on the treatment philosophy and his own experience leads to acceptance and commitment to abstinence (this occurs in the context of his attitudinal and identity changes).

Example 14: Kirsten (Liverpool) aged 42, alcohol

In this final example from the Phase 1 interviews, the participant is presented in the same way, but it happened that during the interview with one of the counsellors (Krissy) the change process for Kirsten, as theorised by Krissy, was discussed with me. The counsellor's perspective is presented immediately afterwards

Kirsten, a 42 year old woman with a dependency on alcohol, had been in the treatment programme for 3 weeks when interviewed. She had been described by the counselling team as having gone through a transformation in the previous week, from being very quiet and withdrawn to being quite verbally assertive and forthcoming, particularly in group therapy. Kirsten said that this change had come about because she had learned that her shy withdrawn personality had been "given to her" by her family in childhood. Previously she

had thought that this was just her nature and she would not be able to change it. She had been challenged in group by a counsellor about her inability to be assertive with a relative, because she felt obligated to him and felt guilty if she expressed her own preference. She was helped to explore the communication in her family when she was a child, how she had been taught that it was not acceptable to express her feelings, and that this had led to her shyness and placating of other people. Kirsten particularly emphasised the importance of being challenged in SHARP, and how this led to better self-understanding. She had previously been to a treatment programme which had failed to help her stop drinking: she said that despite having group therapy, “I didn’t learn anything about myself at all. Nobody really challenged me.”

She contrasts a programme where her assumptions about herself and her problem were not challenged, with the current programme in which a challenge had helped her gain an important insight. This is of course retrospective, and if she had not had her current experience she might not have attributed her failure to respond to the previous programme in the same way.

Describing the insight that produced the change in her, Kirsten said: “It started to make sense. It was a big breakthrough for me because, OK, so I was born innocent and these behaviours were given to me – for 42 years I believed it was just in my blood, I was just wired up to be like this – I was just naturally shy. But I can change it – it was massive for me.” The upshot of this recognition was changed behaviour both in and outside of the programme. She became more actively contributory in group therapy, and was able to challenge her nephew’s disrespectful behaviour at home.

Process component: modified internal conversation led to her risking more assertive behaviour, which was rewarding and made her feel more confident about herself.

Counsellor Krissy on Kirsten:

(Krissy is not Kirsten’s personal counsellor, but has worked with her in group therapy)

“What I think is of particular significance is the interpersonal aspect of group therapy. Through group therapy we were able to kind of challenge Kirsten’s thinking; this was a lady who was very timid and presented a lot as a victim, erm, and when we unpicked her family structure and she gave examples of what happens in her family and the anxiety that creates for her. And, interpersonally, it kind of allowed her to see what other people see in her. And she got a real lightbulb moment! And it was literally just from the unpicking of it in group and the group giving feedback – how they experienced her and what she shows up as. And she was able to discover what was her ‘family rule’ and the patterns, she bought into that. And this woman has just, from that day, made just tremendous and significant improvement! Just from her recognition of the role she played and why it had impacted her. And she’s – er, the idea of being able to challenge a client in treatment, because often they feel that their problems will all be solved if someone else, he, she or they, do something different, and giving them that concept around, er, ‘they change when you change’. So learning how they communicate, that was so obvious within our group and it was possible, interpersonally, to reveal it to Kirsten, what she presented as, and what her body language said, and what her behaviour has created. She’s absolutely turned her significant relationships around. Her communication skills have just turned, er, it’s very very simple really.

Tim: “When you say we, you mean you and the group? Or . . .”

Krissy: “Yeah, me and the group. Me kind of pulling the group in, because often I can see her behaviours or kind of know, about the family patterns, because of my experience, but giving the clients the space to reveal to Kirsten, from a good place, how they experience her, and what her role plays out as.

Tim: “How was she in the group before?”

Krissy: “She didn’t really have a voice. She was full of anxiety, and she’s spent her life in a high state of anxiety, and quite submissive. And her drinking almost gave her an opportunity to have a voice, but she used it in the wrong way. From what has emerged in the group, Kirsten has sought me out a couple of times and we’ve just had little chats, about certain relationships within her family

which have created anxiety for her. And we've modelled and role-played what might want to say differently, what might that look like? And she's literally taken that, and put it into practice.

Tim: "How come she did respond do you think? Whereas you could find someone else who would not respond, who would keep hunkered down in their victim position if you like. She starts out voiceless, what feedback did the group start giving her in the beginning?"

Krissy: "Yeah well they were giving her, er, how she sat back, and how she didn't contribute, and then how at times when she did communicate, it was from kind of a petulant 'you don't listen to me, you don't hear me, this is pissing me off'. And most of the time you didn't really know what she had to say, and the group gave her that space, to show herself like that. And the reason I think it worked with Kirsten was, she was in such a painful place. That realisation was a huge lightbulb moment, and it kind of propelled her into kind of 'OK, I've got to do something different.' (*Krissy's emphasis*) She was stuck in believing that things would not change around these other people. But already it emerged, erm, that change took place in our group, because she actually, er, when this emerged she actually sat up, and we revealed to her 'Wow! Look at your body language right now, Kirsten! We kind of get the feeling there's something you want to say to us.' And she actually told one of her fellow peers about some of their behaviour, and what they had kind of landed on her. And the group unpicked, er, you know, 'What did you give off there?' and she realised that what she had been saying in effect was that it was 'OK to dump all this crap on me, because I haven't got a voice and I'm just gonna take it', but now she was so articulate in that group and was able to say 'That was not OK and I felt really uncomfortable'.

Tim: "How long do you think it was from the time the group started giving her feedback to that lightbulb moment?"

Krissy: "About a week."

Tim: "What I am trying to get at is, what was going on in herself? She was, erm, withdrawn from the group, because she felt nobody could really understand her,

because her family were always going to be like that, and she would always be invisible. So that's what she played out. You and the group begin to pick up on that. When she first got the feedback, what do you think she was feeling?"

Krissy: "It was, er, the very first time . . . umm, Erin (*another female counsellor*) had done a lot of work with Kirsten in group around the family dynamics and the role she played, so I feel that she was kind of working towards, but it was almost as though this just gave her clarity, something so simple."

Tim: "So this insight, that the way she had been was something she had been conditioned into by her family, she was able to use that to say 'I'm not going to be like that anymore'?"

Krissy: "Yes exactly."

Tim: "And you noticed she became more animated, you know, she contributed. How did she do after that?"

Krissy: "Well have you seen her in any of the groups?"

6.4. Field observations

On each visit to SHARP Liverpool I attended therapy groups, group-based workshops, life story sessions (in which a recently admitted client presents to their peer group an account of their life and what had led to them coming to SHARP), and observed the clients interacting during their free time, drinking coffee, smoking outside in the designated area, having lunch together. I engaged clients in informal conversation, mainly with small groups of clients but on two occasions with individuals who happened to be on their own when I encountered them. All were aware of why I was visiting the agency. I took notes privately after periods of observation. I had fewer opportunities to mingle with the clients at SHARP Bournemouth but I did attend two group meetings.

The observations in free time produced confirmation (with a few important exceptions described in the counter-examples section below) of the generally supportive, friendly and encouraging atmosphere in the treatment group. Clients very often offered support to a fellow group member, or made plans to spend

the evening together, perhaps at the cinema, or attending a mutual aid group together. There was a welcoming attitude to me, and I was several times questioned about how I thought things were going, whether I was impressed with the centre. I was able to give simple, sincere replies in general terms, e.g.: "I think it's very impressive, I am enjoying being here." The two individuals I encountered sitting on by themselves had both arrived (on different days) at the agency earlier than the others in the group and were drinking coffee in the common area. I had brief conversations with each opened, after I asked them if they minded chatting and had sat down, with an enquiry about why they had chosen to come to SHARP. Both said similar things. One young woman who lived in the Wirral had made significant efforts to get herself referred to SHARP rather than to her local services, because, she said "SHARP deals with the deeper issues, it's proper therapy." She said that in her opinion the other agencies who had offered her help did not address her emotional issues directly or skilfully enough. The other person I spoke to said that he had heard SHARP was "the best treatment centre. You get to deal with the underlying issues. I wanted to come here particularly."

These comments echo similar opinions expressed in the interviews, perhaps most clearly by Richard in Bournemouth who had managed to stop his drug use through a hospital detoxification but had relapsed almost immediately on his return home, to his surprise, as he had thought that he would be fine and able to stay drug free easily. He said, "it was a big eye-opener to me that I hadn't actually looked into why I wanted to change the way I feel, why I wanted to change my emotions, and um, and that was the start for me I realised that I needed, um, to do something a lot more full on, and a lot more where I could actually work through issues and things as and when they came up, or have more time to talk through certain issues, because I found, I mentioned an issue and talked about it, talking about it brought up another issue which was, which I didn't even realise was sort of there. It was working out, sort of, what the underlying issues were, because they multiplied and changed and turned into other things."

Observations in the group therapy sessions confirmed that the members treated each other with respect and that there was a consistent willingness to offer feedback both to challenge communication that the group members felt was ineffective or self-defeating, and to recognise and affirm changes. Two examples: I observed Kirsten in group sometime after she had had her insight about her timidity and passivity being assigned to her in her childhood family. She was animated and had an upright posture, and made some useful contributions to the group process. Two group members commented on her change and said how good it was to see her emerge in this way.

6.5. Counter-examples – change mechanisms constrained.

In another group Linda, who was to fail to return to the programme the following day and in fact dropped out, spent some time telling the group that she could not achieve recovery with all the pressing problems she had. The group gave her feedback that she brought this issue to every group, that some of them could identify with her problems currently, that their impression was that Linda did not want to take on board the feedback (which was essentially that she should ask for help with some of her problems, and try to focus on her treatment rather than be distracted with outside issues). They agreed these issues were serious and troubling (they were to do with a child custody review), but they believed they could be coped with, with the help of the staff and the support of the group. In the staff meeting that morning, I had heard the team discussing who would accompany her to the child custody hearing, and it was clear that the team felt Linda could continue with the programme if she accepted the help offered. The following morning Linda did not appear, and was not contactable by phone. When news of her did arrive, it became clear that she had taken a (single) drink and did not wish to return to the programme, despite the staff team's willingness to make a re-entry plan for her and for a counsellor to attend the hearing with her despite her non-attendance at SHARP.

A further example of a client not feeling able to continue in the programme occurred during my visit. A man of 30 returned to the programme for a second time, and decided that this time he should disclose more of his childhood experiences in his life story which he would read to the group, which I attended

as an observer. These included being sexually molested by a family member, which is not an uncommon experience disclosed in such life stories. He added that when still a young boy, before puberty, and following this abuse, he had been in bed with his younger sister and had touched her sexually. Several members of the group responded by becoming angry and one man shouted aggressively at the client, that he was a paedophile, using other very insulting terms. The counsellor present stopped the interaction, pointing out the unacceptability of such aggression and judgement, and facilitated a mediation process that culminated in the man who had been most aggressive apologising and offering a hug to the client, which was accepted. The group seemed stunned and did not offer unequivocal support to the client, but some members expressed relief that the hostile interaction had apparently been resolved. The client did return to the programme for the following two days, but I observed him several times standing by himself in the break times, rather than socialising, and he failed to return on the third day. He was reported to have resumed drinking. I have no direct evidence of his reasoning, but it is not hard to imagine that he had found the experience in his life story traumatic, and rather than increasing his feeling of closeness and belonging to the group, it had had the opposite effect. It was clear to me that despite the valued norm of self-disclosure, there are some disclosures that the group are unable to accept. It is possible that if there had been unanimous and clear condemnation of the aggression and judgementalism by the group and consistent empathy and support offered to the client over the following days the outcome might have been different.

6.6. Theories of change and failure to change in the counsellor interviews

The interviews with the counsellors at Bournemouth and Liverpool produced some theories of change (and how the counsellor saw her/his role in helping change) which were in four cases quite explicit. These four are summarised below. The counsellors showed considerable variation in what they thought was important, but their theories were by no means incompatible.

Joan (Bournemouth)

Joan began by repudiating a commonly held idea in this model of treatment that a key goal is for the client to increase their awareness and acceptance of negative consequences of their addiction. She said “Fear of consequences is never going to keep anybody clean.”

Her approach to treatment is not to emphasise ramping up awareness of harmful consequences. She used to do that, “as it seemed so obvious”, but she has since learned that, “What helps people is to have some sort of goal or aspiration for their life . . . so it’s about persuading people how it will be great to be clean, rather than how terrible it is to be using, how they can change, what they can do with their life.”

She went on, “So if they work on improving self-esteem, assertiveness skills, communication, all the things that help to make your way in the world, that seems to shore up the desire for a better life.”

I asked her “So treatment is something to do with helping someone make their way in the world?”

Joan: “I think so, I mean I’m still trying to figure it out myself!”

Tim: “What’s the connection between self-esteem and assertiveness and making your way in the world?”

Joan: “Well, I’ve noticed that passive people are often full of resentment and boiling with anger and self-loathing, because they can’t say what they want, they can’t get what they want, they can’t get the feedback and appreciation from other people that they want, and people who are more aggressive in their style, they tend to alienate people. They blurt things out, are abrupt and people don’t like them so they feel dreadful about themselves.”

I asked, “What else is important?”

Joan: “Well I have come to believe that people who are in emotional turmoil, in a lot of emotional pain, it doesn’t necessarily get relieved, the pain is still there.

So helping people do small but meaningful things each day, what someone can do today to improve their life, like phoning someone and meeting them for coffee. Really small steps, because I've noticed, people feel really hopeless and overwhelmed, with the misery of stopping alcohol and drugs and having to deal with all this turmoil and pain that they've got."

"I want to encourage them to build on their sense of self-worth, and their identity, their idea of who they are, in order to make them strong enough to have a purpose, a sense that it's worth giving up drugs and drinking . . . because one thing I have come to realise is that for many of them, that's all they had, the drug's been their best friend. It's their identity."

Joan feels that the centre itself deals with the actual stopping because of the boundaries, the abstinence expectation, the structure of the programme, so she doesn't need to focus on the drug/alcohol use in her counselling, she sees her role as helping her clients to develop themselves.

I ask about the relationships between the clients. Joan points out that the clients make relationships outside the programme, for instance when they share hostel or dry house accommodation. Those relationships seem to her, when they are transferred into group therapy, to take on a tension. She gives an example of two people who had an informal friendship but one was serious about the programme and recovery, and the other wasn't. The latter was apparently trying to get his friend to abandon the programme and return to using drugs. But the former used group therapy, and the tension that arose between them in the group, to express his disapproval of this and to say that he could not continue the relationship under these conditions. He also affirmed his own commitment to recovery. The result was that the other person changed "quite dramatically" and became much more focussed on his own treatment. The first client had been in some distress as he had felt tempted to go out and use drugs, but realised that he didn't want his previous life which had included recent imprisonment, but wanted something else, in particular to go to college and get an education, to explore new life possibilities.

Joan feels this is crucially important. She expresses this as someone who was not familiar with addiction or addiction treatment before coming to work at SHARP, and someone who was continually learning about the job. She says she has come to realise that if a person just has a desire not to use any more but they don't really know why, she believes they are in great danger of being unable to resist the pull of the drugs or alcohol, which is "overwhelming if they haven't got that clear idea."

When asked whether other things were important in the treatment process, she says "I think Recovery Capital, a new buzzword round here, is important. For example, people need somewhere safe to live. I had a lady who was living in a wet house, struggling every day not to drink, the only thing that was keeping her going was the thought of coming to SHARP. After she got onto the programme she got a place in a dry house, and the difference it made from one week to the next was huge."

She lists some things that she thinks are important: "what support they have, what kind of structure, where they live, who they have around them and whether they have any goals."

I asked her if she thought about formal models or theories of counselling when she worked. She said "I do, but because my training before I came here was psychodynamic-cum-humanistic, a whole jumble of things, and on the 30 month Diploma course I did, we looked at a lot of different models in quite a bit of detail, there's a huge benefit to that, but the disadvantage is that I have no idea which model I work to, because they're all mixed together and I have a few of my own invention, so . ." She thinks in her work at SHARP there's a "fair amount" of CBT, "I mean connecting thoughts, feelings, behaviours." And she keeps her psychodynamic perspective in her assessment of clients' problems though she doesn't work in an obviously psychodynamic way.

Having heard Joan talk about her work predominantly from the perspective of her individual counselling with clients, I asked her what her thoughts were on the SHARP programme as a community.

She said she thinks the community is much more important than the individual counselling work, because even though there is value in the counselling relationship, in the community, “they are getting what they get even without the counselling, to a certain extent”.

She said that simple confronting of inappropriate behaviour is often very important; she does it sometimes: “That’s what I do, I say what I see, directly but kindly”, “But the community does it, massively.”

She attributed the change in a client’s demeanour and attitude to “everyone giving him the same feedback, me and the community, his peers, collectively. He either has to leave or change really, and he’s changed.”

She talks about how ideally people should be ready for the programme when they start it. People who are still stuck in “wanting to be oblivious to life” are much more difficult to work with and get much less from the programme, she thinks.

I ask, “Does that ever change during the programme? And if so, how?” She thinks this depends on “their social network, if they have good friends and support outside of here, they’ve got a better chance.” “If people tend to isolate and then come in here, I’ve seen a lot drop out.” She sees depression in particular as a block to engagement in the programme.

Joan’s implicit theory of treatment:

Clarifying and developing meaningful personal goals are very important.

Strong reasons for recovery are a vital antidote to the lure of drugs and a drug using identity.

Participation in the treatment community is more important than individual counselling.

Treatment works through a person receiving consistent feedback from a group and counselling staff whom they trust and to whom they are attracted.

A social support network is important to sustain perseverance in treatment.

Maya (Liverpool)

In her interview Maya stressed the relationship between counsellor and client as the change agent. She tries to offer a different kind of relationship from those the client has experienced before, “a more healing one”. “If I can communicate caring, authentic communication, that’s what helps people to change.”

Maya then gave an interesting counter-example. She describes a recent client with whom she felt she did establish a good connection, but who left the programme prematurely and did not seem to have benefited from it. She attributed this to his not wanting to make the kind of healthy relationship that would have enabled him to explore his emotions and “what was going on for him internally”. He tended to recreate sexualised relationships which he used to alter his mood in a similar way to using drugs. She believed that the reason he didn’t change despite her feeling a good connection was because “to go inside, to reflect on what wasn’t working for him in his relationships or in his life, looking at who he was as a person, was maybe, not even threatening for him, but just something he didn’t want to do.” She went on, “The connection, I think that’s what helps people change” (but she is clearly aware that in some cases as in this one people do not change, they don’t take up the opportunity.)

She then mentioned two factors which she thinks are part of the treatment process being successful: first, a person should come to SHARP wanting to change, or that desire for change needs to develop soon within the programme. Second, when the process of change starts happening, it must be experienced as satisfying as well as being difficult or possibly painful. The change “has got to mean something to that person.” She gave a current example of someone (Linda, described above) who is beset by painful difficulties (of the kind which the programme could offer emotional support with) but they were experienced as too overwhelming and distracting so that the person left the programme.

Maya said that she sees the relationship developed with the counsellor as very frequently prior to a relationship developed with the peer group.

Counsellors bring different aspects: some are more challenging, some more gentle. Maya sees value in a team offering a range of styles as different clients will respond to different things.

Maya's implicit theory of treatment:

It is important that the client arrives with a genuine desire to change

The relationship with the counsellor is the most important change agent, and this is usually prior to and underpins the changes resulting from the group process.

The changes need to be consciously experienced as challenging, meaningful and satisfying.

If a client is too distracted or does not wish to enter into the relationships offered, treatment will fail.

Tony (Liverpool)

Tony's first point about how his counselling was related to clients responding to the programme concerns helping them settle and engage. He said, "When clients come into treatment they are very concerned about how acceptable they will be to the community. They are emotionally vulnerable. The first task of the counsellor is to help the client settle." He said he observes the new client around the community, in group, and tries to get a picture of how he or she communicates.

I asked "How do you calm and settle clients?" He replied "I try to show tenderness, love and compassion. Clients are used to authority figures who they perceive as uncaring or bullying. I try to show a more caring persona." However Tony said he can be authoritative and is "always boundaried" with clients.

I asked what he thought created change for the client and he said, "Gentle and respectful challenge."

Tony comes from a Cognitive Behavioural Therapy training which seems very structured and prescribed, but he believes “you have to be very flexible as a counsellor”.

He clearly sees himself as a role model, and hopes that the clients will admire certain aspects of himself, and aspire to the same values and thus gain hope for change: “I think they see, what I hopefully will give to people is that they see that being honest is the best way, and the way I try to achieve that is that I try to be honest: they see that they have a counsellor who is honest, that does have values, has had a tough life as well – my mother was a drinker so I kind of come from the other side of the fence – so maybe they can see that here is someone who has been in it and has changed his life.”

He said that he does not self-disclose too much, but offers himself as a role model, an exemplar of change, resilience.

In group therapy, he said his most important task was to make sure the group affirm achievement.

Tony's implicit theory of treatment:

Clients need to settle and to come to experience the environment as caring, accepting and consistent.

Continuing feelings of unacceptability will often lead to treatment drop-out.

Gentle and respectful challenge leads to change.

Inculcating the benefits of honesty and hope for change are crucial treatment tasks.

The group help cement change by affirming it.

Krissy (Liverpool)

Krissy said that she believed the interpersonal aspect of group therapy was the most important factor in helping clients to change. She spent most of the interview speaking about two current examples of clients changing, one of

which has already been described above, following the presentation of Kristen's interview.

The second example involved Saul, whose own account of his change process was described above. As well as providing a matching account of the work done to 'let go' of the conflicted feelings about the murdered stepfather, Krissy described some countervailing mechanisms as well as mechanisms for change. Preoccupied with resentment, and expecting judgment and rejection from others, Saul isolates himself and disconnects from his support system: "He shuts down and blocks the whole world out." She said that this state is strongly associated with drinking and urges to drink. Krissy said that after years of feeling rejected by others, "Saul has learned here that most of the rejection has been from him." As a result of exploring this in group therapy, Saul has formulated this resentful rejecting state as a legacy of his childhood, and is strengthening an adult "grown-up" identity through which he can let go of resentment, take responsibility for his life and make use of an extensive support system, which Krissy says has always been available to him, and is now enhanced with the connections he is making in treatment. This new identity also includes an understanding that he is very vulnerable to any alcohol and drug use, and that his resistance to complete abstinence has been in part caused by his resentment and loneliness.

Finally Krissy comments about Linda, discussed above, who dropped out of the programme. She attributes this to Linda's inability to make supportive relationships either with her counsellor or with her fellow group members. She remained distracted and unfocused, and unable to access the support that was available to her. As her counsellor, Krissy encouraged her to make connections with other women in the programme, for example by getting their phone numbers, but Linda had not done this, or responded to offers of friendship and support from her peers. Krissy's explanation for why Linda did not make connections was that because of her involvement with Social Services concerning the care of her child, she was "in a state of high alert, in fight or flight mode" and that this prevented her from settling and building trust.

Krissy's implicit theory of change:

The interpersonal learning that takes place in group is the most significant aspect of treatment.

Looking at patterns of response learned in childhood family situations is often helpful in helping people relinquish these.

Change is most likely to occur in the context of social connection. If that is absent change is unlikely and treatment discontinuation probable.

In previous published research into the SHARP programme, following a separate set of brief interviews with counsellors, I wrote, "We can see here that the programme team, to the extent that they succeed in achieving their aspirations, are enacting a 'living theory' which implies certain mechanisms of change. In this case the theory is that by providing a trustworthy, respectful space, participants will open up, connect and develop richer self-awareness, which ought to lead to more adaptive choice-making, and thus to the achievement of the aim of the programme.

Here is a slightly different version of this theory. Another counsellor interviewed told me that his main aim in a counselling session was to have the client leave the session 'with head held high'. The idea here is that a condition inhibiting the mechanisms of change in the programme is one of shame, self-denigration or a feeling of failure. This counsellor, when asked what was the most important function of his counselling at SHARP, makes it clear that he is more concerned with facilitating a state of being in the client which will enable them to take up the resources offered, than in specifying the model or approach he is using." (Leighton 2013).

In the following chapter, what have been described here as process components will be refined to produce a set of key components that require theoretical redescription. The theoretical apparatus primarily comprises Archer's conceptualisation of personal and social identity, human emotions as commentaries on our ultimate concerns, and the process of personal identity reformation through involvement in a social entity comprised of arrangements,

conventions and agreements (Archer 2000, p.295, Greenwood 1994, p.93). The key components will be used to create a questionnaire, and this will be used as the basis of a set of 'theory-driven interviews' (Pawson 1996) with a third group of participants, this time at the SHARP programme in Braintree, Essex, which will form the second phase of the research programme.

Chapter 7: Key components, theoretical redescription, retroductive identification of candidate mechanisms, contexts and outcomes.

The material from the interviews not only provides evidence for the tentative identification of contexts, mechanisms and outcomes: I will argue that there is explicit support for theoretical processes such as the internal conversation and its mediating role, and identity (re)formation.

In this chapter, the key components will be identified and presented. The identified components will then be theoretically redescribed in relation to Archer's theory of emotion as commentary on our concerns, and the emerging ability to manage first order emotion by means of second order emotional responses. Mechanisms resulting in modification of the internal conversation, together with facilitating and constraining contexts, the latter including countervailing mechanisms which prevent change mechanisms from being activated, will be posited in theoretical terms (a move to the abstract). Some components which emerge from the clients' accounts, such as 'trust', also require abductive analysis. The relationship of these theoretical redescriptions to the mediators of outcome identified in the published literature, particularly by John Kelly and colleagues, will be considered.

The 'interplay of objects' (Bygstad & Munkvold 2011) will be analysed as part of the retroductive identification of candidate mechanisms. The route by which respondents get themselves referred into the programme, those characteristics of the programme which are relevant to catalysing the change process, the threat to the activation of change by a range of countervailing mechanisms, the role of counsellors and peer group members in activating change mechanisms, and the manner in which changes in the internal conversation enables behaviour change, which together with the responses of others, reinforces the internal change. The effect of the modification of the internal conversation on identity and identity projects will be analysed to the extent that this may be validly inferred from the data. The aim is to ensure that the retroductive process remains grounded in the data to the greatest possible extent. The following table summarises the key components identified in the Phase 1 client interviews.

Table 7.1: Tentative identification of contexts, mechanisms and outcomes prior to theoretical redescription

	Contexts	Mechanisms	Outcomes
Robert	Commitment based on hope offered by supportive family. Treatment activities offer opportunities for risk-taking.	Trusting bond formed with group Challenge from peers that he did not open up to them. Accepted and responded to. Reciprocal care leads to a feeling of belonging and authenticity.	Increased confidence that emotions can be experienced and managed without resorting to drinking Aspirations for a better life clarified and specified
Anne	She enters treatment with a career aspiration that is incompatible with her continuing to drink.	Identification in group – risks speaking about herself – receives feedback – finds it hard to accept, but reflects on it.	More confidence in expression of feelings and concerns. Increased assertiveness
Philip	Commitment through desperation (lost everything). Trust built through admiration of integrity and perceptiveness of peers and counsellors.	Challenge and feedback from peers and counsellors re his self-pity and inability to honestly evaluate his inconsistent relationship with his children. Acceptance and re-appraisal. Active participation in group and in art room.	Building a new identity based on taking responsibility. Increased self-belief, self esteem.
Michael	Crisis, breakdown and hospitalisation led to decision to change. Experienced acceptance when returning to the programme after lapses.	Commitment to the programme as result of acceptance. Trusted by staff to research, source and buy equipment for photo lab. Encouraged by staff and group to confront a bully assertively.	Increased confidence Feeling trusted, competent. Increased self-esteem.
Keith	Treatment as a condition of probation. Prior decision to get involved, not to resist or argue with the process. Living in supported housing after release from prison.	Taking care of himself and supporting others in the programme. Exploration in group of how he thinks and reacts in emotional situations. Receiving feedback.	Increased self-esteem Proud of himself for persevering with the programme. Reordering priorities Wanting to be an effective and consistent parent to his daughter.
Richard	Relapse after detox and attendance at aftercare groups made him see the need for 'deeper' exploration. Realised his concerns were radically limited to drugs and money.	Recognising his emotions using suggestions and resources offered by the counsellors. Risking being open and vulnerable with others Experiencing and identifying emotions in group and receiving affirmation.	Developing self-awareness, building oneself as a person. Aspiration to be a kind honest person, who helps others. Awareness of what he is coming to care about.
Julian	Lost everything materially as a result of his relapse. Confidence "smashed to bits" Feeling of safety at SHARP	Beginning to trust others, risking self-disclosure	Increasing confidence, but early days.

	Contexts	Mechanisms	Outcomes
Jason	Trust built by acceptance and welcome at recovery based agencies pre-SHARP and at SHARP Norms of honesty and courage at SHARP Admiration of others' honesty.	Learning to reformulate emotionally arousing utterances from others. New emotional appraisal of a difficult situation, he feels different, proud of himself. Use of imagery to change his emotional response.	Old values returning, pride in his achievements, reordering of his emotional responses and concerns. Discovering care.
John	Commitment due to bereavement Norms of honesty and courage at SHARP Admiration of others' honesty.	Challenge by counsellor and group – angry resistance to challenge overcome by trust and admiration. Reflection on challenge leads to acceptance.	Values of his family returning. Changing perspective. Feeling more honest, authentic and connected.
Charlotte	Desperation/suicide attempt due to sudden divorce. Given time to build trust in early weeks.	Identification with others, recognition in herself of what they are describing. Has an emotional reaction and realises "that is how I am actually feeling!" Acceptance of challenge by counsellor (significance of flippant/sarcastic remarks).	Less distracted, restless Discovery of her own feelings and wants: what is important to her emotionally. Relief at acceptance of her feelings.
Kristen	Norms of respectful challenge at SHARP Trust built in counsellors and peer group.	Acceptance of challenge to behavioural presentation and underlying belief. New insight, leading to interpersonal risk taking.	Confidence, assertiveness, new self-understanding. Improved family relations.
Francis	Increasing trust through acceptance and interest from others. Impressed by honesty and courage of others, he was able to become involved himself.	Overcoming urge to flee the emotional intensity through his reflection about lack of alternative and encouragement from others. Challenge from two counsellors - initial resistance – reflection – acceptance of accuracy and relevance.	Taking responsibility ("I play a part"). More effective interpersonal behaviour. Intention to change his tendency to run away from difficult situations.
Simon	Desperation, wanted to drink himself to death. Went to recovery café and received encouragement. Personal commitment to complete the course. Given space and time to settle, not forced.	Group 'chipping away' Invited to contribute feelings and opinions in group, he found it very difficult to express himself in any way. Felt listened to and taken seriously in life story.	Gradual 'coming out of himself' Feeling of belonging, sense of community Improved social network – friends whom he can meet or phone.
Saul	Went to the Brink (recovery café) after hospitalisation. Encouragement from others builds trust.	Challenge from peers -> modification in his expectations of judgment and less defensiveness. Ritual 'letting go' of stepfather, in collaboration with counsellor. Reflection on treatment philosophy	A new openness and a change of attitude. A 'grown-up' self takes over from the petulant 'child' self. Commitment to abstinence.

n.b. everything noted in this table is explicit in the interviews.

7.1. Key components

Despite considerable variation in the individual narratives, the key components that emerge from these interviews and observations consist of trust building, increasing active participation, responding to challenges resulting in a modification of thinking and emotional responses. The construction of new or renewed aspirations, values, and self-image also emerges in many of the narratives. Feeling valuable through contribution and a sense of belonging are also described by several interviewees. A common issue shared by all of the clients interviewed is an account of the addiction culminating in a severe loss of confidence and uncertainty about themselves, particularly about what was important to them. The changes taking place in the programme were resulting in increased confidence, returning values, pride in new behaviour and increased self-esteem, and the discovery of their feelings and concerns. A related idea is the taking of personal responsibility for one's feelings and actions. These changes appear contingent on active participation/involvement in the community and the acceptance of the value of others' feedback, which challenges their own perspective. The level and manner of participation and the readiness to accept feedback varies but both of these are salient features of each account. A typical pattern is to hold back and build up involvement tentatively over the first few weeks, and to resist feedback at first, but a couple of respondents (Keith and Richard) said they entered treatment ready to get involved from the beginning.

The change mechanisms appear to depend on the programme environment for activation. Certainly that is the belief of the clients themselves who either explicitly or implicitly state that they needed to come to the programme to make the changes.

7.2. Contexts

These fall into three areas: individual/family situations precipitating referral, access to recovery resources before treatment, and the structure and cultural norms of the treatment programme itself. These are all quite proximal contexts: the interviews and field-work did not allow recognition of more distal structural

or cultural contexts, other than that one of the respondents was referred as a condition of probation following a prison sentence, and another as a condition of receiving a prescription and being provided with accommodation in a 'dry house'. The availability of resources such as the Brink 'dry bar' in Liverpool, where people considering treatment could spend time, drink coffee and have the opportunity to talk to people who had been through the treatment was clearly considered important as a preparatory and motivating context. Several, but by no means all, had been attending mutual aid groups, while struggling with abstinence, before entering the SHARP programme.

Half of those interviewed in Liverpool and Bournemouth made a point that they were in a bad way before arriving at SHARP: four had been hospitalised either as a result of alcohol-related illness or suicide attempts in the preceding three months. Three more reported losing everything materially, and another had been isolated in a bedsit for a year prior to admission. Others mentioned some kind of crisis, such as bereavement, or a family ultimatum, and one had been referred by the probation service after serving a prison sentence.

The majority of interviewees said that it was not easy to participate for the first days, most said they found it difficult to speak in treatment activities. A typical example was Michael who was isolated with social anxiety problems. "At the beginning I sat in a corner, anxious, very fragile mentally and physically, I didn't talk. I felt broken." He found it difficult to get up and go into the programme each day. When I asked him how he managed it, he replied, "My mum instilled in me a battling "don't give up" attitude." He describes an inner dialogue between this and the "I've given up, I'm broken, I don't care" position. So at first he relied on this inner dialogue, but he revealed there was another important contextual factor, the acceptance and welcome he received at the centre, even after he had had a lapse:

"When I used I swore I wouldn't come back, it doesn't work etc., but when I did go back I got accepted every time. That acceptance made the difference, being believed in." Michael, Bournemouth.

It was emphasised by all respondents that the treatment environment was an indispensable factor in allowing them to settle and participate. Qualities mentioned included acceptance and welcome from staff and fellow participants, the predictable structure, the encouragement and advice of their peer group and the respectful way in which challenge and feedback was provided.

This led to a feeling of safety:

“It felt safe – I mean as angry as I got and all that, I didn’t feel I was at risk of any harm, d’you know what I mean, I didn’t feel like I was being judged even” (John, Liverpool.)

“I feel safe here . . . It’s like an air bubble, if you get what I mean.” (Julian, Bournemouth.)

Another factor that was important for two of the interviewees, Robert and Michael, was the intervention of families. In both cases they had become estranged from their families and isolated, but family members came forward with offers of arranging help, which were responded to with gratitude and commitment. Although there were only two instances of this the stories were strikingly similar and it seemed useful to explore how frequent this was and whether it was a significant factor for those in Phase 2.

7.3. Mechanisms

Of the possible candidates for mechanisms, the interviews reveal that the first process is one of building trust. Most report not participating very fully or revealing themselves at first, but as they listen to others in their treatment group, usually to those who are further ahead in the programme, they recognise what they hear in themselves and they begin to identify with others. They begin to recognise others’ care and interest, both from their peers and from counsellors. This is several times associated with the ‘life story’ assignment and the response of the group. A frequently mentioned occurrence is that they are impressed and admiring of the honesty and courage of others when they disclose painful material (explicit examples are given by John, Jason and

Francis, others give illustrations of how they came to admire and trust the group, for example for their integrity and perceptiveness.)

Following this they experience challenge or reframing by others. Often the first challenge is that they are holding back, not telling the group very much about themselves or showing their feelings (e.g. Robert, Michael, Charlotte, Simon). They start to receive feedback about their presentation in the group, some of which may put an entirely new perspective on their experience, for example Kristen's passivity and timidity is reframed as originating in her experience in her childhood family rather than as an innate character trait, and it is suggested that John's anger and hatred towards others is the result of his having been mistreated as a teenager.

When the challenge is offered, the interviewees describe a process of reflection on it, reflection that is emotion-laden, far from dispassionate. Several said they resisted it, that it was hard to hear, or that they felt angry initially. It is clear that in all cases the challenge was taken seriously, and it was often heard from several group members and counsellors simultaneously. The acceptance of the relevance and probable accuracy of the feedback came about from a combination of the respectful manner with which it was delivered and the attraction and respect felt to those delivering it. Sometimes this process was quite agonising: John was consumed with anger at people he assumed were 'abusers', even though he did not know them and they hardly impinged on his world. His counsellor asked whether he had been the victim of abuse himself. John angrily rebutted any such suggestion, but then remembered that he had been brutalised and persecuted in the Young Offenders unit where he had spent his early teens. He said that he was eventually able to process this feedback and feel relieved of a great deal of tension and anger, because he felt safe and not judged. John's interview provides evidence for reflexivity, the modification of the internal conversation and the reclaiming of lost values and is further analysed in the section below on theoretical redescription.

Alongside and dependent on these processes of building trust and responding to challenge is a process of developing care for self and others. As well as receiving challenge, as participants in the group they are also involved in giving

respectful challenge to others, and although this is not explicitly referred to in any of the interviews (perhaps surprisingly), the reciprocity of the relationships certainly is frequently referred to, for example by Robert in terms of reciprocal caring.

Several, including Simon, Robert and John, referred to a sense of belonging to the group, of fitting in, of there being a sense of community. This was also expressed as a feeling of connection, in Francis' case naming new friendships he could rely on for support.

7.4. Outcomes

These processes produce outcomes. It might be said that the connections and new friendships described in the last paragraph are outcomes rather than mechanisms, but it could also be maintained that these new connections act as mechanisms in turn to enable further changes and the maintenance of changes made. This research is limited to within-treatment changes, however, and does not provide evidence for this in itself. However the outcomes that are produced may be compared with factors that predict recovery in the literature, for example in the work of John Kelly and colleagues, as will be done later in the chapter.

The main outcomes that are described in the interviews are changes in what a person cares about: new priorities, values, commitments, and new emotional responses. Also frequently mentioned are better self-esteem and increased confidence. Many of the interviewees said that when they entered treatment their confidence had been badly damaged and that participating in treatment had improved it. In the interviews this seems to mean most commonly confidence to cope with life, and to develop aspirations, but less frequently it refers to confidence to remain alcohol and drug free. This will be explored more fully in Phase 2.

7.5. Countervailing mechanisms

A number of mechanisms have been identified which might act as constraints on the change mechanisms. These can be categorised as 'sustain' mechanisms which tend to perpetuate addictive behaviour, and 'treatment quit' mechanisms.

An example of a sustain mechanism is given by Francis where he describes bottling his feelings up, failing to express them, until they blurt out in an inappropriate way and the consequent embarrassment and shame are responded to with drinking. More commonly heard about in the interview are processes that lead to treatment drop-out, or might have done had not change mechanisms been activated. The mechanisms that counteract the tendency to drop out involve reflexivity and the context for their activation is usually active support and encouragement from others. When for example the man who had disclosed material hard for the group to accept did not receive support and encouragement the result was his dropping out from the programme within a few days. Whereas when Jason and Francis were affected by the emotional intensity of some of the interactions they saw in the first few days they both received encouragement to stick it out from fellow group members. This seems to have made it more likely that their private reflections would result in perseverance.

7.6. Theoretical redescription

So we can see that under certain conditions, reflexivity can mediate encounters with the structure and culture of the treatment programme. As Greenwood puts it, social phenomena are “the constitutive product of arrangements, conventions and agreements” and in his view “identity and emotion are social psychological phenomena that are grounded in commitments to sets of arrangements, conventions and agreements.” (Greenwood 1994. p.93). It will be argued here that the shifts in emotional response and identity are the product of involvement in and commitment to the arrangements, conventions and agreements of the treatment programme.

Greenwood’s formulations are compatible with Archer’s view that emotions are “socially constituted properties which are emergent from the internal relationship between the subject’s concerns and society’s normativity.” (Archer 2000, p. 215).

Archer also, in a way similar to Greenwood, links emotion to the development of personal and social identity: “the individual, as presented here in his or her concrete singularity, has powers of ongoing reflexive monitoring of both self and

society, which enables this subject to make commitments in a genuine act of solidarity.” (Archer 2000, p.295). Greenwood sees trans-temporal personal identity as “determined by the maintenance of sets of fundamental beliefs, principles and commitments”, and that these beliefs, principles and commitments “play a central role in the psychological explanation of the intentional behaviour of persons” as well as determining the “things we care about in our everyday lives” (Greenwood 1994 p.106). Both theorists link emotion, identity and identity projects and claim that these phenomena are intrinsically socially constituted.

Archer (2000, 2003), having described emotions as commentaries on our human concerns in the natural, practical and discursive orders, identifies reflexivity as the medium through which our emotional life and identity can be articulated, reviewed and developed. The internal conversation mediates between the person and the situations she encounters, both natural/physical, performative and discursive, and allows intentional responses to social phenomena with their arrangements, conventions and agreements, whether those be refusal or compliance, resistance or commitment. Archer and Greenwood diverge in their accounts of how first-order emotional responses (to situations in the natural, performative and discursive orders) are modulated by emerging second-order emotionality. Archer (2000, p.223) claims that Greenwood sees this process as essentially cognitive: a process of “rational persuasion” (Greenwood 1994 p.156). It is clear from his endnote on this phrase (*ibid.* p.176) that he is thinking of persuasion as coming from another person or persons, as in, for example, cognitive therapy. Archer rejects this perspective as separating *logos* and *pathos*, whose inextricability it is her philosophical project to maintain. She also criticises Charles Taylor’s account of ‘transvaluation’ as she thinks it conflates “our concerns with our emotional commentaries upon them” (Archer 2000 p.225). This is an important distinction: as a realist she maintains the reality and “ontological worth” of the objects of our emotions. In other words, our bodily suffering or comfort, our performative competence or lack of it, and our worth as reflected by our social situation are real and independent of our epistemic judgements.

Archer's account of the morphogenesis of second-order emotions, as she calls it, depends on an internal conversation which is not all dominated by *logos* but infused with passion. The internal conversation is envisaged as between an "I" and a "You" and is derived from the work of Charles Peirce. Reference may be made by the "I" or the "You" to an historical "Me". It is not a dialogue between logic and feeling: as she puts it "*logos* poses questions and *pathos* gives its commentary" (ibid. p.231). Both are made use of by each participant in the internal conversation: each has its own reasoning and emotional commentary. She delineates the process as one of three overlapping stages over time, as in her earlier accounts of morphogenesis (Archer 1995, ch.6). First-order emotions are conditioned by prior events, but there is then the possibility of progressive articulation and re-articulation of the emotional experience, leading to an elaboration of second-order emotion. The process is characterised by stages she calls discernment, deliberation and dedication.

What seems to be missing from Archer's account is the role of external interactions in this process. What is the relationship between external conversations and the internal one? How do the former influence the latter? Archer (2012) develops a typology of reflexivity, including a class of 'communicative reflexives' who require interlocutors to complete and confirm their internal conversations. Although she characterises this class as cleaving to interpersonal solidarity, she sees them as potentially conservative, tending to replicate the values and limits of their natal family life. Her research sample is made up of those involved in undergraduate study at an English university, and it may well be that the limits of her classification are to be understood in terms of the limits of that sample. It is not at all clear how interactions with others may be used in the reflexive process to progress the elaboration of new emotional responses, the reordering of priorities and the development or renewal of an identity project.

In order to redescribe theoretically the key components identified above, evidence must be adduced about how the clients encounter and engage with the arrangements, conventions and agreements of the treatment programme (or fail to do so), how this involves a building of trust, and how participating in the practice of the programme facilitates a process of self-articulation (discernment,

deliberation and dedication) leading to the emergence of an elaborated second-order emotionality. Concerns are prioritised and/or accommodated: as Archer points out we all have a plethora of concerns, some of which are mutually incompatible and therefore responses to some concerns must be subjugated to responses to others.

At this stage there is simply a process of redescription occurring. In order to posit a convincing explanatory model, the phase 2 'theory-driven' interviews based on questionnaire responses will be brought to bear to clarify and focus what is being redescribed here.

7.7. Arrangements, conventions and agreements – the causal powers of the programme

There is no doubt that participants who enter the programme encounter an unusually clear set of arrangements, conventions and agreements, and as they involve themselves in it they become party to and commit themselves to these. If this fails to happen the programme is not able to exercise its causal powers, and the participant will not receive the potential benefit.

Arrangements

The programme is characterised by a very clear structure and predictability. There are efforts made by the staff team during the pre-treatment assessment process to engage the client and to explain the expectations of the programme. The induction process includes introductory workshops about the way the community works, about group therapy and about the abstinence expectation. There is a clear and well disseminated timetable of activities, and participants are expected to attend all of these promptly. There are clear and published sets of procedures for various contingencies.

The structure is not tyrannical; it could be described as firm and caring. When participants struggle with the expectations, for example for regular prompt attendance, the staff will make a phone call inviting the person to return the following day and the importance of this expectation is reiterated. The peer group of participants offer role-modelling, encouragement and information for newcomers.

Conventions

The expectations for interactions between all participants, clients and staff alike, are also clear: as honest and direct as possible but always respectful. Aggressive, disrespectful, belittling or discriminatory interactions are considered unacceptable. Inclusivity, as manifested in the expectation that all clients to participate in all the activities, is an important norm, but as the interviews reveal clients are not pressured to participate, they are gently encouraged to express their views (i.e. to be active participants offering their own thoughts and feelings, not passive recipients of advice and feedback). Many of the first phase interviews emphasised the accepting and welcoming ethos and how important that was in attracting and retaining clients:

Michael from Bournemouth says that when he returned from lapses, he was “accepted every time.” It was this acceptance that he says “made the difference, being believed in.”

Jason in Liverpool described the first glimmerings of trust emerging as he experienced the warmth and acceptance of the SHARP programme. This counteracted feelings of wanting to run away when he felt raw and vulnerable.

Agreements

There are a number of examples of the participants in the programme entering into agreements. The rules of the programme are carefully explained to the participant together with their rationales, and assent and commitment to these is requested by means of the person's signature. During the first weeks of the programme a process of constructing a personal treatment plan with individualised goals takes place: this is explicitly intended to be a collaborative process and both counsellor and client sign the draft plan, which is open to review and revision by both parties. Clients exchange mobile phone numbers with each other and agree to support one another 'out of hours'.

There is preliminary evidence from the first phase interviews that the causal powers of the programme, whose structural and cultural aspects pre-exist the entry of each participant, reside in these arrangements, conventions and

agreements, and that the mechanisms by which they actualise these powers is by activating the internal conversation of each. This aspect will be subject to more focus and elaboration in Phase 2. However, it is clear from all interviewees that the structure and culture of the programme is valued and welcomed, including the very clear behavioural expectations.

7.8. The internal conversation

In the first phase interviews theoretical terms were avoided by the interviewer (the exception is 'identity', but this was only asked about if the word was mentioned by the interviewee first). The internal conversation or dialogic thought are not concepts that are widely understood outside academia. However Archer points out that "I says to myself, says I" is an expression that shows the concept of the internal conversation is meaningful to the lay person. Archer's starting point is "unslavishly" Piercian (Archer 2000, p.228) and I follow her in that. Is there convincing evidence in the interviews for the causal effects of the programme affecting the internal conversation?

Possibly the clearest example comes from Francis (Chapter 6 pages 141-144). He explains that his first response to the emotional intensity was the thought "*I didn't come here for this!*" and he considered leaving the programme. However he returned the following day "*feeling more chilled*" but still confused. These thoughts do not have any explicit dialogical character. He must have expressed his confusion and doubt in some way to other people, as he received encouragement from others in the programme to "stick it out, you'll be ok." This led to some private reflection at home over the weekend – "*a good long think*" as he puts it. He asks himself, "*What's the alternative?*" This is clearly a piece of internal dialogue. He refers to the Piercian "me" by thinking "*I don't have it in me*" (to carry on the way he had been). In the following few days he eventually involves himself in the programme activities. He says "*I can't really put in to words what happened. I could see people taking a step back and taking a serious look at themselves – being scared to do it but doing it anyway. I could see that they were scared like me. I thought 'I'll give it a go. Fuck it, let's go for it!'*" The "let's go for it" reveals that this thought process is an internal conversation. This is a rich example as it shows the impact of other people's

interaction in influencing his reflection, by normalising his confusion and advising him to “stick with it”. He then prioritises his concerns, deciding that the lack of viable alternatives and the need to change override his fear and anxiety about the intensity of the programme.

Francis also mentions the importance of reflection in making use of the feedback his counsellors give him: *“It was not easy to hear at first, but I had a think about it. I could see I was doing that and she wanted me to look at my part in it.”* And on another occasion in response to similar feedback: *“What do you mean? . . . But I thought about it and could see she was right.”*

He clearly attributes changes in himself (which he acknowledges are just starting and are by no means complete) to feedback he receives from people he trusts, and a process of internal reflection leading to a new emotional appraisal of problematic situations, which he regards as highly significant: *“It’s a game changer, this!”*

Charlotte also gives an account of her internal conversation:

“I cried when I did my life story – when I wrote it I didn’t feel it much but when I read it out I put myself back there. I thought ‘Why am I crying?’ I thought these things didn’t affect me. But obviously they must have as I had no control over my tears. I realised I was feeling something about what had happened to me. At the time I wasn’t allowed feelings I just was told to get on with it.”

The upshot of this and similar reflections was that it allowed her to discover what was important emotionally to her, which is crucial to the reformation of her identity.

Jason from Liverpool (Chapter 6, pages 134-138) also gives a very clear example of how his first order emotional reactions to a very challenging situation with his wife were responded to with a new restraint and the second-order elaboration resulted in feelings of pride in himself and increased self-worth. He describes how the process did not simply involve new behaviour, but reflection on himself at the same time:

“And I must admit, well, it’s about a ten minute walk from the bus stop to the station you know, and walking to the station I felt a bit sad, because of the way . . . probably because of the way she’d spoken to me. But then again I’m thinking, well, I thought about myself, and what I was like, and I thought . . .”

And then: *“I just felt stronger as a person, to step back from that . . .”* In his reflections in the interview, he feels proud and happy about the changes he is making: *“I am absolutely over the moon, no, because I can feel the changes in myself, I can, I really can.”*

As we have already seen, Jason was prepared for a new response to the situation by work he had done in the programme. He had learned to interrupt his reaction to emotionally arousing statements from others by a process of internal reformulation, which shows clear indications of internal dialogue, for example: *“Hang on, whoah! that’s not mine, that’s yours!”* Jason several times describes his inner thoughts as including *“whoah!”*, an exhortation to himself.

Jason’s interview also contains a very clear example of how dialogue with his peer group can be internalised to replace or challenge old internal dialogue with his critical “inner committee”, establishing a mechanism whereby external interactions permit or activate changes in the internal conversation.

In order for this to happen, it seems the new utterances must come from valued and respected others. Moreover the feedback that is given and received is representative of a new form of life, a new social/cultural practice. The individuals in the peer group have not been coached to give formulaic feedback in any specific case, indeed its value in part resides in the perceived sincerity, spontaneity and concern of the individual giving it. But what gets focused on, and the way it is responded to, is the result of the participants being inducted into a ‘community of practice’, the culture of the programme being transmitted explicitly and implicitly by counsellors and prior clients.

7.9. Discernment, deliberation and dedication

The interviews provide very limited evidence that the internal conversation in these cases proceeds through these stages. The excerpts from Francis’

interview above do seem to indicate a process of discernment: he recognises that the other people in the programme have similar fears to himself but are daring to speak about themselves. He describes a process of deliberation, concerning his ambivalence: should he involve himself or not? And finally the thought “*Let’s go for it!*” seems straightforwardly to indicate at least an initial dedication.

Anne, Francis and John all give an account of a process of deliberation when peers or counsellors give them feedback. They all report finding the feedback difficult. But each says they came through a process of deliberation to see the feedback as accurate or relevant. This occurs at different rates. Anne writes the feedback down so that she can reread it and consider it. John is the most explicit about the initial emotional impact of the feedback. On being presented with the possibility that he had been a victim of abuse, he says:

“It was like ‘fuckin’ hell!’ I was shocked. Because I didn’t think I’d suffered abuse, to be honest. And I hadn’t seen that as abuse at the time, it was just the way it was. I remembered it but I had just shut down. I remember that at the time, just shut down you know what I mean. In the past I used to blag myself I was OK. I used to tell myself it didn’t bother me you know.”

So in order for this new perspective to gain a purchase, John has to revise his established way of dealing with these events, shutting down and rationalisation. He goes on:

“Well I just slumped. You know I remember feeling: ‘fuckin’ hell’. I couldn’t process it there and then . . . Well, it was that he was stepping right into something even though I was resisting and going ‘fuck off’ and doing all that stuff – my peers were asking questions of me as well it wasn’t just Don – and they were asking in a way - well if had been abusive – it was ok to step into, y’know.”

Alongside the emotional response to this impactful reformulation was a feeling of trust and safety. This seems crucial to allow the discomfort of the feedback to

be tolerated. Later in his programme he was similarly challenged by the same counsellor, and his reflection on his own struggle produced a significant change:

“My first reaction was ‘I don’t have a fuckin’ problem, what are you on about?’ I mean the denial came in again and I was pushing him away, and I got into a big heated argument with him. To the point where, er, I was fuming. And he kept giving it back to me – he wasn’t - he wasn’t letting it go over his head and he kept putting it back to me – ‘cos it was my stuff, and I didn’t really get it at the time and when I was in it with him I was really fuckin’ angry – actually I was more angry with meself. And I turned round and said to him ‘You know what – I can’t fuckin’ communicate with ya!’ But I felt me shoulders drop as well, you know what I mean – and I went to see me own counsellor Erin and she sort of . . . and I went to her ‘what the fuck are youse smiling at?’ cos I was right in myself and I had just had a really harsh experience, and she said ‘I can see you’ve given in – you’ve surrendered.’ And I had! I’d had enough of the back and forth, the fighting, the verbal.”

The awareness of his shoulders dropping, and the significance of that, is surely an example of the ‘messiness’ of the process of the modification of the internal conversation. In situations like these it does not occur in a neat, stage by stage progression. Doubtless, many other incidents and periods of reflection would have led up to this event, which is perhaps best thought of as a moment of dedication. He feels relieved of the need to react, to struggle. Later in the interview he describes how this new perspective has endured and how he can use his internal conversation instead of relying on feedback from others:

“Yeah, you know, I got a better understanding, because that reality, for me, I really fuckin’ believed it, until it got pointed out in that way. It’s a much more true way of living. It really opened me eyes. I can always check meself now, I don’t necessarily need other people to do it.”

7.10. Personal identity

There is considerable evidence from many of the interviews that the programme provides the opportunity to begin the process of reforming a personal identity. In Archerian terms, as we have seen, personal identity emerges from our ultimate concerns, and our prioritisation of the competing concerns which impinge upon us. Greenwood holds that identity is about the maintenance of sets of beliefs, principles and commitments. In the interviews there is a contrast between John and Richard, who have a year and two years of abstinent recovery respectively since they went through SHARP, and the others who are currently in the programme. The latter are clearly describing an incomplete process, as with Jason, who says:

“. . . I find a lot of me values are coming back. I am most definitely changing, I mean I've been, as you're aware of, er, not just this weekend, I mean probably since I've been here, I've been here five weeks and I've had four or five (crises), when I say crises, normally I would have, would have walked out on them. I would have normally, without a shadow of a doubt – there's no ifs or buts – but I do feel as if I've taken on board some of the tools that we learn here. It's reminding me of me old values, of what I am, or who I am. And I've been able to use those.”

His account supports the intrinsically social nature of this process:

“The compassion I felt, you know the warmth, was amazing, and it did help me open up, a lot of things, it helped me get a lot of things off me chest . . . I realised ‘Hang on, whoah! These people really care.’ Which I hadn't . . . I've not, er, felt for quite some time. Erm, which is unusual for me - I've not really had anything like this before you know . . . I can feel - I can feel for other people. I mean I have heard other people's life stories, but even interacting in group therapy I find that I can relate to people. I mean if somebody shares something that I can relate to I can relate back. I find that helps, I find it uplifting, I find it helpful, as well . . . I can feel, er, I can feel their pain, that's what it feels like to me, so I can, er, I can relate to their

pain, so I can sort of feel how they're feeling. And, er, you know if there's anything I can say or do to help them alleviate that, I feel that's good, on a two way basis, I mean, if someone who's sharing if I can speak to them or I tell them how I'm feeling, I find that helps – I feel as if that's a two way thing."

His commitment is constituted in mutual caring as a member of a social group.

John was able to tell me how he left behind a criminal addict identity which he never felt comfortable inhabiting:

I asked him: *"I mean if you were to describe your character changing through those kind of experiences, what was it changing from and what was it changing to? You mentioned honesty and open-mindedness, but can you be a bit more personal about it?"*

He replied: *"Er, personal? Er, you know even in addiction and all this crime that I'd done I never fuckin' felt that I was bad. I come from good values as a kid – from me mum and me dad, you know. I come from a good home actually. There were issues obviously, but it was a good home, it was a loving home. And I never ever felt that comfortable in the circles I mixed in as well – I never felt comfortable being a criminal. Yeah, I used to get excitement and stuff like that, but when it got to hardcore criminality, like violence and things like that, I fuckin' didn't like it, you know what I mean, and there was only a certain, like, a certain level of things that I would go to. Don't get me wrong – I stepped over the line many times – but I didn't want to. I didn't want to do those things, you know what I mean – I didn't feel good about it. And I think the change, what I felt was, 'I don't have to do like that anymore' – you know, I can step into somewhere else and get a bit of peace."*

Richard, about a year out of the programme, remembers:

"My rock bottom wasn't when I was homeless or anything like that, my rock bottom was just looking at myself in the mirror, and actually

looking at myself and saw, you know you were talking about identity, that identity thing, what I saw in the mirror wasn't who I thought I was. So I have this inner image of, you know, everything is really good, no problem, and then one day I actually looked at myself and thought 'What have you done to yourself?' I realised that time had . . . it was as if I'd gone to college and time had stopped, and I just fast forwarded 15 years, and then, boom, sitting front of me was half a person, well less than half the person that I was back then."

Describing the change during the 12 weeks of the programme, he says:

"Well it wasn't massive. I think my, er, my understanding of my potential I think. I just wanted to be a kind honest person, that didn't have ulterior motives, and, you know, wanted to help . . . But the thing I just started to believe: belief in my self-efficacy - that was one of the words that one of the counsellors used, 'cause I was always asking, and I love new words and things like that, and I'd never heard of self-efficacy before: I didn't have much occasion to use it with my lifestyle (laughs).

These extracts illustrate what is contained in almost all of the accounts (see the outcomes column of table 7.1): before entering the programme, there was a great sense of uncertainty about one's self, emotions and concerns, and a diminished confidence. As a result of involvement and commitment, the participants felt accepted, received and gave feedback that reflected caring, took part in what were experienced as significant and meaningful activities, and grew in confidence as their uncertainty about themselves and their values and priorities diminished.

7.11. Social identity

Whether there is evidence of an emergent social identity is more difficult to establish. Archer's account of the dialectical relationship between an emerging personal and social identity reiterates her concern to preserve agency, and to emphasise that social roles are not simply the gift of society but are inhabited by a person with 'personal emergent powers'. This is problematised in Part IV of

'Being Human' (Archer 2000), as each identity seems to require the other in order to emerge. It is possible to speculate that something similar is occurring in the social microcosm that is the SHARP treatment programme. Within the programme there is a social role available as an involved and committed member of the community, and the programme serves as a kind of training in both reflexivity and mutual helpfulness. The adoption of this role enables the emergence of a (transitional) social identity. This social identity is in a dialectical relationship with the emerging personal identity as one creates the possibility for the other, in the context of the social and cultural properties of the programme itself. What are not heard about in the interviews are the social roles available to 'recovering people' in the longer term, as for the most part those have yet to be presented and explored. In the following chapter the interviews with those who have left the programme for various length of time, from both phase 1 and phase 2 (a total of 5 people) will be re-examined for evidence of post-treatment social roles.

7.12. Comparison with factors associated with durable recovery

As was described in the literature review, John Kelly and his colleagues have published a series of papers which explore what he calls the "mechanisms of behavior change" by which people maintain durable abstinence in the mutual aid society Alcoholics Anonymous. They conducted a systematic review, which suggested that "AA helps individuals recover through common process mechanisms associated with enhancing self-efficacy, coping skills, and motivation, and by facilitating adaptive social network changes," (Kelly et al. 2009, p.236.) I have argued that what Kelly and his colleagues have demonstrated is that the acquisition of certain characteristics mediates the outcomes, and that mediators are not the same as the underlying mechanisms. The phrase "mechanisms associated with" indicates that this distinction is not lost on these authors either.

A paper published later (Kelly et al. 2011a) ranked the relative importance of multiple mediators, using the large dataset from both arms of Project MATCH, half of whom were recruited from the community and half having completed a brief residential treatment programme. The second group ("the aftercare arm")

were somewhat more impaired in the severity and duration of their alcohol dependence and in their mental health. The authors found that for both groups together, increased social self-efficacy and social network changes were significantly associated with good outcome. For the more impaired aftercare cohort, two other factors mediated outcome: reduction in negative affect and increased 'spiritual practices'.

Assuming that the social practice exemplified in the SHARP programmes has developed to provide an effective grounding for durable recovery, the current study might begin to provide an account of the mechanisms underlying the initial acquisition of such characteristics. In phase 1, the term confidence is generally used by participants as a generic term, or one which signifies confidence to assert oneself. It emerges from trust in the acceptance and respect of others in the programme, and from active participation responded to with affirmation. Although there is hardly any direct expression of confidence to avoid drinking, more than one interviewee makes the point that patterns of behaviour which were associated with drinking are being changed (e.g. Francis' bottling up of feelings). The exception to this is Saul, who speaks of his new 'grown-up' identity as accepting of the need for abstinence and less prone to hanker after drugs and alcohol. While this is not a direct expression of self-efficacy, it provides an interesting clue that self-efficacy might be shored up by an emerging identity rather than by the use of 'coping skills'. Exploration of whether this confidence reflects self-efficacy to avoid drinking will be explored in phase 2, via the questionnaire and the theory-driven interviews.

Changes in social network are clearly occurring, in that bonds of friendship with others in the programme are developing, and association with these new companions during both the daily treatment programme and the evenings and weekends entails less interaction with drinking or drug using friends. However there is much less explicit emphasis on the latter than might be expected in any of the interviews. What is stressed is the sense of belonging, and the mutual support available from recently acquired abstinent peers.

Also entirely absent from any of the interviews save one, either with clients or with counsellors, is any mention of spiritual practices. Saul is again the

exception, describing himself as “a very spiritual person” and as we have seen, devising with his counsellor a spiritual ritual, involving meditation, to help him with his enduring burden of conflict concerning his step-father. The Kelly group’s papers that deal with spiritual/religious practices (Kelly et al. 2011a, 2011b, and Kelly & Greene 2014) are measuring these items: ‘thought about God’; ‘prayed’; ‘meditated’; ‘attended worship services’; ‘read or studied scriptures/holy writings’; ‘had direct experiences of God’. Apart from Saul’s ritual there is no mention of anything of this sort at all, despite the support for attendance at Alcoholics Anonymous and other 12 Step groups during and after SHARP, and several of the interviewees stating that they have attended meetings of these groups, are currently attending or intend to continue attending them after the programme. This most likely represents a cultural difference between the United Kingdom and the United States although an analysis of this is beyond the scope of this dissertation. It is perhaps possible to conclude that for these groups of participants meaningfulness and purpose in life is not framed in religious or spiritual terms. There is consistent mention of the significance of relationships being forged, of an intention to live by different principles and beliefs, and some talk of aspiration to live a more responsible and purposeful life, but this is all couched in secular terms.

It is clear that so far there is not sufficient evidence to clarify satisfactorily the mechanisms by which self-efficacy, motivation, coping ability, purpose and meaning in life are developed, and how taking one’s place in a modified social network facilitates this. Some strong hints are emerging, but more data are required, so in phase 2 a search for more focused accounts of the contexts, mechanisms and outcomes will be undertaken. The following chapter will describe the construction of a questionnaire and the recruitment of a cohort of clients at another SHARP programme, this time in Essex, to collaborate with me on elaborating the tentative theory by means of ‘theory-driven’ interviews.

Chapter 8: Key components questionnaire, theory driven interviews, towards an explanatory model

As was made clear in the last chapter, in order to strengthen the developing explanatory model, and in order to elaborate how the change mechanisms are activated in particular contexts, a second phase of enquiry was required. Influenced by research by Pawson (1996) in a British prison, the next step was to conduct a set of 'theory driven' interviews. A questionnaire based on the key components identified was prepared and sent to staff at the third research site, SHARP Essex, and were completed in confidence by 17 people, 14 currently in treatment and 3 who had graduated from the programme. Interviews were carried out with 6 of the current treatment participants, chosen by lot, and with the three graduates. The method of questionnaire development and the process of questionnaire completion and interview are described and justified in Chapter 5 – Methodology. The questionnaire does not stand alone: the items originate in the phase 1 research and the responses require elaboration and extension in the phase 2 interviews.

The questionnaire was arranged in three sections, representing the tentative contexts, mechanisms and outcomes identified in phase 1. After assigning a score to each item, each questionnaire respondent was asked to choose, in each of the three sections, what they currently considered the most important item for them, and the second and third. The interview focused on these three choices in each section. The interviews enabled in-depth explanations of the questionnaire responses.

The responses to the 17 questionnaires were tabulated in a Microsoft Excel spreadsheet. The scores were averaged in order to produce a ranking, and participants' first three choices indicated by red, orange and yellow cells, as shown in Table 8.1.

8.1. Validity of questionnaire responses

The responses by 16 out the 17 participants seemed coherent, reflecting good understanding of the items and how they applied in their own case. I asked the whole group how they had found the questionnaire and there was general agreement that it had been clear, easy to understand and that it had seemed

relevant. I also probed for understanding in the 9 interviews, and received explicit evidence in each case that the questionnaire had 'made sense' and that it had not been difficult to respond to the items. However there is one exception. Respondent 11, Jeremy, who was not interviewed, uniquely answered the item about safety with a low score of 1, and in the 'mechanisms' section, chose as his first and second choices items to which he had given low scores of 1 and 2. Other items were scored similarly to his peers, so these low scores do not seem to represent a systematic tendency to score low. Removing his responses does not alter the rankings, except in one instance: the first two items in the 'context item' ranking are reversed. Results tables are presented with his responses included.

8.2. 'Context items'

The items ranked in terms of the highest endorsement were as follows: (the number of 'top three' endorsements is in parentheses)

1. I found the treatment programme accepting and welcoming. (12)
2. The treatment programme felt like a safe place. (14)
3. The programme here felt well structured. (11)
4. I had little alternative to coming here as I was in such a bad way. (2)
5. I went to recovery activities (meetings, recovery café etc.) before I came here. (5)
6. Members of my family helped or encouraged me to come here. (5)
7. Criminal justice involvement made me come here. (0)

There is a very strong and near universal endorsement of the first three items. With the exception of Jeremy every person scored each of these items 5 or 6 with the majority awarding a score of 6. The instructions, both written and verbal, emphasised that the response was not to be how true they felt the statement to be, but how important it had been to their engagement with the programme. There is no difference in response to these first three items from the three graduates compared to the in-treatment group: they are equally emphatic that the welcome, structure and feeling of safety were very important to their own treatment experience. It seems justified, bearing in mind the

limitations of the sample size, to claim that the questionnaire lends strong support to these factors as providing a necessary context for change.

Table 8.1 Responses to 'context' items
(red: first choice, orange: second choice, yellow: third choice)

	Family encouraged	No alternative	Criminal justice	Recovery activities	Accepting & welcoming	Well structured	Felt like a safe place
1	0	6	0	6	6	6	6
2	6	5	4	2	6	6	6
3	4	5	0	6	6	6	6
4	6	3	0	1	6	5	6
5	4	6	0	0	6	6	6
6	6	2	0	0	6	6	6
7	0	6	2	6	6	6	6
8	6	4	1	3	6	5	5
9	1	3	0	3	6	4	6
10	4	5	0	6	6	6	6
11	0	1	0	4	3	5	1
12	6	0	0	0	5	5	6
13	3	6	0	6	6	6	6
14	6	5	0	6	6	5	6
15	2	6	0	6	6	6	6
16	3	6	0	0	5	5	6
17	3	6	0	6	6	5	6
Average score							
	3.53	4.41	0.41	3.59	5.71	5.47	5.65

The other items (4-7) reflect individual differences. Each has a wide range of scores from 0 to 6. Clearly family encouragement is seen as important for some (six scored this item as a 6), but not at all for others (four scored it 0 or 1). Similarly some had attended recovery resources, and seven respondents indicated that this had played a significant part in their application to and commitment to the SHARP programme by scoring the item 5 or 6. However six respondents indicated that this factor was of minimal importance by scoring it 0, 1 or 2.

For this cohort, criminal justice involvement played no part in the process of being referred to SHARP. In the three cases where this was scored anything

above 0, all of whom were interviewed, it turned out that it was not their own involvement that was meant, but that of a partner. The person who scored this item 4 had a partner who was currently charged with domestic violence towards her.

11 out of 17 respondents thought that their 'being in a bad way' had contributed to their wanting to undertake the programme. This seems sufficient, combined with the frequency of similar accounts in phase 1, to suggest that it might be typically important in providing a context in which the appeal of the programme might be increased.

All of these items will be further discussed, both as they are elaborated upon in the theory-driven interviews and in the process of delineating an explanatory model. The relationship of these responses to the phase 1 accounts and to what is known from the literature will be explored.

8.3. 'Mechanisms items'

The items ranked in terms of the highest endorsement were as follows: (the number of 'top three' endorsements is in parentheses)

1. I began to see the counsellors and the group cared about me. (7)
2. I began to identify with others in my group. (6)
3. The honesty and courage of others has helped me open up. (9)
4. My perspective on myself was challenged by counsellor(s). (6)
5. The way I think about myself is changing as a result of challenge. (10)
6. The staff/peers helped me focus and not get distracted by outside issues. (4)
7. My perspective on myself was challenged by my peer group. (4)

There was a very high level of agreement in the responses that all of these items were relevant and important in the change process. Each item received a large number of endorsements both as Likert scores and as 'top three' choices. It is not possible to draw firm conclusions about the relative importance of these items, but there is a suggestion that challenge from the counsellors is perceived as somewhat more influential than challenge from the peer group. Three items turned in an average score of >5.0. A feeling of identification with and admiration of the honesty of others in the group are endorsed as of great

importance, and the most highly endorsed item is the perception that the counsellors and group care about one. Despite the limitations of a questionnaire such as this, discussed in detail in Chapter 5, the ranking of these three items lends further support to the idea that change is activated through membership of a social group within which one gradually finds a place to be, that the process is not simply one of rational persuasion resulting in cognitive change. Once again these issues will be explored further in the subsequent interviews.

Table 8.2 Responses to mechanisms items
(red: first choice, orange: second choice, yellow: third choice)

	Helped with distractions	Counsellors/ group care	Began to identify	Honesty of others	Counsellors' challenge	Peer group challenge	Thinking re myself
1	6	6	6	6	6	5	6
2	5	6	6	6	5	5	5
3	6	6	6	5	6	5	6
4	6	6	4	6	5	4	5
5	6	6	6	6	5	5	6
6	6	6	6	6	6	6	6
7	6	6	6	6	6	6	6
8	5	6	6	6	4	3	4
9	3	6	5	3	5	4	6
10	5	6	6	6	6	6	6
11	2	5	6	5	2	1	5
12	5	6	6	6	5	5	5
13	5	4	6	6	4	6	3
14	5	6	6	6	5	4	6
15	3	5	6	5	6	2	4
16	3	6	3	0	2	3	2
17	3	5	5	5	5	4	2
Average score							
	4.71	5.71	5.59	5.24	4.88	4.35	4.88

8.4. 'Outcomes items'

The items ranked in terms of the highest endorsement were as follows: (the number of 'top three' endorsements is in parentheses)

1. I have new priorities in my life, what and who I care about is changing. (11)
2. I feel my values are changing as a result of this programme. (6)

3. I am clearer about the kind of life I want. (9)
4. I am making new friendships and connections. (1)
5. I am more confident I can live an alcohol/drug free life. (9)
6. My relationships outside the programme are improving. (5)
7. I feel more confident about myself amongst people. (3)
8. I have more self-esteem as a result of participating in this programme. (6)

Once again, there is a high level of endorsement for all items. The lowest ranked had an average score of 4.71, and 6 out of the 8 averaged over 5.0. As with the mechanisms section, there is a less clear correlation between scores and 'top three' choices than in the contexts section, perhaps indicating more difficulty in choosing the most important factors among a group of seemingly very relevant items.

Table 8.3 Responses to outcomes items
(red: first choice, orange: second choice, yellow: third choice)

	New priorities	Values changing	Self-esteem	Confidence abstinence	Confidence re people	Friendships connections	Relations improved	Clearer about life
1	6	6	6	6	5	6	6	6
2	6	5	3	5	4	6	4	4
3	5	5	3	4	5	5	4	5
4	6	6	4	5	6	5	5	6
5	6	6	6	6	4	4	4	6
6	6	6	6	6	6	6	6	6
7	6	6	6	6	6	6	5	6
8	5	5	4	6	6	5	5	6
9	5	4	6	4	4	5	4	4
10	6	6	5	5	5	5	5	5
11	6	6	5	5	6	3	3	3
12	6	6	5	5	5	6	6	6
13	4	5	3	4	4	6	5	5
14	5	6	6	6	5	5	6	6
15	5	5	4	4	5	5	6	6
16	3	3	2	4	3	6	6	4
17	6	6	6	5	5	4	5	5
Average score								
	5.41	5.41	4.71	5.06	4.94	5.18	5.00	5.24

No claims are made here for the amenability of the questionnaire scores to meaningful statistical analysis. In particular the average scores may not legitimately be treated as continuous data. The intention was to provide a 'rough and ready' ranking, with the top choices invited as a way of focusing the interview to a manageable number of areas. Bearing these limitations in mind, it is notable that the top three items in the list above are those most associated with the reformation of identity and burgeoning identity projects. Two of these three items were the most frequently selected as 'top three' choices, together with the item about confidence to remain alcohol and drug free.

New friendships and connections were seen as a very important outcome (score 5 or 6) by 14 of the 17 respondents, resulting in an average score of 5.18, but only one chose this as among their top three. It is possible that the development of a new social network is better seen as a mechanism, albeit an important one as reflected by the high level of endorsement, whereas the respondents tended to choose as outcomes changes that they perceived to be about themselves.

The interviews following the questionnaires are intended to clarify the questions raised by these results.

8.5. Theory-driven interviews

Nine interviews were carried out within a week of the questionnaires being completed. Six were with current participants in the programme and three were with people who had graduated at various time points: Melvyn had completed the programme two months previously, Laura eight months before the interview took place, and Abbie had been part of the first cohort when SHARP Essex was launched in late 2013. The interviewees (names changed) were:

Derek, aged 52, cocaine and heroin, currently in treatment

Libby, aged 31, alcohol, currently in treatment

Malcolm, aged 45, alcohol, currently in treatment

Molly, aged 21, cannabis and cocaine, currently in treatment

Lucy aged 22, alcohol, currently in treatment

Martin, aged 30, cocaine, alcohol, currently in treatment

Melvyn, aged 47, alcohol, graduated from treatment seven weeks before interview.

Laura, aged 48, cocaine, graduated from treatment eight months before interview.

Abbie, aged 51, alcohol, cocaine, heroin, cannabis, graduated from treatment two and half years before interview.

All three of the graduates had remained completely abstinent from alcohol and other drugs since treatment.

In accordance with Pawson's recommendation, the idea of a theory-driven interview was presented to the interviewees both in the written instructions for the questionnaire and in the preamble to each interview. At each interview the interviewee was asked how it had been to answer the questionnaire, and I briefly described the background to the study and invited them to help me refine the developing theory.

The nine interviews provided a chance to focus on the contexts, mechanisms and outcomes that each person thought was or had been important in their change process. Material from the interviews that enhances the evolving theory of change is presented in the following sections.

8.6. Contexts in the interviews

Seven of the nine interviewees selected "I found the treatment programme accepting and welcoming" as a top three choice in the contexts section, three of whom made it their first choice.

Martin said: *"Peers and staff make a point of the fact that addiction doesn't discriminate. There are all kinds of different people. It feels like there are no conditions, no agenda that you have to conform to. No matter who you are, where you have come from, whatever your situation, if you have an addiction problem and want to tackle it, you are welcome."* Interviewer: *"How did you pick this up?"* *"It was said in those words on a couple of occasions."* He went on, *"This is a very good group of people, very friendly, very open to getting to know each other."*

Abbie gave an example of how the welcoming ethos ensured that she made it to the programme: *“I got called a couple of days before the programme started by a counsellor. This gave me a connection, and hope, and my feelings of fear were validated and made to feel ok.”*

Two of the respondents showed how the welcoming friendly atmosphere helped to calm nerves:

“Everyone’s really friendly. You don’t know anyone when you first get here. You have to start bonding with them. And they’re very friendly, even the counsellors, they are all very friendly, and you can always go to any of them. I didn’t know what to expect, I was scared, nervous.” (Libby)

“The first day, Alex was sitting on the sofa and she could just see how nervous I was. It made me feel relaxed and calm within minutes of being here. And I realised I wasn’t actually on my own, everyone was feeling the same way. I could see the body language, everyone was sort of on edge and nervous. But everyone was so friendly, I was able to relax.” (Molly).

Eight people had selected “the treatment programme felt like a safe place” as one of their top three choices. The ninth also gave this the maximum score. When asked to explain why they had chosen this item, the following responses were made:

“A place I can go where I am free from drugs, free from any fear that there are drugs. Where I can be myself without drugs.” Interviewer: *“What makes it safe?”*
“I can identify with the other people here, we’re all drug addicts trying to find a way to live without drugs so we’re all trying to do the exactly the same thing, we’re trying to exist with our feelings, with our emotions, trying to make the right choice.” (Derek)

“Obviously there are no drugs and alcohol on the premises. Safe in that if you have the urge to use, or are struggling with your feelings, you’ve got a close network of people around you, both the peers and the staff that you can go to. When we go home in the evening we’ve got the phone, and we’ve got a Whatsapp group set up to stay in contact.” (Martin).

"I looked forward to coming here, I could be me here! I often said I felt like I was in cotton wool here. Even though it was hard to come here 6 days a week for nine weeks, I looked forward to coming here, it became part of my life." (Laura).

"I was entrenched in addiction, the buying of drugs, the taking of drugs, recovering from drugs, hospitalisation from drugs, suicide attempts in the last year before coming in, so from 8 o'clock in the morning till 5 at night I was safe. At no time during that period was I going to have access to drugs, simple as that." (Abbie)

"Safe for not going out there and using alcohol. And also safe to have feelings. You go through so many feelings here. Half the time if I'd had the feelings I've had here I could have walked out and used alcohol, but you learn so much here, you don't want to let everyone here down, you don't want to let yourself down." (Libby).

"Safe from reality, to be honest. It was that bubble environment, where I was with people that understand, that empathise. Safe from life I suppose. When I go home I stay in, I can't go and socialise yet. I do go to meetings. I feel safe anyway, I feel safe at home." (Lucy)

The other two gave briefer accounts;

"It just felt a safe place, safe from drinking for a start. And learning to cope with the outside world. In good hands really." (Malcolm)

"The people here, they have the same problem as you, nobody will judge you. The staff are here to help you." (Melvyn)

These responses confirm what the phase 1 interviewees said about the contribution of the experience of identification with others, of an accepting and non-judgemental ethos, and of a clear structure to the feeling of safety. This was safety to reveal oneself and to express feelings, which was reiterated in four of the quotes above, but what six of the phase 2 interviewees also stressed was safety in the sense of protection from temptation or opportunity to use alcohol or drugs. This seems of great importance and has two elements to it:

first, the clarity about abstinence, the firm proscription of any drug or alcohol use on or off the premises for the duration of the programme, and the random testing of clients on a regular basis, were seen by all those interviewed as welcome and reassuring. Second, as Martin and Libby make clear and others imply, the emergence of feelings is a risk factor for using or drinking, so the ability of the programme to normalise, contain and manage feelings through mutual support and the availability of approachable staff, was critical to allowing participants to persevere.

The experience of safety, as we see, is linked to the structure and to the welcoming and accepting atmosphere. In regard to the structure, selected by six interviewees in their top three, Martin said:

“I associate structure with normality. My life over the last decade or so has been lacking structure, massively, and it’s been very chaotic. So to come into an environment where there is structure has been very conducive to recovery”.

Interviewer: *“Have you found it easy to fit into that structure?”* *“Yeah, it’s very clear. It’s outlined on the timetable, and you very quickly get accustomed to it. Within the first couple of weeks you get to know what’s coming and what you are going to be doing.”*

“Well the structure is all about timing. You have to be here on time, do things on time, and I like that.” (Libby)

Abbie said: *“I felt the programme was clearly laid out. It was clear and concise and I got very quickly what they were trying do and what I had to do to achieve it. The structure made me feel safe, it was almost like being locked in, which I needed at the time and I embraced it with both arms.”* Interviewer: *“How did you hold on to that safety when you went home at night?”* *“Well it was the structure again: I’d been given the promise that if I turned up the next morning at 8 o’clock it would still be there. All I had to do was get there.”*

The responses to the other context items reinforced what had been found in phase 1: that some contextual factors are very important for some individuals but perhaps not at all for others. For Laura, her confession to her family, and the consequence that her daughter left their shared home and removed Laura’s

access to her grandchildren, was of great importance in stimulating her desire to change and restore her identity as a mother and grandmother. However, she explains that it was only because her family members were caring and supportive once she asked for help that made change likely. Otherwise, she says, she might have remained isolated and carried on with her cocaine use. On the other hand for Abbie, family relationships were irrelevant, as she had been isolated and without meaningful human relationships for decades:

“During my drug use everything just became more and more internal and isolated. I lost all my connection with anything human. I never looked to another human being for warmth or love or comfort or any of that, because you’ve got it all in here.”

Most of the respondents in both phase 1 and 2 had to some extent described themselves as being ‘in a bad way’, and it seems that all were in their own ways highly dissatisfied with themselves and their lives, but the range described in these interviews runs from Lucy’s demoralisation and despair to Martin’s more considered appraisal of how his life had failed to develop.

“I felt helpless, completely helpless. I did two residential before. It wasn’t the health or relational consequences. Something had to change, I was fed up of being fed up. I just felt so low, too low. I have had serious suicide attempts where I’ve been in intensive care. The thought of death didn’t scare me. I didn’t care about anything. There was an option to be happy, so I just thought I’d give it a go. If it didn’t work, if I didn’t feel better within a certain time, within six weeks, if I hadn’t made any progress in six weeks, well then I would kill myself.” (Lucy).

“I was fed up with the way my life was going. I started to use relatively early and lots of other people I knew were doing the same thing. I didn’t feel like an outsider or an outcast. I’m 30 now, and a lot of the people around me are moving on with their lives: they’ve got families, they’ve got children, they’ve got jobs, responsibilities, and I have an issue with addiction and I’ve been left behind.” (Martin).

However, it became clear that Martin's motivation for recovery was far from dispassionate. Very usefully for this study, he had embarked on the SHARP programme twice within a few months. He had come with very different attitudes on each occasion and with very different results: comparing this episode to the first occasion he says:

"I feel part of something, I feel part of the group. In the past – I've been in treatment before and I didn't, at that time. I felt kind of like emotionally numb, and kind of like a lone warrior, even though I was surrounded by people. It was actually here, at the beginning of the year. The course was much the same as it is now, but my state was very different. I didn't have any recovery experience then. When I came in here before, I'd been using cocaine non-stop for a decade, and yeah, I was emotionally numb. Whether it was an actual barrier or whether I was putting up a barrier, there was a barrier there. To the people and the caring and the support that was here."

This is an account in which he makes clear that he was aware of the resources that might have activated the mechanisms of change for him, but his state of mind constrained those mechanisms.

8.7. Mechanisms in the interviews

However, during the current episode of SHARP, Martin describes a process of emotional engagement that is vivid and convincing.

"I came back here a couple of months later, very much in a recovery state of mind. I'd moved forward to the point where I can start to embrace it. I can give you a specific example: the peer evaluations. We did our first peer evaluations yesterday, and I really cared. I could feel the feelings inside. I really cared about the people I was talking to, I cared about offending them, I felt good about affirming them, and I was concerned about what people had to say about me. Whereas last time I was here six months ago, I didn't care. I was almost like a robot, I could have said anything to anybody and it didn't mean anything . . . I think recovery is caring, in quite a big way. Caring about yourself, caring about other people, caring about what's going on around you. As opposed to just caring about obtaining money and obtaining drugs." (Martin).

When I asked how he knew he was cared about, he said, *“It’s things people say in group, that they value me, they value my contribution. I feel part of something, I feel part of the group.”*

Derek gave an example of how the perception of being cared about helped him to remain in the programme:

“I wanted to leave because I felt by expressing my feelings I had hurt others. The group told me that was the wrong thing to do as it would mean I didn’t get what I needed. I felt cared about.”

Identification was seen as a very significant process, but it was described with some subtlety. Laura makes the point that the differences in the drugs used came to be unimportant as other commonalities were discovered:

“Well you think you’re a one-off, you think you’re the only one with this bad addiction, so although a lot of them were here for alcohol, we all had the same hang-ups if that is the right word: we all had low self-esteem, everybody had no confidence, everybody had no self-worth, everybody didn’t like themselves. So as much as it was different addictions, the root of it all felt the same.” (Laura)

She explains how this began to modify her internal conversation:

“I realised I wasn’t alone. My husband doesn’t smoke drink or take drugs so he doesn’t understand. It made me feel better that it wasn’t just me. I started to realise that there are a lot of people out there that have addiction, and have problems, and don’t feel good about themselves. I’ve wanted to kill myself so many times, and other people are the same, it just eats away at you.” (Laura)

The process of identification is made possible by other people being open about themselves, and the feeling of belonging to the group did not entirely depend on close similarities but on sharing group attitudes and norms as Libby explains:

“Other people opening up was such a big thing for me. I was quite quiet when I first came in. I didn’t want to open up because I felt my life was just the same every day, just drinking, and I didn’t have any feelings at that time because I was drinking through my feelings, but when I heard others open up it made it ok for me, I didn’t have to worry about it. And joining this group gives you a really

good kick: everyone's in the same boat as you and that's what I really enjoy, people opening up to you, you opening up to them. And everyone has their own story. Some you may think 'oh yes, that's me' and others I might not think they have got anything in common with me, but they've still got that courage to come out and talk about it, and that's what I really like." (Libby)

This illuminates to some extent Maxwell's (2012) point about solidarity being engendered by similarity and/or contiguity. The interviewees appeared to value both the sense of identification and the preservation of individual differences and distinctiveness. Certainly the perception of caring from the staff, exemplified in their making special concessions to two of the interviewees who had mobility and chronic pain problems, and the trust in them that ensued, did not depend on identification. However, both Abbie and Melvyn said that they believed the staff to be very knowledgeable about addiction: *"they are the experts"* (Abbie), *"they really knew their stuff."* (Melvyn), and that this was another factor that enabled trust to develop. Melvyn was reluctant to open up. He had had serious health problems from childhood including arthritis and hearing difficulties, and had experienced bullying and teasing in his childhood and into his adulthood, but he says that because *"everyone else was opening up and being honest"*, he felt he should do likewise. He specified two things that helped him: one was the bond of trust that developed over the first weeks of the programme between the participants and the other was challenge/encouragement from his female counsellor, *"a kick up the bum"* was how he put it, but the context and his tone of voice made clear he regarded this as respectful and helpful rather than confrontational.

8.8. Challenge and change

Several examples are given of the kind of challenge clients experienced and how those challenges produced a change in perspective. Two related issues were the subject of challenge: being quiet and withdrawn was challenged frequently both by the peer group and by counsellors, (Mike, Melvyn, Abbie, Molly, Libby and Laura all described this), but in each case the challenge was not perceived critically: it typically took the form "we don't accept that you have nothing of value to contribute here, we would like to hear your opinions and

experiences". When asked "What did the group pick up on in you?" Libby replied:

"My confidence was very low, my self-esteem was very low, due to my ex-partner. They said I needed to come out of my comfort zone a bit more, because I can shut off, I can go quiet, because, er, I'm dyslexic and I have trouble with the paper work. But they helped me do that. And I feel like I'm challenging myself. The peers have told me I'm very friendly, very approachable. I knew some of the things, but when people tell you that it does give you a boost."

This was related to the other most commonly reported challenge, which was towards the participant's self-perception of worthlessness. These challenges could be verbal or expressed in behaviour: Abbie saw the structural and cultural aspects of the programme as constituting a challenge in themselves:

"The only things normal about me at that point were that I was female and I had clothes on. Everything behind that, that they saw, was broken. And I was disbelieving in anything. So immediately without saying a word, they challenged my perspective of myself by welcoming me. I hadn't been welcomed for years. By providing a place that I could come to that was safe, and by providing a programme that I could get involved in, they gave me worth. That they believed in my worth, that I could do it . . ." (Abbie).

I asked Laura "What did you get challenged on?" and she replied:

"Everything! I got challenged on how I felt about myself, I felt so disgusting and ashamed of myself. It was navel-gazing as they say, I couldn't hold my head up and have eye contact with people. You'd be talking to the top of my head! So I got challenged about my confidence, I got challenged about my self-worth, I got challenged about me. And I got challenged about my life and the reasons for what turned into drugs. And it was good to talk about it and get it out, because it didn't have to be such a secret." (Laura).

I asked: "You said the way you think about yourself is changing. How did that happen?"

“Because the more I done of the programme the more . . . I used to love group therapy and I don’t know, the penny dropped about the kind of person I used to be. I think maybe because I was coming in drug-free, and I was actually enjoying waking up and seeing the sun and having a clear head. I was actually enjoying eating, something I hadn’t been used to doing. And enjoying the company, again something I hadn’t been used to doing. And it made me see there is a life out there. I started to realise that I’m not such a bad person. They helped me: because they liked me, they helped me like me.” (Laura).

Martin was challenged on the way he approached his life and he described how this was helping him change his thinking:

“I’ve been challenged by the counsellors and by my peers and by myself. Mainly on my attitude towards life and my attitude towards responsibility. I had a lightbulb moment this morning: I realised that a crucial thing for my recovery is becoming independent, standing on my own two feet, separating from my family and having a life for myself.”

8.9. Outcomes in the interviews

The interviewees’ remarks about the changes that were happening for them frequently focused on being able to take a renewed role in their family. In response to the items ‘I have new priorities in my life, who or what I care about is changing’ and ‘I am clearer about the kind of life I want’, five interviewees (Derek, Laura, Molly, Martin and Libby) described their relationships with their family members changing, with three explicitly connecting this to their commitment to abstinence.

Describing being clearer about the kind of life he wanted, Derek said, *“I want to be able to live without drugs, I can’t go back to that.”*

I asked, *“What would that life be like?”*

“Contact with my son and daughter who I haven’t seen for three years. Last time I saw them we didn’t connect because of my heroin use. They don’t know me without drugs, they’ve never seen me clean. My son wants contact now, he came here and we played football together. My daughter was very scared by

my drug use, she is now willing to talk to me. Reconnecting with my family is the most important thing to me, but we will need time to adjust.” (Derek).

In response to the question about priorities, Libby said *“Well, with my children. When I am with them now I am sober I can listen to what they are saying. I still love them but it’s not that drunken love.”*

Laura responded to the question by saying: *“Family! I have three children and I have six grandchildren, and I was putting the drug, as I said, before them. Now, they are my priority. I obviously went through a stage when I was in my addiction, that when my addiction was clear to them, nobody would let me have any of the grandkids. Before that I used to have them all the time. So not being able to have them broke my heart. Now I’m trusted to have them again. I’ve worked to get that! It’s really, really important to me.” (Laura).*

Martin said: *“Family members, my mum, my sister. My friends, I’m starting to have real relationships with them, even in this short time, you know. My friends have seen the decline in me, and they’ve tolerated me, and they’ve been hoping that one day I was going to pull myself back to what I was.” (Martin).*

Asking the interviewees to elaborate on the items about increased self-esteem, changing values and being clearer about the kind of life that was wanted produced an emphasis on pride in achievement: stopping drinking and using, persevering with and in three cases completing the programme, caring about themselves and looking after their bodies and home environment. Laura said: *“How do I feel about myself now? As I said it’s nice to wake up, it’s nice to feel fresh, it’s nice to see the sun coming up, it’s things that I’d forgotten, happening every day! It’s nice to just have a shower in the morning, rather than just sit around and not care.” (Laura).*

Melvyn said that he was becoming *“a better person, I’m determined to be a better person”*, and when asked what he meant by a better person, he mentioned being active, doing things, helping others and keeping his body and home clean.

Martin felt his self-esteem had improved as part of his active involvement in a new social group:

“I think prior to coming into treatment my life was very static. I was in the same place all the time, doing the same things all the time, same people. But just to get out of that rut, to be with a group of new people I don’t know, to interact with them, to be accepted by them, that is what has helped me develop a bit of confidence.” (Martin).

Derek said his confidence had increased not only because he had made mistakes and had been able to continue with the programme but because of his commitment to active participation:

“I have been allowed to make mistakes. And the longer I come here and don’t run away from feelings, the more I learn about myself, and the more I learn about myself here the more chance I have of staying away from drink and drugs. I have to play a part: I have to keep bringing myself here, I have to keep pushing myself, because if I don’t I won’t just be letting myself down I’ll be letting the other people in my group down.”

Laura emphasises how her view of herself emotionally had moved from shame and embarrassment to pride:

“When I first came in here I told everyone that I was going on a floristry course, because I was embarrassed with the stigma of, you know, being an addict. Now, I’ll shout it from the rooftops. I really don’t care, I am so proud of where I’ve come, and that is thanks to here. As I say, I wouldn’t have told the truth in the beginning, I’d talk to anyone about it now I’m passionate about recovery now! I want to give back, even to one person, what I’ve been given.”

8.10. What does phase 2 add to the explanatory model?

The questionnaires and interviews strongly support the idea that a warm, welcoming and accepting ethos provides an essential context for engagement and change. What was made clearer in the interviews was the importance of a clear, consistent and predictable structure, and the positive light in which this was viewed. It seems as though before entering the programme the

expectations were seen as very daunting, but once encountered were experienced by the participants as supportive, even gratifying. Laura explained:

“When I came in the first day, I had to hand in my phone. And I was distraught, absolutely distraught; I thought the world was going to end. Because I had been such a secretive person, in my head (and I still came in here with a load of secrets) I thought someone was going to find out something about me outside and there would be an argument, and I wouldn’t have my phone to defend myself. And then as the days went on and that wasn’t happening, and this knot sort of started to release in my stomach, it was actually a pleasure not to have my phone for the day. And then I started leaving my phone – I left my phone in the cab, I left my phone here. And even that little scenario changed me, you know; there’s not always bad things that are going to happen. So I gradually started to relax and become easier in myself.”

Abbie described how the structure acted as an antidote to her tendencies to sabotage help, which she attributed to her addiction:

“Well it was the structure again: I’d been given the promise that if I turned up the next morning at 8 o’clock it would still be there. All I had to do was get there. And they came to pick me up, and they gave me a sandwich: all the million things I could have put in my way, or my addiction could have put in my way of getting here, the structure of SHARP had a response to. “Oh, I can’t get there.”, “Well, we pick you up.” “I haven’t got any money for food.” “Well, we feed you.” So every block I put up they said it’s not a block. And even that Friday phone call before it started was important. And I did get there, every day.”

I will argue that these are illustrations of structural and cultural emergent powers, which are encountered by persons whose internal conversations mediate between their own personal emergent powers and the powers of the programme (Archer 2000).

The interviewees describe how the norms of mutual care and respect and honest self-disclosure stimulate initial involvement, and that this involvement is a prerequisite for the successful processing of the “challenges” which are offered in various ways as part of the activities of the programme. Moreover, it

appears that these challenges usually take the form of respectful reformulation of a person's beliefs about themselves, or feedback about what is blocking them from full participation, rather than the authoritarian behavioural confrontations of the classic Concept House described in the first chapter. The challenges invite and encourage reflexivity. Group members are valued both for their willingness to share vulnerable, painful or shameful parts of themselves but also for thoughtful and caring contributions towards others. Reciprocity is encouraged: active participation involves not only revealing oneself and listening to the responses from the peer group and from the counsellors, but also attending carefully (in its literal meaning) to the other participants.

The phase 2 interviews did not add much to specifying the process of modifying the internal conversation other than to supply further examples. There was further evidence of the intertwining of *logos* and *pathos* concerning the physical, practical and discursive/social orders: feelings of physical relaxation and well-being (appreciating the sunshine, walking in the park without shoes, feeling clean and refreshed after a shower) led to emotions of pleasure and enjoyment, which were reflectively contrasted with feelings of tension and discomfort experienced during the period of using. Feelings of failure and incompetence at life tasks were mitigated by appreciation of the achievements and skills inculcated by the programme: for example, regular attendance, maintaining abstinence, offering caring and attention to others. Feeling believed in fostered self-belief and aspiration. Feelings of isolation and alienation, of being stigmatised and judged, were mitigated by the experience of acceptance and the opportunity for active involvement, which led to feelings of belonging, being valued, of fitting in. Belonging to the group did not entail a surrendering of individuality: it was clear in both phases of the research that people were valued for their individual differences and for their authenticity: it was this that allowed them to make a contribution to the group from their own perspective.

The inclusion of three people who had graduated from the programme, in addition to the two from phase 1, added to the picture of how the identity project begun in the programme was carried on, but it also made plain some of the limitations of the study. In particular, it made plain that whatever changes a

person makes in the programme, they are preparatory to the continuation of identity development as that person encounters different cultural and structural emergent powers. These are manifested in the resources of the “recovering community”, to which they themselves contribute in various degrees depending on how their social identity as a “recovering person” evolves, and on which roles they might take up as part of that identity project. If the aim is to explain how changes are sustained and developed after the programme, it would be necessary to conduct a separate study.

The following chapter will delineate the emerging model and discuss its limitations, compare it with other models and suggest its contribution to knowledge.

Chapter 9

9.1. An explanatory model

The object of this study is to delineate the mechanisms by which personal transformation may or may not take place in response to participation in a structured group-based treatment programme. The main components of the theoretical apparatus that will be used to create a model of this process are the internal conversation and its emergent powers to initiate an identity project. The internal conversation mediates between the self as actor and the cultural and social emergent powers encountered in the form of enablements/opportunities and constraints. The internal conversation proceeds through a process, characterised by Archer (2003, p.102) as discernment, deliberation and dedication, in the service of reforming one's personal identity (i.e. modifying what one cares about and what one is committed to) and the development of an identity project or projects. In order for the model to be explanatory, an account must be made of the internal conversation, how a person responds in terms of this internal conversation to interactions with others, including self to other conversations, and how this in turn modifies the internal conversation. Further it must be explained how the internal conversation exerts its power as a mechanism for change. The shortcomings and limitations of the model, both those entailed in my own limitations as a researcher and in the inevitable limitations in scope and scale of the study itself, will be discussed in depth in this chapter.

However, in the process of laying out the model, I will be preserving some of Archer's theoretical scheme but diverging from her in other respects. Analytical dualism is retained as essential: as "central conflation" of agency and structure is rejected. In order to properly analyse a 'personal emergent power' it is necessary to separate it from social and cultural powers and then to examine the relationship between them. Moreover, in this study it is possible to say a great deal more about personal powers than social/cultural ones: the latter may only be glimpsed partially or detected only in a local manifestation: how broader, more 'macro' social and cultural powers impinge is beyond the scope of this research.

As Archer claims, it is assumed here that the internal conversation is a personal emergent property as opposed to a psychological faculty, because of its relational make-up (Archer 2003, p.94). It is her account of the internal conversation that is modified here.

In her discussion of the concept of the internal conversation in Chapter 3 of "Structure, Agency and the Internal Conversation" she is critical of Vygotsky, whom she suspects of reducing the internal conversation to the 'gift of society', a deficiency she also (correctly) attributes to Mead (Archer 2003. p.120). She argues a) for the primacy of practice over language in the development of the self, and b) maintains that it is only because the internal conversation is genuinely self-to-self and not, pace Mead, a conversation between the self and the 'generalised other' of society, that a person may maintain autonomy and creativity and the ability to reflect on society (ibid. p.121). While the data are compatible with both these points, it could be argued that she is wrong to dismiss Vygotsky in this way, as he illuminates how the sense of self, both linguistically and pre-linguistically emerges from self-to-other relations, and that extension of Vygotsky's ideas may be used to understand how the self-to-self conversation may be modified by interactions (including conversations) with others. Vygotsky asserted:

"Every function in the child's cultural development appears twice: first, on the social level, and later on the individual level; first, between people (interpsychological), and then *inside* the child (intrapsychological). This applies equally to voluntary attention, to logical memory, and to the formation of concepts. All the higher functions originate as actual relations between human individuals." (Vygotsky 1978, p.57)

I have argued elsewhere (Leighton 2004, pp.92-93) that the concept of the Zone of Proximal Development, that is to say, the temporal area in which a person may acquire a capacity *in relation to another* (with their practical assistance, in discussion with them, or even simply in their presence) before coming to possess the capacity on his or her own, may be extended from childhood development into adulthood. Indeed the origin of any capacity (and certainly what Vygotsky calls the "higher functions"), in an external interaction

(practical or discursive) and its translation into either an internalised self-to-self conversation or a self-governed practice, is what I claim gives rise to the power of reflexivity. It may also have the potential to shed light on the relationship between habitus and reflexivity. The point here is that what is internalised is a relationship, that what it turns into is a fully self-to-self relationship. In adulthood at least, the process of internalising the ‘other’ role may proceed through a conscious phase of imagining the other (“I remembered what my therapist said to me.”) but that at some point the helping, coping, competent, encouraging role is fully occupied by the self, in relation to the striving, uncertain, unpracticed aspect of the *same* self. It is not necessary to elaborate the full complexity and polyphony of the set of internal dialogical relationships before returning to Archer’s scheme, but in this context it is important to notice that there may well be, and usually is, another internal conversation involving the uncertain self, and that is with the self who says “You don’t have to do this. You can just stay in bed/get drunk/distract yourself etc.” As may be clear these ‘selves’ all involve both pathos and logos: there are emotions and values involved in each position, and that these emotions derive, from a realist point of view, from the relationship with reality in the physical, practical and discursive orders. It is crucial to differentiate the priority setting and decision making powers of the internal conversation from an enactment of a preference schedule as rational choice theorists would have it. The motivation for action in this model derives from one’s concerns and commitments, which I have already argued (in Chapter 7) are integrally socially constituted. Which internal dialogue outlined above ‘wins out’ and results in sustained action depends on at least two conditions:

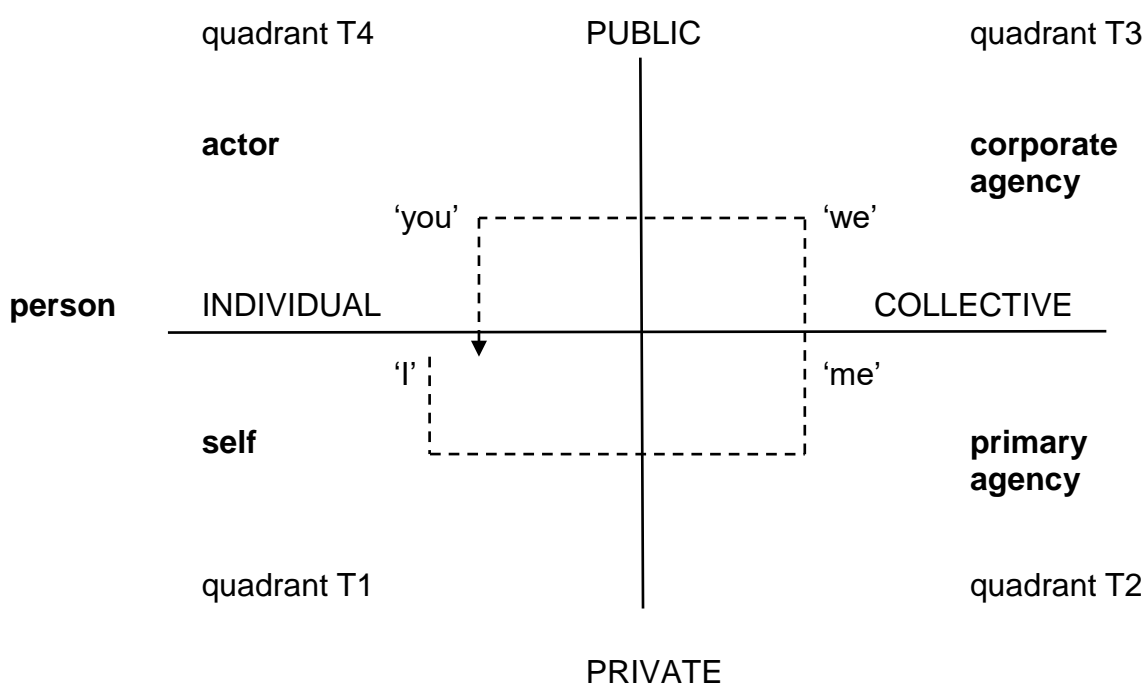
1. The ability to tolerate the distress of the “uncertain” position in relation to the tension between the two examples of internal dialogue. (Those whose internal conversation results in increasing and unmanageable distress are recognised by Archer as “fractured reflexives”).
2. Trust that following the path of the encouraging, guiding conversation and enacting its suggestions will result in the occupation of a social role

recognisable to oneself and to others and that carries with it value in the form of improved well-being, usefulness and/or social esteem.

I will argue that the programme enables these conditions to be met, and that the social roles available within it are transitional ones, but ones which foreshadow and prepare for more sustainable ones, available in society generally but also those generated for example by the 'recovery movement'.

At this point we may return to Archer. She provides a diagram, reproduced here (figure 9.1), which she claims represents a repeating cycle through the life course. "Each circuit represents a new personal morphogenetic or morphostatic cycle" (Archer 2003, p.124)

Figure 9.1: How the subject reviews itself as social object (Archer 2003, p.124)



Archer maintains that the 'mature emergent person' can "revisit, as it were, each quadrant and engage in internal conversation about it", and may then through the power of reflexive deliberation, endorse old projects or devise new ones, producing either reproduction or transformation. At this point in the chapter she reminds her reader of what each quadrant represents after the first cycle in which a person emerges as an actor: at each T1 the self "consists of things that have happened to it and which it has made happen" including

commitments such as marriage, career, skills and life choices. T2 represents one's positioning in relation to "society's distribution of resources" which offer a set of life-chances, T3 represents "collective action", and T4 the occupation of social roles most expressive of one's ultimate concerns. The 'I', who has personal emergent powers of self-consciousness, personal identity and reflexive deliberation, may thus create projects for the future 'you' (the person the 'I' seeks to become), and these powers provide efficacy in modifying oneself and in meeting and responding to the cultural and social emergent powers it encounters (Archer 2003, p.128).

The application of this cycle to persons who have suffered the impact of addiction is complicated, as unlike a person whose life has been less disrupted, it may be harder to "build upon what exists", as the fruits of former commitments may well have been seriously attenuated. Marriages or partnerships, and relationships with friends and children will usually have been damaged or destroyed, as the stories of the participants make clear. Careers may have been abandoned, jobs lost. Run-ins with the law may have produced criminal convictions, which affect certain life opportunities.

As more than one participant made explicit, the addiction becomes a powerful concern of itself. Examples given by participants include the narrowing of things cared about to drugs and money, or the prioritising of drug use over, for example, family responsibilities such as caring for grandchildren. The evaluation of oneself prior to treatment entry seems to invariably include awareness that "I am an addict" in the sense that one's concerns have become so narrowed and that consequent upon this is a sense of loss of, or attenuation of, one's non-addict identity.

Self-consciousness and the ability to reflect have usually not been lost. As was shown in Chapters 6 and 8, the participants were able to give clear descriptions of inner dialogue, some of which retained efficacy, for example by deciding to return to the programme rather than drop out. But the internal conversation prior to entry to the programme, with regard to one's self-assessment and life chances, tended towards pessimism and hopelessness. Most of the participants described a loss of confidence and self-worth. Some, such as Richard and

Martin, explained that they had simply missed out on the formation of any kind of life project at the beginning of adulthood. They both said they had been left behind by friends or siblings. Others had developed identity projects which had been disrupted or made unviable as a result of their addiction. Charlotte had had her life project imposed on her through her early marriage in which she had been dependent on her husband for her life choices.

So in a simplified account, remembering that self-evaluation in each quadrant may be mistaken, even though the events and life-chances have an objective reality, failed attempts to quit or moderate the addiction will have involved a pessimistic appraisal in the first two quadrants, or an avoidance of conscious deliberation about them, a return to 'collective action' in relation, usually, to other drug users or drinkers and with concerned friends and family, and in the fourth quadrant, either an unequivocal return to the 'addict' role, or a struggle to balance that role with a more aspirational one as parent or as someone developing their career, for example.

The final iteration of the cycle before entry into the treatment programme, in the cases of several of the participants, involves the intervention in quadrant 3 of the family, who facilitate the entry into treatment with the (passive) cooperation of the addicted person. At this point the limit of the roles available to occupy is the role of help-seeker. There may also have been, prior to admission to the programme, interactions with others in hospital, during detoxification or after a suicide attempt or overdose, or through attending services which are able to refer the person to the programme. These situations entail some reflection, mulling over, the weighing up of options for future action. The internal conversation at this point may be somewhat desperate (Lucy: "If this doesn't work I will kill myself") or it may stimulate awareness about ultimate concerns (Robert's elation to be alive, his gratitude and love for his family and his readiness for commitment).

The cycle within the programme depends for its morphogenetic potential on:

1. The altered positioning as primary agent, and/or the reappraisal of that.

2. The corporate agency in quadrant 3 providing an opportunity for active participation in a 'joint endeavour', as the SHARP manual has it.
3. The building of trust, either through identification with others, admiration of their honesty and openness, or the apprehension that others care for one.
4. The development of mutual valuing and care, as a result of 2 and 3.
5. The activity of this joint endeavour consisting in part in the giving and receiving of challenge, and the effect on this on the internal conversation.
6. The rearrangement and prioritising of concerns in the internal conversation.
7. The emergent powers of the internal conversation to initiate an identity project.
8. The availability and accessibility of new social roles to occupy.

The evidence derived from the interviews provides strong support for this model, and where these conditions or processes did not occur, the result was that transformative change did not occur either. This was illustrated by the observations of clients dropping out of the programme (when they did not feel accepted by the group, or when they were too distracted by outside concerns) but also by Martin's account of completing the programme the first time without emotional engagement.

As far as the identity project is concerned, in most cases only the first stage of this is normally reached within the timeframe of the programme. While a few of the interviewees had specific career ambitions (Simon wanted to retrain as a train driver, having been a bus driver, and was already looking into it, Anne wanted to be a paramedic), most had emerging aspirations without a specific plan to implement these. Martin and Robert wanted to enter or return to higher education; in Martin's case he wanted to take a degree in psychology with a view to becoming a counsellor. Molly also thought she would like to become a counsellor at some point in the future. Several, including Keith, Laura, Libby and Derek, wanted to become more committed and responsible parents or grandparents. The graduates, from Bournemouth (Richard), Liverpool (John) and Essex (Laura, Abbie and Melvyn), had all availed themselves of opportunities to volunteer as support workers, or embark on training as recovery

mentors, and they have been joined by Kirsten from the Phase 1 interview cohort, who now also volunteers. The opportunities for new social roles based on being a member of the recovering community are of importance in understanding the mechanisms of sustained recovery, although an exploration of them is beyond the scope of this study (though see Best et al. 2016).

The processes described above flesh out the statement by Pawson (2006) that “programmes offer resources and whether they work depends on the reasoning of the subjects.”

9.2. Contexts, Mechanisms and Outcomes

As Pawson & Tilley (1997 p.77) state, realist research constructs explanations in the context-mechanism-outcome form, to which we now return. From the analysis of the first phase interviews, followed by the elaboration in phase two, we can say with confidence that the important contexts are:

1. Timely referral for the client, in which a process such as is described above (page 212) takes place.
2. A welcoming, accepting, consistent and clearly structured treatment environment.
3. Norms of respect and honesty in the whole treatment community.
4. Clear behavioural expectations which significantly challenge the client but which are achievable.
5. The provision of recovery-based social roles to occupy.

Mechanisms include:

1. The building of trust through norms of acceptance, honesty and the sharing of vulnerability.
2. The modification of the internal conversation through conjoint practice, challenge, internalisation of new appraisals, commitments and capabilities (an adult version of the zone of proximal development).

Within-treatment outcomes include:

1. A stronger, clearer sense of self, experienced as increased confidence, ability to feel and care, and new personal and social commitments.

These emergent outcomes permit greater reflexivity and risk taking, thereby reciprocally reinforcing both mechanisms listed above.

2. The initiation of a new identity project or projects.

9.3. Strengths and Limitations

A model has been delineated consisting of contexts, mechanisms of change and outcomes of those mechanisms being activated. The analysis of a total of 23 interviews with programme participants and 6 counsellors has provided strong support for this model.

The strengths and limitations of this study and of this model will now be considered. The model will be compared with others, and constraining factors explored in more detail. Consideration will be given in the final chapter as to how the findings of this study might be used for programme improvement, counsellor training and case management.

At this point a series of questions arise;

1. What are the strengths and limitations of the study in terms of creating a valid model of change?
2. What are the strengths and limitations of the model in explaining the change process?
3. How does the model respond to the complexity problem outlined by Pawson (2013) and described in Chapter 2?
4. What more can be said about constraining mechanisms that tend to obstruct change?
5. How does this model compare with competing theories and what does it add in explanatory power?

The question of validity was initially discussed in Chapter 5 on Method. Maxwell (2012, pp.139-141) describes theoretical validity as concerning the validity of the theoretical concepts used in the model, and the validity of the relationships between these concepts. To what extent does this study present coherent

relationships between the theoretical building blocks, and how are these relationships supported by the data?

The participants in both phases (whose representativeness will be explored below) were all articulate about their treatment experience, and there is clear evidence of the reflexive process in many of the interviews. The theoretical redescription showed convincingly that this reflexive process was often in the form of an internal conversation. The causal power of the internal conversation is demonstrated explicitly or implied. For example, Jason's ability to constrain angry retaliation in response to his wife's aggressive provocation, and his feelings of pride at his new capacity for control are clearly described, as are the origins of the change in his internal conversation in feedback from his peer group and his counsellor. His internal conversation is efficacious both "in the moment" ("that's not mine, that's yours.") and in the process of self-re-evaluation ("My values are coming back", "I can feel the changes in myself, I can, I really can."). This both permits and is fostered by the occupation of a (transitional) social role as a member of the treatment community. As recently mentioned, the group of five programme graduates who were included in the sample were all taking advantage of the role opportunities offered by the community of recovery. The second phase of the study confirmed the pattern which had been detected in the first phase. The appearance of this pattern outlined in the Contexts, Mechanisms and Outcomes section, in three settings in different parts of the country, with the participation of the majority of the clients in the treatment programmes at the time of interview, as well as graduates from each of the settings, suggests that the model is indeed valid within the limitations of the study.

The study limitations include:

- Its inability to explore the contribution of more distal social structures.
- Limited scrutiny of counter-examples.
- Limited representativeness of the participant sample.
- Its inability to detect a typology of client change.

The study aimed to describe, theorise and build a model of change processes that might be considered transformative: that is to say, enduring change in a person's concerns and commitments and role opportunities, leading to the possibility of a different life experience. It relies on conversations with participants being able to produce descriptions of how change processes are experienced by them (descriptive validity), how these data are analysed in terms of recognising and interpreting these processes and identifying patterns (interpretive validity), and how coherent and credible is the theoretical redescription (theoretical validity). There is always more observation that could have been done, more participants that could have been interviewed, but within the frame of this study these elements, together with other supporting evidence that change is in fact occurring (the changes on cohort ARC scores and CEST presented at the end of Chapter 2), have produced a coherent, if inevitably incomplete picture.

However, what have only been glimpsed are the more distal social structures which influence an individual's journey. The study, which focuses on the change mechanisms actually activated during treatment episodes, and relying for data on the interviews with clients and counsellors and on field observations, did not produce much material illuminating the effects of childhood, adolescent and adult social environment, the life opportunities offered within these, and the impact of class, gender, level of deprivation, education, or involvement with the criminal justice system. There are hints of gender roles having an influence on the development of addiction, for instance Charlotte's limited control of her life in relation to her father and her husband, Kristen's role as voiceless and subservient, apparently assigned to her by her family, tensions between paternal expectations of masculine toughness and heterosexuality and a very different self-image in the case of Saul.

The effects of the local structure of drug and alcohol services were occasionally glimpsed in the interviews. Laura had visited an advisory service run by Open Road, which offers services across Essex. She told me that she began a conversation with a drugs counsellor there who told her "I have the perfect programme for you" (meaning SHARP Essex in Braintree). This counsellor then

arranged the referral with Laura's agreement. This came about due to an active campaign of information and relationship building with referring services in Essex by the manager of SHARP. Sarah Senker, in her second qualitative evaluation of SHARP Essex, writes:

“Service providers, family members, past and present cohorts, struggled to imagine what the recovery system would look like in the absence of SHARP. SHARP was said to be positioned appropriately, with most individuals describing that they had presented at Open Road, Oxford Road, their GP or Synergy in the community before being referred to SHARP. The relationship that SHARP has built up over the last two years with community treatment providers was seen to be essential in supporting individuals to transition to the next stage of their recovery.” (Senker 2016).

The situation was different in Liverpool, with less developed relationships with community referral services, but with the existence of a much more developed community of recovering people, and the alcohol-free recovery-oriented bar, The Brink, with its “Brink of Change” service designed to prepare people for SHARP. The importance of the Brink was alluded to by several participants, with Jason providing a nuanced opinion: *“As a precursor to SHARP I’d been at the Brink for I think it was 6 or 7 weeks, which initially gave me, some sort of, a little bit of value, before I came in here. Had I not done the Brink, I would have probably have managed here, because it’s totally different, but as a precursor I think it’s a good idea.”*

Accessibility, and help with this, varied across the three research sites. In Liverpool, clients of SHARP are provided with a bus pass for the duration of the programme as part of the contract with the commissioners. In Essex, taxis are hired to transport clients to and from their homes each day, usually in small groups of two or three who live in the same town or area. As we have already heard, this was regarded as important by Abbie: *“and they came to pick me up, and they gave me a sandwich: all the million things I could have put in my way, or my addiction could have put in my way of getting here, the structure of SHARP had a response to. “Oh, I can’t get there.”, “Well, we pick you up.” “I haven’t got any money for food.” “Well, we feed you.” So every block I put up they said it’s not a block.”*

One of Senker's interviewees makes a similar observation: *"My car journey is two hours (meaning the journey each day in both directions) but that's an extra two hours of group therapy. The taxi driver is amazing, the same people, a husband and wife team, they will always listen, never tell us what to do, but it's nice to bond in the taxi. I have come in every day and I cannot say if I was bringing myself in I would have made it."* And a family member invited to the centre for a conjoint session told Senker, *"We were very well looked after: they provided us with a taxi."* (Senker 2016).

This provision was often experienced as an act of generosity and understanding on the part of the agency, which contributed to the feeling in clients that they were cared about, but such provision was in fact dependent on the commissioning arrangements, and on the effects of more distal powers such as the prevailing drugs strategy and its local interpretation, in particular regarding the emphasis on treatment and recovery. The commissioner in Essex had particularly wanted to set up a pilot SHARP programme in the county and had been committed to finding funding so as to ensure the programme would be able to provide the highest standard of service.

Contrastingly, in Bournemouth, clients of SHARP were not provided with similar help to travel to and from the programme, and journey times from some parts of Bournemouth could be long. The then manager of SHARP Bournemouth told me that this lack of provision negatively and significantly affected retention. Clients dropping out of the programme frequently cited the problems of travel to and from the centre as a factor. (Emma Thornton, personal communication, November 2016).

Despite these indications that **C**ontexts, **T**ime, **O**utcomes, **R**ivalry and **E**mergence (from Pawson's (2013) **VICTORE** acronym encapsulating aspects of complexity, discussed in Chapter 2) are in need of further exploration, the results of this study are clearly limited in what may be said about these. The study method revealed more about **V**olitions and **I**mplementation, both from the interview material and from the field observations of the programmes in action. The interviews with graduates of the programme certainly revealed emergent effects, in particular through the establishment (in Essex) or strengthening (in

Bournemouth and Liverpool) of a local community or social network of recovering people. These were connected not only by acquaintance and joint recovery activities such as attending mutual aid meetings, but also by participating in the mentoring service run by Foundation 66 (n.d.) as trainee mentors, sharing their experience of SHARP with prospective clients of the programme and supporting them during and after their participation in the programme. Role-modelling of recovery may well be an important adjunct to the mechanisms of change: Francis, for example, struggling in AA for several years in Liverpool, said in his interview that he met several friends who had completed the SHARP programme, some with multiple years of abstinent recovery, and this was a factor both in his seeking to enter the SHARP programme and in his internal conversation about sticking with the programme when he was considering dropping out.

When the question is addressed below as to whether a model of intensive day treatment like SHARP might be the template for abstinence-based 'rehabilitation' services in the next decade, in place of the residential model which was dominant in the second half of the 20th century, the relationship of the treatment programme to the local community will be considered further.

9.4. Constraining mechanisms

This study has only been able to shed limited explanatory light on the mechanisms that work against change. Once again these mechanisms may be distal or proximal, structural or agential. The field observations (Chapter 6, pages 151-152) produced an example in which the client's self-disclosure was not acceptable to the group, resulting in his experiencing a disruption in trust, as this is dependent on his acceptability. This led to a premature self-discharge and a return to drinking. In another example, observed by me in group therapy, a client, Linda, who felt beset by a range of pressing family problems in the first couple of weeks after starting, was unable to use the group's help to prioritise remaining in treatment and obtaining assistance with some of these problems from programme staff. The problems in themselves were not at all unusual for programme participants in type or scale, but she seemed overwhelmed by her first-order emotional response and despite receiving caring and consistent

feedback from group members identifying with her situation, reassuring her of her place in the group and expressing wishes that she should stay, she failed to return the following day and dropped out.

These observations are concordant with the opinion of the counsellor concerned, who felt that Linda was “in a state of high alert, in fight or flight mode” and that this prevented her from settling and building trust. Her description is to be found in Chapter 6, on page 162, and, although useful, does not provide an explanation of why in this case the normal responses of the group members and the counselling team were ineffective in prevailing over her emotional state. Interviews with the other counsellors also provided useful but limited theories of constraining mechanisms. Maya (Chapter 6, page 159) also cited Linda but also gave an example of someone who did not engage with the kind of relationships offered in the programme, and she suggested this was due to an inability or unwillingness to “to go inside, to reflect on what wasn’t working for him in his relationships or in his life, looking at who he was as a person, was maybe, not even threatening for him, but just something he didn’t want to do.” This implies an avoidance of entering the reflexive morphogenetic cycle and the maintenance of familiar relationship patterns, but again it is not clear what the causal mechanism is here.

Notwithstanding these examples, the limitations of the field observations for this study are clear. The interviews produced far more rich data than the observations, and it is these data which form the main source for analysis, with the observations playing a subsidiary role. Future study focusing on more in-depth and extended observations might well enrich understanding of constraining mechanisms. In particular interactions between group members and between counsellors and programme participants could be more systematically observed and recorded, especially concerning struggles with the programme, experiences of being excluded, whether later transcended or leading to drop-out.

Interview participants described threats to remaining in treatment, particularly in the early stages, in which the emotional exchanges between group members were sometimes experienced as intense and frightening. It is not unreasonable

to assume that for those less prepared for the programme this might result in drop-out, but in all these cases the mechanisms causing the person to stay prevailed.

There is clearly a great deal more research required if we are to understand the constraining mechanisms more clearly. It is more difficult to access participants who do not respond to the programme for interview, but it would be useful to attempt this, even if their inevitably partial knowledge were only able to shed light on proximal mechanisms: as with those who were interviewed in this study, it is unlikely that they will be aware of more distal, structural mechanisms, and it may be that such people might be less able to reflect on and articulate their experience.

It is perhaps important to note that the simple fact of dropping out of the programme does not mean failure to respond. Elwell-Sutton (2014) in the first of three independent evaluations that have been carried out on SHARP Essex stated: “Even those who did not complete treatment felt that they had gained something from the programme” and quoted a client who had not graduated: *“There is massive improvement. It’s just a long journey I’m on...I’ll get there though.”* Georgakis (1995), in his outcome study of Clouds House residential treatment programme, which could be considered the ‘ancestor’ of the SHARP programme, found that those who dropped out of treatment late (in the last two weeks of a six week stay) did not do significantly worse on drug and alcohol outcomes and other recovery outcomes such as quality of friendships and family relationships than completers 30 months after treatment. Those who dropped out in the first two weeks, however, did much worse, and most of these were in the problematic/unimproved group at follow-up and seemed to have been more or less continuously unimproved throughout the follow-up period.

9.5. Representativeness of the sample

To say to what extent the participants in this study are representative and what exactly they are representative of is problematic. They are all treatment seekers, and all have elected to enter an abstinence-based programme, and this differentiates them from those who receive services on account of the

medical, social and legal problems associated with their alcohol and drug use who may not wish to stop or reduce their use. Their level of substance dependence is high and the duration of their problem use is from a few years to 20 years or more. The criteria for referral are similar to those in place for a residential service such as Clouds House, with the added proviso that they must either be in stable housing or have such housing arranged for the duration of the programme. The population who are referred to all three of the SHARP programmes, including those who participated in this study, are neither very deprived or chaotic, nor particularly privileged or socially advantaged. Their demographic profile is similar to those in Georgakis' (1995) study of Clouds House. It would be of interest to be able to make justified statistical comparisons between the sample here and treatment entrants generally in the U.K. but adequate data are not accessible to me. Based on my three decades of experience of several abstinence-based charitable residential treatment centres, most of whose clients are funded statutorily rather than privately, I estimate that the clients entering SHARP are essentially similar to those admitted to residential services, in terms of severity of dependence, range and severity of life problems, and social and family support.

9.6. No typology of change detected

The small number of participants also prevented any tentative typology of client change to emerge. Although there were individual differences in how trust was built up, how each person chose to reveal themselves, and what form the challenges from peers and counsellors took, these were insufficient to detect any systematic differences on the basis of gender, age, strength or severity of addiction (West 2013, pp.108-110) or any other variable. Since there is some evidence that, for instance, men and women in North America use recovery resources such as mutual aid differently and vary on the predictors of recovery (Kaskutas 1994, Timko et al. 2002, Timko, Finney & Moos 2005, Moos, Moos & Timko 2006, Kelly & Hoepfner 2012), it would be useful to explore further whether there is any evidence that different mechanisms are in play during treatment programmes. Considerably larger samples and different methods would be required to research this question.

9.7 Limitations of the qualitative analysis

Patton (1999) usefully considers a number of approaches for strengthening the credibility of qualitative analysis. He points out that there are strict rules for statistical analysis whereas “qualitative analysis is a creative process, depending on the insights and conceptual capabilities of the analyst. . . . “it depends from the beginning on astute pattern recognition” (p.1191). He considers various forms of triangulation, ways of studying the research object from different perspectives, which can improve credibility by revealing different aspects of the phenomenon, and supporting, challenging or elaborating the emerging thesis.

He points out that triangulation is “expensive” as a researcher’s budget, time-frame and individual expertise will affect the extent to which triangulation is possible. These limitations certainly apply to this present research. The design did include some elements which come within Patton’s categorisation of triangulation which were partially successful, but considerations for future studies should incorporate a more systematic approach.

Patton describes various forms of triangulation, including methods triangulation, data source triangulation, investigator or analyst triangulation, and theory triangulation. There are examples of each of these in this study design (apart from analyst triangulation) but each was limited. It has already been pointed out that the observational data were not as rich and extended as they might have been. If this aspect had been improved, it might have been possible, for example, to compare what was said in the public forum of treatment with what was said in a private interview, or whether counsellor behaviours were consonant with what they had said in their interviews.

In section 9.5. above, it was pointed out that the use of quantitative data for comparative purposes was limited by its quality, it being insufficient for convincing statistical analysis.

The use of a second analyst to analyse the interview data was not practical in this study, but the two phase design was intended to serve something of the same purpose: the theory-driven interviews with a new cohort of “experts by

experience” was intended to involve other minds in critiquing and elaborating the emerging model. This was successful with the client group but the study would have been strengthened by conducting theory-driven interviews with a group of counsellors in Phase 2. The Phase 1 counsellor interviews did strengthen the emerging set of key components of the model, but it is striking that each counsellor stresses a different aspect. In a couple of instances client and counsellor perspectives on the same change process were obtained.

Further investigation of counsellor theories of change will be the focus of a future study, as will the experiences of clients from different cultural or ethnic backgrounds, whose voices are absent from this research as none were in treatment in the research settings at the time. This is a limitation which it is important to remedy.

9.8. Limitations of the Phase 2 questionnaire

The questionnaire which was developed from the tentative set of contexts, mechanisms and outcomes produced in Phase 1 had a special purpose. It was intended that the responses to it should be used to focus the theory-driven interviews. This method was inspired by a similar questionnaire in Pawson and Tilley’s study of prisoners’ reasons for embarking on higher education while in prison (Pawson 1996). The route to interviewees helping me to elaborate and refine my theory was to display the products of Phase 1 in the form of a questionnaire for their consideration and evaluation. During the interviews, they would be asked to explain their responses and expand upon them.

In some ways the normal rules for constructing a valid questionnaire had to be suspended, although some principles were essential to retain, such as avoiding items asking a complex or multiple question and minimising overlapping or ambiguous items. Instead of reducing a questionnaire from a larger pool of questions, I constructed items for each tentative context, mechanism and outcome. On reflection I believe a process of item reduction, possibly aided by client review, would have improved the questionnaire.

The questionnaire did serve its purpose, as described in Chapter 8, but there are some deeper problems with it. These have to do with the presentation of the

scores, and the use of averages. Mixed methods research is full of pitfalls. The scores, on reflection, do not stand up as quantitative data. The significance of the Likert scoring is not clear and there are questions about how participants responded which lead me to find the attempt at quantitative analysis unconvincing. This seems the weakest part of the study design, although I do maintain that the scores do in fact represent a strong endorsement of many of the items and did allow discrimination between items that were as good as universally endorsed and those which had considerable individual variation in response. This was useful for the Phase 2 analysis.

I do not think this weakness is sufficient to damage the overall scheme of the research, but if a similar study design were to be repeated, the issue of how to create an instrument that would stimulate and structure participant elaborations of emerging theory and also demonstrate validity in itself, would require significant reconsideration.

It is unusual to be expert in both qualitative and quantitative research. The assistance of a statistician to advise on the validity of quantitative claims and to ensure the appropriate tests are used, and to interpret the results correctly is both acceptable and advisable, and to have made use of this would have strengthened this aspect of the study. I was able to use the same test as Elwell-Sutton (2014) in the presentation of outcomes in Chapter 3 (p.80.).

9.9. 'Addiction' as a constraining mechanism

Perhaps surprisingly, there was not much expressed in the interviews with the clients in treatment about the power of addiction, temptation to use or craving as current problems. Most of those in the first phase of interviews mentioned that they were aware that their drinking or using was associated with feeling states, or ways of managing feelings, usually those provoked by interpersonal relations. Nine interviewees from this stage attributed their drinking or using to specific situations. These attributions are presented in Table 9.1.

I have presented the first phase interviewees and not the second phase set, as in the first phase the interviews were kept as open as possible and prompts to describe drug or alcohol use, addiction, or the processes of change in treatment

were minimised to the greatest extent possible. As has already been noted (Chapter 8, pp.198-203), five of the six interviewees in Phase 2 said that the structure and support of the programme protected them from the urge, desire or opportunity to use or drink, mentioning the strict abstinence expectation, and the network of phone and Whatsapp support in the evenings.

All of these participants felt that either the work they were doing in the treatment programme to develop the ability to respond differently and to cope with difficult feelings, or the development of a new 'recovering identity', based on commitment to a new social group, or both of these, would protect them from the temptation to return to using or drinking.

Table 9.1. First phase interviewees' reasons for drinking and drug use.

Interviewee	Attribution of reasons for their own drinking or drug use
Robert	Drinking associated with hurt feelings responded to with 1. isolation and withdrawal, or 2. a passive aggressive, sarcastic mask.
Anne	Bottles her feeling up or expresses them too aggressively. Both of these lead to anxiety, and then to drinking,
Philip	Used alcohol and drugs to suppress feelings of distress and loss. Sees his ongoing entrenched drug use as resulting from an "identity as a relapsing drug user" which was "negating my responsibility as a human being."
Jason	Conflict with his wife, other people's criticisms 'getting to him'.
Charlotte	Isolation, resentment about her life being controlled. Failure to recognise her own feelings, wants and needs.
Kirsten	Felt timid and unassertive. Alcohol gave her a voice, but not in an effective way, and with serious negative consequences.
John	Treating himself after a period of abstinence, leading to relapse. Not coping with bereavement.
Francis	"little things would happen and I couldn't speak about them they would build up they would kind of blurt out and I would go and drink on them."
Saul	Unresolved issues concerning the loss of his murdered father. He wants to use drugs when he feels like "a child, self-destructive, stubborn, self-piteous and lonely"

Only one of the five counsellors interviewed talked about the relationship with drugs or alcohol and the client's attachment to the addiction as being an important factor in their theory of change. Joan said that because the structure, boundaries and clear abstinence expectation of the centre was protective, her work did not need to focus on the drug and alcohol use itself. But she believes that if a person just has a desire not to use any more but they don't really know why, they are in great danger of being unable to resist the pull of the drugs or alcohol, which is "overwhelming if they haven't got that clear idea." She goes on, "one thing I have come to realise is that for many of them, that's all they had, it's been their best friend (*the drink and drugs*). It's their identity." So, she feels that treatment needs to encourage, support and amplify strong reasons for recovery.

What is absent from any of the interviews is any conceptualisation of addiction as a disease entity, either in the quasi-metaphorical sense of a 'threefold illness', physical, mental and spiritual, used by Alcoholics Anonymous (Kurtz 2002), or as a brain disease (Volkow, Glibo & McLellan 2016).

This is of some interest as the interviews were with clients and staff of a programme highly supportive of mutual aid groups such as Alcoholics Anonymous and Narcotics Anonymous, and in the past (particularly in the last decades of the 20th century) treatment centres which promoted 12 Step recovery were rather keen to inculcate some version of the disease concept (Anderson 1981, Leighton & Barton 2005).

However, in terms of the explanatory model, it is clear that the extent to which addiction, as a biologically-based or psychologically-based phenomenon, acts as a mechanism either causing relapse or preventing engagement with the change processes of recovery remains unquantifiable. West (2013) offers a definition of addiction as "a repeated powerful motivation to engage in a purposeful behaviour that has no survival value, acquired as a result of engaging in that behaviour, with significant potential for unintended harm." The circumstances and manner in which this powerful motivation, which has clearly been active in the lives of all of these clients prior to their engagement in the treatment programme, acts as a mechanism constraining the identified change

mechanisms cannot be included into the model presented here, and this must represent a significant limitation.

What is clear is that it does not have to constrain them, as is amply attested both by the participants in this study, and by the millions of people who have stopped their addictive behaviour and remained durably abstinent (White 2007). It is clear that under certain conditions it is often possible for a person to persevere with their abstinence despite cravings, urges, temptations, desires, opportunities and so on, whatever their biological, psychological or social basis. This consideration leads to a discussion of where the model of change delineated here fits into the plethora of theories concerning addiction.

9.10. Models of addiction and recovery

West (2013) has written a valuable monograph in which he details and discusses a range of models of addiction, looking both at models which apply to the individual and those that apply to populations. The range of these models is very wide. The theoretical categories which West proposes for modelling addiction in the individual are:

1. Automatic processing theories
2. Reflective choice theories
3. Goal-focused theories
4. Integrative theories
5. Biological theories
6. Process-of-change theories

Categories for modelling at the population level include:

7. Social network theories
8. Economic models
9. Communication/marketing models
10. Organisational systems models

Within each of these categories, he provides several examples of models. He reviews the evidence which might support each model and discusses limitations. He points out that most of the individual models concern themselves with the development and maintenance of addiction (although there may be implications for recovery), but those in the process-of-change category look at the cycle of addiction from initiation, through the development of addiction, to attempts at recovery and the success or failure of such attempts. He notes that several of these, including Relapse Prevention models, Acceptance and Commitment theory, and Cognitive Dissonance theory each propose or suggest mechanisms or processes by which progression through the cycle is initiated or sustained (West 2013 pp.73-76).

Having reviewed this plethora of models, and noted that each has some evidence to support it and each has significant limitations, West lists a series of key concepts drawn from these models which he thinks should be taken into account in the attempt to create a comprehensive theory of addiction (West 2013, Table 6.1, pp.89-94).

Using a framework which intends to explain behaviour as produced in interaction between an individual and his or her environment, the COM-B framework (Michie, Stralen & West 2011), West proposes a theory he calls PRIME. This was elaborated in West (2006), and is summarised in West (2013 pp.98-103). Despite claiming that this theory combines key concepts as coherently and comprehensively as possible, West is modest about the theory in two related ways. He says,

“PRIME theory addresses concepts only within the areas of motivation and psychological capability as it relates to motivation. Its focus is on providing a basis from which to develop interventions to change behaviour. It is not a replacement for other models but only an attempt to integrate their key constructs into a single framework.” (West 2013, p.98)

And in “Theory of Addiction” he makes the point that his discipline of psychology and his expertise in the area of tobacco use inevitably influence his approach (West 2006, p.2). He suggests that his theory be treated as a ‘base-camp’ for further exploration and he is welcoming of elaborations that may ‘pegged in’ to

the theory from sociological, economic, psycho-neurological or any other scientific insights.

West lists a series of ten propositions on which PRIME theory rests, and it is in relation to these that I will compare the findings of this study and the explanatory model that has emerged from it. Of course, the latter is not a comprehensive theory of addiction, nor is it a model that primarily explains how people act in the moment, or at least not directly.

The following paragraphs will consider to what extent this model is consonant with PRIME theory and to what extent it extends it. Fundamentally, this model proposes mechanisms for the modification of personal and social identity via modification of the internal conversation. The mechanism for modifying the internal conversation works through the building up of relational bonds with others, reflecting on challenges in the light of these emotional bonds, and integrating new appraisals, commitments and capabilities.

The key propositions of PRIME theory outlined by West (2013 pp. 98-99) are:

1. At every moment we act in pursuit of what we most desire ('want' or 'need') at that moment.
2. Wants and needs involve imagined futures and associated feelings of anticipated pleasure/satisfaction (wants) or relief from mental or physical discomfort (needs). They form part of our conscious experience but we are not necessarily conscious of them.
3. Beliefs (propositions that we hold to be true) influence actions only if they generate desires that are strong enough to overwhelm those arising from other sources (e.g. drives and emotions) or impulses and inhibitions arising automatically out of learned or unlearned associations; imagery plays a key role in this.
4. Plans (self-conscious intentions to undertake actions in the future) provide overarching structure to our actions, but in order to direct our behaviour they need to be recalled and generate desires at relevant

moments that are sufficiently powerful to overcome desires and impulses arising from other sources.

5. The motivational system can be characterised in terms of dispositions for its components to respond in particular ways to internal and external inputs. Processes that lead to changes in dispositions include associative learning, habituation, sensitisation, direct imitation, analysis and inference. A wide variety of patterns of change can occur with sudden large changes resulting from apparently small triggers.
6. Identity (our mental representations of ourselves and the feelings attached to these) is an important source of desires and provides a degree of stability to our behaviour by virtue of the labels we apply (e.g. ex-addict) and the rules that govern our behaviour (e.g. no longer using drugs).
7. Identity change is a starting point for deliberate behaviour change (in terms of a new label and a new set of rules governing our behaviour) and can be regarded as an 'act' that occurs when the desire to make the change is momentarily greater than the desire not to.
8. Deliberate behaviour change is sustained when the desires arising from the new identity are stronger at each relevant moment than the desires arising from other sources to revert to the previous behaviour pattern or are able to overwhelm habitual or instinctive impulses.
9. When identity change results from self-conscious beliefs about what is good and bad, maintaining behaviour change requires 'self-control': the effortful generation of desire to adhere to a rule that is sufficiently powerful to overcome desires arising from other sources.
10. Personal rules that have clear boundaries and a strong connection with components of identity that involve strong emotional attachments will generate more powerful desires when required and better suppress countervailing desires and so have a stronger lasting impact on behaviour.

The explanatory model emerging from this study seems broadly compatible with PRIME theory in the following respects. To the extent that this is a treatment programme aimed at recovery from addiction, one of the tests of its relevance will be the extent to which addictive behaviour is avoided, and some other behaviour that does not involve the consumption of a drug takes place instead. West explains that very often our wants and needs are in conflict and the behaviour that ensues will be the outcome of how these wants and needs are balanced. So in a situation such as Jason's when he is being critically attacked by his wife, his discomfort engenders a need to relieve his painful feelings. He explains that in the past he has often taken a drink to assuage this need. West emphasises that wants and needs are feelings, and not at all the same as ideas or beliefs that such and such an action is right or wrong or good or bad. This avoids the trap of rational choice theory that posits a fixed preference schedule and that decisions to act are based on these purported preferences.

West's is a hierarchical model, in which behaviours are impelled or inhibited by neuronal responses, but these are created by the 'wants' and 'needs' he has described as the desire to engender pleasure or satisfaction or to relieve distress states. These desires, he claims, may be generated by beliefs and plans: in fact he is claiming that beliefs and plans can *only* produce behaviour by generating desires that are more powerful than those generated by drive states (such as hunger) or emotions (such as a fear or anger response). Jason's example of how he responds to his hospitalised wife's angry attack and his angry and sad emotions resulting from that remains relevant here. He decides to leave the hospital before the emotions become overwhelming and produce an angry retaliatory response from him, leading to escalating guilt, anger and frustration and from there to a drink. He converses with himself (internally) to inhibit his response and the feelings subside to manageable ones, primarily of sadness. His new-found ability to inhibit his usual response produced feelings of pride and satisfaction, so that there was much more likelihood of his maintaining this new pattern.

West points out that people are broadly disposed to act in particular ways, that they have a repertoire, but that this can be changed through various processes

as listed in proposition 5. He goes on to explain the importance of identity in stabilising behaviour, and it could be said that the remaining propositions are all elaborations of this importance. West conceives identity as a set of representations of ourselves, “all those thoughts feelings and images that we have of ourselves, and the labels we use to describe ourselves” as he expresses it in a video lecture available on his PRIME theory website. He also includes the characteristics we attribute to ourselves. He also includes the rules about what we do that are implicated in these labels and characteristics (West, 2010a. 0m06s-1m25s). He thinks that these rules condition our wants and needs in the moment and thus influence our behaviour. He goes on to say that a person’s identity can be coherent or it can be fragmented and unstable. Interestingly, he claims that if our self-image is negative then we will find it aversive to think about ourselves and thus reflexivity will be painful and will tend to be avoided. This is a valuable addition to Archer’s ideas about ‘fractured reflexives’ and people with limited reflexive ability. It adds explanatory power to the observation that as clients in the SHARP programme are encouraged to practice reflexivity, this capacity seems to flourish as they feel more accepted and part of the group and their self-esteem improves. West thinks that the more a person has a sense of well-being and a positive view of themselves, the more they will be self-aware and more likely to act in consistency with the rules that their identity sets for themselves (West n.d. 3m17s-3m30s).

PRIME theory posits low level responses which are generated by impulses (reactions to internal and external stimuli), but these can be activated or inhibited according to our desires (motives), which govern our purposeful behaviour. Activation of this higher level of desires which allow us to inhibit behaviour is, according to West, possessed by people in varying degrees. Higher level desires which are capable of competing successfully with desires deriving from drives (or for a relevant example, from dependence on a substance) are to a great extent the product of one’s identity, via the evaluations that our identity provides about what is good or bad, right or wrong behaviour. West seems to be saying that identity works through self-awareness, which is required to apply the rules that can generate desires, so that if a person does not have a strong identity, or if their identity is negative and painful

so that it inhibits self-awareness, then it will be much less likely to be able to generate desires of sufficient strength and consistency to prevail against an addiction.

This summarises the RIME (responses, impulses, motives, evaluations) in the PRIME acronym, and brings us to the final letter P, for plans. West says that humans have the capacity to plan in accordance with our intentions, but that whether planned behaviour will ensue is a matter of whether, in the moment, the plan is brought to mind, and whether it is capable of generating a desire of “sufficient strength, as a result of our identity (or other factors), to make us want or need to do what we planned to do more than we want or need to do something else.” (West 2010b, 1m17s-1m36s).

West (n.d.) emphasises that “a strong, coherent, deeply entrenched identity that places clear boundaries around a category of behaviour and which anticipates potential challenges will provide strong stability to that behaviour and yield a powerful predictive measure” and says that “fostering such an identity around a new behaviour pattern is a potentially important target for behaviour change interventions” This reiterates the point of propositions 9 and 10, which imply that an identity change which primarily consists of developing new rules may be effective in changing behaviour but that it will require the application of effortful self-control. The effort required is lessened if the plans are very clear and boundaried, and the identity change which generates the intentions involves “strong emotional attachments”. West makes the point that the plans should be linked to “core identity” and “the things that really matter to you.” (West 2010b, 4m50s-4,59s)

The emphasis on identity clearly links the explanatory model of change in SHARP programmes to West’s ideas. There are many examples from the interviews and observations which are explained by the theory, both of people learning new ways of responding and failing to respond, for instance by dropping out and relapsing. In those latter examples, there had been no opportunity for a new identity to be developed and the commitment which had brought the person into treatment was not strong enough to prevail. For those that did respond, the PRIME theory adds to the rationale that the kind of

changes this study has identified ought to predict more stable and enduring abstinence.

However, the present research adds to the PRIME account by identifying more closely how identity change occurs. Moreover, the theoretical framework through which the model was created from the data emphasises to a much greater extent than West the integrally social constitution of identity and emotion, elaborated here in Chapter 3. PRIME theory is open, and is not concerned to specify exactly how identity is modified, simply suggesting that this might be an important target for interventions. There is no claim made here that the mechanisms that have been outlined as a result of researching the SHARP programmes are the only ones that can produce changes in identity, or that these changes are the only bulwarks against relapse. It is clear that most of the people studied by Cloud & Granfield (1994) did not adopt an identity in which consciousness of being 'a person in recovery' was foregrounded, nor did they require a process of identifying with and trusting a peer group who could then provide constructive challenge. It was found that a modified 'post-addict' identity was an important feature of their respondents (Cloud & Granfield 1994, p.165), but different mechanisms were most likely responsible.

What of the 'other factors' that West mentions above? In bringing plans and intentions to mind and acting in accordance with them, other factors are likely to play a part other than a strong and boundaried identity. Having established a desire to avoid drug or alcohol use, coping skills are required, both decisional and behavioural, to enact the chosen behaviour. It was noted in Chapter 2, (page 42) that Finney et al. (1998) found that traditional 12 Step residential treatment programmes produced increases in self-efficacy and active coping as much or more than cognitive-behavioural residential programmes, and Morgenstern et al. (1997) found that affiliation with the 12 Step programme of Alcoholics Anonymous after treatment also predicted more active coping and higher self-efficacy, which in turn predicted better outcomes. These capacities are strengthened by their habitual use, and Marlatt's (1985) cognitive-behavioural model of relapse prevention predicted that the successful use of coping would lead to higher self-efficacy and thence to a reduced chance of

relapse. This in turn would have the effect of strengthening a person's emerging identity, particularly if and when such successes are affirmed and praised by the valued peer group.

In the final chapter, the explanatory model will be considered in relation to the activities of the treatment programmes and its implications for the training, supervision and professional development of counsellors discussed. The relationship of the SHARP model to the so-called "evidence-supported" therapies is explored and conclusions drawn. Suggestions for further research arising from the limitations of this study are offered.

Chapter 10

10.1. The SHARP programme as a template for the future of 'rehab'.

The SHARP programmes are structured in a similar way to residential psychosocial or 'rehab' programmes, particularly those evolved from the Minnesota model (see Chapter 1, page 12, and Leighton 2004, 2013). This is a period when residential treatment is apparently in decline: in a 2014 survey conducted by Public Health England, a third of commissioners expected their funding of residential treatment to decrease, there was a perception that local authority cost savings would impact negatively on commissioning of residential services, and 60% of providers reported feeling under threat of closure. The survey report stated, "Many commissioners expected to be commissioning more community-based abstinence services and some reported that improvements in local community-based services was a reason for sending fewer clients to out-of-area rehabs." (PHE 2014). White (2008) argues that intensive structured treatment programmes delivered on a day basis may have a superior rationale to residential programmes in that the participants are not isolated for a period from their usual environment, and that as a result transfer of learning from the programme to everyday living is facilitated and that connection to local recovery resources can be made while participating in the programme. The traditional residential centre's distance and isolation from the clients' usual social environment does not usually permit this. As White puts it, "the greater the physical, psychological, social, and cultural distance between the treatment environment and the natural environment of the client, the greater will be this transfer-of-learning challenge". He thinks that there should be "greater emphasis on delivering home- and neighborhood-based (eg, health clinics, neighbourhood centers) addiction treatment and recovery support services" (White 2008, p.91).

This study and three independent evaluations of SHARP Essex (Elwell-Sutton 2014, Senker 2015,2016) have shown that clients with a similar profile to those treated in residential treatment can benefit from day treatment and there are emerging indications that the SHARP programmes achieve very good outcomes. For example according to a very recent quantitative evaluation of the

first 12 cohorts (September 2013-January 2016) produced for Essex County Council, the programme is achieving similar or better completion rates (72%) than comparable residential centres such as Clouds House (Essex CC Organisational Intelligence 2016). The same report also showed that there are low re-presentation rates to substance misuse services: 79% of all those admitted to SHARP who had been referred by county agencies using the county case management system did not re-present to services up to September 2016. For cohorts 7-12, no more than one participant per cohort had re-presented. There are currently active efforts being made to follow up those who have participated in all of the SHARP programmes (both graduates and those who dropped out before completing) to establish credible knowledge about their recovery status. The programmes in Liverpool and Bournemouth have achieved similar completion rates to those in Essex. Senker (2015, 2016) was able to locate and interview 12 recent completers and a total of 16 graduates of previous cohorts. She was able to establish that SHARP Essex has contributed to a community of recovery in Essex (Senker 2016, pp.16-17). The Essex experience has also shown that programmes like SHARP are not restricted to large conurbations: they are also accessible from different areas of a county if a transport system is put in place. Elwell-Sutton (2014) did show that the transport provision was one factor that increased costs significantly, but these costs have now been reduced, as the commissioner who originally supported the pilot programme has commissioned for 2017 a second SHARP programme in Essex and funds have been raised for a 12-seater minibus in each location to reduce the cost of taxis. These results are all promising indicators of success, even though no experimental evidence of outcomes is yet in existence. It is possible, perhaps even likely, if the trends outlined above are indicative of the future, that programmes similar to SHARP may represent the future of 'rehab' in the U.K. in the coming decades.

Understanding how these programmes create their effects will be important for training counselling staff as well as for supervision and programme improvement. As the review of the literature in Chapter 2 showed, there was a substantial and valuable literature published in the last century which was interested in treatment processes, although there were very few of the micro-

process studies called for by Finney & Moos (1986) ever published, and none were located in the literature search which went beyond a positivist approach to causality. The sidelining of process research while experimental efficacy studies were in the ascendancy was followed by resurgent interest in mechanisms, and a recognition that knowledge about these would require a range of research strategies and methods (Longabaugh & Magill 2012). This present study represents a modest contribution to this effort. What might its contribution be to the improvement of programmes such as SHARP and of psychosocial interventions more generally?

10.2. The activities of the SHARP programme

In order to consider this, the treatment manual for SHARP will be revisited along with a number of relevant research papers. There are a number of elements to the treatment programme which were outlined in a recent book chapter (Leighton 2013). The journey through SHARP is conceived of as involving four overlapping stages: motivation and engagement, generating psychosocial change, building recovery capital, and reintegration/sustaining recovery. These elements, together with a statement of the ‘spirit of SHARP’ as it applies at each stage, are shown in table 10.1, which is taken from the manual. This manual has already been referred to in Chapter 3, page 77.

It seems clear that the participants in all three centres considered that particular elements were more centrally implicated in their personal change process than others. In fact the interviews rarely referred to the formal activities at all, apart from group therapy sessions, with one or two exceptions. Philip, for instance, explained that for him the benefit of treatment was more about interaction, relationships and connection than formal learning of skills. He does acknowledge the value of the relapse prevention skills workshops: *“I did get something out of them, some were very good.”* This may be because the first phase interviewees were responding to the focus of the interviews, which was to address the question “How are you changing while you are here?” The second phase of theory-driven interviews underlined the importance of clear structure but also produced very little commentary about the formal activities

Table 10.1: Elements of treatment mapped onto the Treatment Process Model

Motivation and Engagement	Generating Psychosocial change	Building Recovery Capital	Reintegration and Recovery
Assessment/ treatment tools CEST Assessment of dependence (and range of drug/alcohol use). Risk assessment re treatment goal. Family and social situation. Review of current care plan with client.	Assessment/ treatment tools Social History. Assessment of relationships and goals. Personal meaning and values.	Assessment/ treatment tools Assessment of Recovery Capital (ARC). Fit-to-12 Step Questionnaire.	Assessment/ treatment tools
Core activities 2-3 sessions using Motivational Interviewing, including feedback of initial assessment: Newcomers' workshops on philosophy of treatment, mutual aid and interpersonal group therapy.	Core activities Developing an individual treatment plan. Interpersonal Group Therapy. Individual Counselling. Aims: Commitment to recovery. Empowerment of responsible choice-making. Developing more fulfilling relationships.	Core activities Building a recovery plan. ITEP node-mapping Mutual aid exploration (12 Step, SMART, others). Relapse prevention training (initial). Family and significant others: relationship building/repairing.	Core activities Relapse Prevention training (stage 2). Family and significant others: expectations and distribution of responsibilities.
The spirit of SHARP Introducing people to the idea that they are going to become part of a community or joint endeavour. This starts a journey of empowerment intended to continue after the programme is completed. Mutuality as empowerment.	The spirit of SHARP Acceptance, valuing and aspiration. Self acceptance and acceptance of others through mutual acceptance. Development of hope and increase in self-efficacy. Recognising the relationship between interpersonal relating and the ability to participate in mutual support.	The spirit of SHARP A central concept in the SHARP model is participation in a network of mutual support. However the team take a pluralistic and open minded view of mutual support and although unequivocally supportive of 12 Step fellowships will help clients explore other forms of mutual aid.	The spirit of SHARP The position of SHARP is that a treatment intervention does not complete the recovery process: changes begun in treatment must be continued and developed afterwards, and new choices and changes will become necessary. Recovery entails increases in health, well-being and quality of life.

other than interpersonal group therapy. As already mentioned, the manual states that group therapy is the “central feature of the programme” and it is perhaps reassuring that the participants should have described their change process in terms so compatible with the aims of this type of intervention. The model delineated in the last chapter indicated that change mainly derived from a response to challenging feedback from valued peers and counsellors. This happens mostly in the interpersonal group therapy sessions (of which there are four 90 minute sessions each week) but it also happens outside of these sessions in informal interactions throughout the day. Most of the descriptions in the interviews of feedback received by the participants were in the context of the group therapy sessions. The process of interpersonal learning in this model of group therapy according to Yalom & Leszcz begins when group members are escorted through the following steps:

1. Here is what your behaviour is like:
Through feedback and later through self-observation, members learn to see themselves as seen by others.
2. Here is how your behaviour makes others feel:
Members learn about the impact of their behaviour on the feelings of other members.
3. Here is how your behaviour influences the opinion others have of you:
Members learn that as a result of their behaviour, others value them, dislike them, find them unpleasant, respect them, avoid them and so on.
4. Here is how your behaviour influences your opinion of self:
Building on the information gathered in the first three steps, patients formulate self-evaluations. (Yalom & Leszcz 2005, p.180)

This process, Yalom and Leszcz make plain, is dependent on the development of group cohesiveness. Group members will take more risks and be more honest with each other the more they value the group. They will be more open to influence from other members and try harder to influence them in turn (ibid. p.75).

In a typical outpatient therapy group members return to their own lives between the sessions, but in a programme such as SHARP there is a great deal of interaction outside of the group sessions, spending time talking together during the breaks in the daily programme, during journeys to and from the centre and in the evenings and at weekends. All the treatment groups made use of phone

contact, and apps such as Whatsapp, to stay in touch out of hours and to offer each other support if needed. Attempts were made to include those who were struggling, and in the observed instance where this did not occur (page 151), the individual dropped out of the programme quite quickly. On the other hand Francis mentions that the group members urged him to “stick with it” when he felt like quitting, and Simon said despite being very withdrawn at the beginning, “I now have people in my group who are only a phone call away if I need help.” It is likely that this emphasis on mutual support and inclusion works to increase the effectiveness of the group therapy process.

But Table 10.1. also mentions the use of Motivational Interviewing, ITEP node link mapping, relapse prevention training, and mutual aid exploration, the last of which is akin to formal models of 12 Step facilitation, such as MAAEZ (Kaskutas et al. 2009) or ‘intensive referral’ (Timko et al. 2006). What is the relationship of these “evidence-supported” interventions and the model of change that has emerged from this study?

10.3. “Evidence-supported therapies” and their relationship with the model.

I have already quoted (Chapter 1, p.17) a senior counsellor at SHARP Liverpool as having said that staff “express attitudes and behaviours towards clients that are non-threatening and convey honesty, respect, caring and understanding. In my view SHARP follows this basic philosophy rather than simply implementing certain counselling techniques or methods.” (Leighton 2013 p.176). Revisiting this statement makes clear that she is not saying that certain counselling techniques and methods are not used: she is saying that their use has to be integrated within a particular form of ethical practice. Counsellors have all received brief trainings in Motivational Interviewing, Beck’s model of Cognitive Therapy, and facilitating Relapse Prevention workshops on a range of topics derived from sources such as the Recovery Training and Self-Help manual (McAuliffe & Ch’ien 1986), and the Project MATCH cognitive-behavioral coping skills manual (Litt & Hester 1992). The clients of all the SHARP programmes attend a workshop session called ‘Relapse Prevention’ once every week. There is evidence from supervision sessions that the relapse prevention sessions and

12 Step exploration sessions are delivered competently and consistently (Leighton 2013).

However none of the clients interviewed mentioned any of these approaches except for Philip's comment above, and neither did any of the counsellors interviewed about what they thought they were doing when counselling individually or in groups, apart from Joan, who said she thinks in her work at SHARP there's a "fair amount" of CBT, "I mean connecting thoughts, feelings, behaviours". Nobody described the systematic application of a series of CBT sessions targeting specific problems derived from a cognitive-behavioural formulation. It appears that the counsellors use the models they have learned eclectically and pragmatically, but not as a set of 'techniques' that can be taken off the shelf, used for a while, and then replaced and another set taken down and applied. A set of interviews with SHARP counsellors that was used in the preparation of a chapter on the SHARP model (Leighton 2013), is worth revisiting, as they provide clues as to how the practice of counselling is thought about in a way that supplements the interviews carried out for this study. The counsellor quoted above went on to say:

"There is also capacity to develop good interpersonal relationships as clients learn to relate freely and openly with each other (and staff) on the basis of immediate 'here and now' experiencing and in so doing developing a richer self-awareness. At times it seems the sense of 'realness' in interactions at SHARP is probably the most important element in client interactions along with empathy or understanding where our clients seem most anxious and vulnerable." (Leighton 2013 p.176).

Other counsellors made it clear that their task was to provide an environment in which the resources offered by the programme could be taken up. One stated that his aim was to have clients leave a counselling session with him 'with their head held high', as he believed states of shame, self-denigration, and feelings of failure precluded people, if they were left unimproved, from benefiting from the programme. Another described a process of 'internal supervision' she used while working with individuals and groups in which she asked herself, when she was aware of ambivalence in a client, how congruent she was being with the 'spirit' of Motivational Interviewing, or during a group therapy session, to assess to what extent the group is engaged in interpersonal learning in the 'here and

now' and what she might do to help the group work productively (Leighton 2103 p.177).

This has profound implications for counsellor training and development. It seems essential, in order to optimise individual counsellor-client relationships, to target the cultivation of a counsellor's interpersonal skills and the ability to challenge sensitively once a trusting relationship has been established. An unexpected but interesting finding relevant to the mechanisms of change identified here, emerged from a study by Moyers, Miller and Hendrickson, which was part of Miller et al.'s (2004) Evaluating Methods for Motivational Enhancement Education (EMMEE) project. Behaviours such as confrontation or challenge, giving advice and direction are regarded in 'orthodox' Motivational Interviewing as inconsistent with the spirit of the approach. However the study found unexpectedly that such behaviours actually enhanced the client involvement if provided in the right context, that of a secure therapeutic relationship:

"Specifically, therapist instances of confrontation, warning and directing clients did not decrease client involvement in the MI session as proposed by Miller and Rollnick (2002) and reported by Miller et al. (1980). To the contrary, these proscribed behaviors showed an unexpected positive relationship with client participation when, and only when, they were observed in the larger context of clinician interpersonal skills. Furthermore, the statistical relationship of clinician interpersonal skills with client involvement was enhanced in the presence of these MIIN behaviors. This raises the possibility that therapist behaviors that have traditionally been viewed as inconsistent with the spirit of MI are in fact compatible with this method if clinicians convey them with the requisite interpersonal skills." (Moyers, Miller & Hendrickson 2005, p.596).

Beck et al. (1993) also make the point in their book 'Cognitive Therapy of Substance Abuse' that effective work in their model is predicated on excellent relational skills and that clients are much more likely to engage and use the therapy productively with a skilfully empathic, respectful counsellor.

Although it has been shown convincingly that aggressive confrontation in addictions treatment is never associated with good outcomes and has the potential to cause psychological harm (Moos 2005, White & Miller 2007), it seems that under certain conditions clients welcome and respond positively to

respectful challenge, as this study has shown. For example Kristen said that in her previous treatment episode in a residential centre she was not challenged and therefore learned nothing about herself, whereas SHARP had not only provided her with a transformative insight but had provided a safe space to practice her newfound assertiveness and receive validating feedback. Chapters 6-8 provide many other pieces of evidence that challenge contributes to change. It seems important to integrate into the training and supervision of counsellors attention to the development of the therapeutic relationship and to the art of timely and skilful challenge.

This is true for individual counselling work but also for group work and the maintenance of the therapeutic culture of the programme. Transferring these mechanisms for change from individual counselling to group counselling is both made more complex due to the multiplication of involved persons but may also be made easier if the power of the group culture is appropriately mobilised. The setting and maintenance of group norms is regarded as a central task of the group facilitator (Yalom & Leszcz 2005, pp.117-140), and this is task that is shared with participants as they commit to the arrangements, conventions and agreements of the programme. The client of the programme is not simply the recipient of counselling, she or he is an active participant and contributor to the culture of the community and the therapeutic work. Active involvement and helping others have been shown to be associated with good outcomes in substance misuse treatment programmes (Zemore & Kaskutas 2008) and this present study provides some insight into the mechanisms of this. Mobilising and facilitating such mechanisms should be a fundamental part of training for counsellors and staff teams in group based treatment programmes. More research into how these skills are developed is surely needed: we know that the SHARP counsellors “felt it was crucial to maintain a culture of inclusivity and respect, which they believed if modelled consistently by the staff would transfer into the client group and create the conditions for individual participants to take up the resources offered by the programme and make life-changing choices,” (Leighton 2013 p.176) but what is not known and is not integrated into counsellor training is exactly how this is done: it remains at the level of craft knowledge. A useful supplement to this present study would be further

exploration focusing on the counselling team, the way they make interventions, communicate with one another, transfer and share knowledge and deal situations arising in individuals and in the treatment group.

10.4. What does this study contribute?

A paper published by Fiorentine, Nakashima & Anglin (1999) researched factors associated with client involvement in day treatment programmes in California. It was a fairly large study with 417 clients, in programmes which are not directly comparable with the SHARP programmes but in which one might expect similar mechanisms to be operating in terms of the relationship between the client and the agency. The paper's findings

“contradict a popular stereotype of the drug treatment process. It is often assumed that the clients themselves are the most active force in treatment engagement, and in the more general process of recovery. Treatment programs, by contrast, are viewed as receptive to the clients' needs, but nevertheless limited in their ability to engage the client. The findings of this study indicate the opposite. Rather than a treatment- “receptive” client who engages in treatment due to intrinsic or other individual characteristics, the findings suggest that the perceived utility, or helpfulness, of the services, along with a favorable client–counselor relationship actively engages the client in treatment.” (Fiorentine, Nakashima & Anglin 1999, p.204.)

They go on to say “

“our findings indicate that what clients “bring” into treatment is frequently less important than what they find when they get there.” (ibid.p.205.)

In their conclusion the authors put forward their opinion that “further research may benefit from a more concerted focus on the *treatment experience* of the client”. (ibid. p.206, emphasis in the original). This present study adds support to their statements and is a modest contribution to the large gap in our knowledge about this experience and how it relates to the change processes clients are undergoing.

This study begins to show the importance of the context for change mechanisms to be activated, and it seems that while personal situations and past experiences have some bearing on the entry to and engagement with the programmes, these vary considerably, with different factors apparently very

important for some but not for others. What is universal however is the importance accorded to structure, consistency and boundaries on one hand, and acceptance, welcome and respectful attention on the other. Experiences which might be expected to be aversive, such as the monitoring of strict abstinence expectations and the challenging of behaviours and attitudes were in fact welcomed by all participants and deemed to be essential to the programme's success. It is true that some of these were unfamiliar and uncomfortable at first; for example, Laura's initial reaction to being deprived of her mobile phone (page 205), and John's initial reaction to being challenged (page 137), but the welcoming, accepting and encouraging context, provided both by staff and programme participants supported the wavering in persisting with the programme, and the clear structure engendered a feeling of safety. Due to the very high level of engagement and completion in the group of participants I encountered at all three agencies, it was hard to get a clear view of what caused the programme to fail to help in some cases, but it was clear in at least one instance (page 152) that the intrusion of condemnation by the group for what a client had revealed about themselves overrode the norm of acceptance. Unfortunately it was not possible to hear the client's own account of this, but on the basis of my observation it was a major factor in his self-discharge followed by a return to drug and alcohol use.

The most important source of data for this study were the voices of the clients themselves. Although there have been a number of studies which have presented the voices of those in recovery from addiction (e.g. McIntosh & McKeganey 2000, Neale, Nettleton & Pickering. 2012), there has been surprisingly little on treatment experiences as heard through the voices of those undergoing it.

The use of a realist paradigm is also unusual in research into addiction treatment. As was traced in Chapter 2 there is currently an increasing interest in understanding the mechanism of interventions. There is recognition that research must begin to use a range of approaches and methods to address this, but the published literature continues to be almost exclusively dominated by positivist statistical methods, even of ever-increasing complexity and

ingenuity. Certainly the findings of realist research benefit from empirical confirmation or disconfirmation, and there is a need to understand not just how these mechanisms relate to sustained recovery. It is likely that this will require qualitative and quantitative research. The finding in Finney, Moos and Humphreys (1999) that the proximal outcome composites they measured at treatment discharge were only weakly correlated with abstinent outcome 12 months later, but that the same outcomes measured at the follow-up point were much better correlated and accounted for much more of the variance in outcomes, suggests, not that the changes that occur in treatment are irrelevant or that somehow the characteristics that are associated with sustained abstinence were acquired afterwards, but that there are mechanisms and contexts that explain why some people sustain their recovery and some do not. This is beyond the scope of this study, but the explanatory model (suitably modified) will be used in future follow-up studies to attempt to understand the processes of sustaining or failing to sustain recovery. Miller & Harris (1999), testing a scale to measure the risk of relapse in alcohol dependent people concluded that:

“the warning signs that were related to slips and relapses consistently clustered together in a single factor that significantly improved the ability to predict outcomes. Our findings indicated that this factor reflects a general demoralization, low purpose in life, depression anxiety and anger.”

This factor is bipolar, and the other pole, the authors say, reflects “a sense of meaning in life, honesty, hope, low levels of emotional negativity, stable eating and sleeping patterns, clear thinking, absence of self-pity, and a sense of peace and stability” (Miller & Harris 1999, p.765). They suggest this might represent “the elusive concept of recovery”. This study has shown how such a self state can be generated though the process of a group-based treatment programme. Further studies may illuminate how this is sustained or otherwise on the journey of recovery that follows treatment.

This study has responded to the call for new approaches to understand how treatment works. The deployment of this particular combination of methods guided by a realist framework contributes further to the originality of the study. Despite group methods being used very commonly in addiction treatment there

has been a preponderance of focus on individual interventions and when groups have been included in research there has been a tendency to see these simply as a mode of delivery of the individual intervention rather than investigating the unique social psychological power of groups and therapeutic communities. And as a result of this neglect, addictions counsellors are trained mainly in models that were designed for individual work. Counselling teams in treatment centres have formed communities of practice and developed craft knowledge which has been transmitted by tradition. I hope it is clear from the voices of the counsellors as they have appeared in this thesis that this has resulted in the creation and maintenance of some very effective treatment environments. But there is not much alignment with the picture presented for example in the 'Skills Hub' developed by the independent U.K. sector-led Skills Consortium (2010).

What is presented in this thesis is the development through research of a model that explains the kind of contexts required for change to occur, the kind of mechanisms that create that change, and the outcomes that are produced from these change processes. The model in its contexts-mechanisms-outcome form is in the end rather straightforward and intuitive – I believe it is also novel. It lends itself to and invites future elaboration and extension.

What it implies, even in its embryonic form, is the preservation and encouragement via professional education of addictions counselling as a creative and social activity. Moreover, understanding that the impact of an intervention is dependent on the activation of mechanisms which require facilitating contexts and which may be blocked by constraining powers, and having a model of the way the emergent personal and social powers interact, provides the potential for improving programmes and paying attention to individual participants in a new way, and thereby increasing the numbers of people who benefit. What is particularly pleasing to me personally is the confirmation that for the most part the participants of this study were by no means characterised by a preponderance of social advantages, particularly in terms of formal education, financial assets or social status. And yet each one of them was showing how the development of subtle and articulate reflexivity in a context of social support was producing both personal empowerment and

solidarity, strengthening emerging social structures and transforming not only themselves but those who follow on.

References

- Adams, J. and White, M. (2004). Why don't stage-based activity promotion interventions work? *Health Education Research*, 20(2), 237-243.
- Alcoholics Anonymous (1957). *Alcoholics Anonymous Comes of Age*, New York, Harper Books.
- Anderson, D. J. (1981). *Perspectives on Treatment: The Minnesota Experience*. Center City MN, Hazelden Foundation.
- Anton, R. F., O'Malley, S. S., Ciraulo, D. A., Cisler, R. A., Couper, D., Donovan, D. M., & 14 others (COMBINE Study Research Group) (2006). Combined pharmacotherapies and behavioral interventions for alcohol dependence: the COMBINE study: a randomized controlled trial. *Journal of the American Medical Association*, 295(17), 2003-2017.
- Archer, M. S. (1995). *Realist Social Theory: The Morphogenetic Approach*. Cambridge, Cambridge University Press.
- Archer, M.S. (2000). *Being Human: The Problem of Agency*, Cambridge, Cambridge University Press.
- Archer, M.S. (2003). *Structure, Agency and the Internal Conversation*, Cambridge University Press.
- Archer, M. S. (2007). *Making our Way through the World: Human Reflexivity and Social Mobility*. Cambridge University Press.
- Archer, M. S. (2012). *The Reflexive Imperative in Late Modernity*. Cambridge, Cambridge University Press.
- Armstrong, D. (1983). *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century*. Cambridge, Cambridge University Press.
- Avants, S. K., Margolin, A., Sindelar, J. L., Rounsaville, B. J., Schottenfeld, R., Stine, S., ... & Kosten, T. R. (1999). Day treatment versus enhanced standard methadone services for opioid-dependent patients: a comparison of clinical efficacy and cost. *American Journal of Psychiatry*, 156(1), 27-33.
- Baert, P. (1998). *Social Theory in the 20th Century*. Cambridge, Polity Press
- Barlow, D. H. (1996). Health care policy, psychotherapy research, and the future of psychotherapy. *American Psychologist*, 51(10), 1050.
- Barnard, M. (2006). *Drug Addiction and Families*. London, Jessica Kingsley Publishers.
- Bateson, G. (1971). The cybernetics of "self": A theory of alcoholism. *Psychiatry*, 34(1), 1-18.
- Baumohl, J. (1990). Inebriate institutions in North America, 1840–1920. *British Journal of Addiction*, 85(9), 1187-1204.

- Beard, G. M. (1876). Causes of the recent increase of inebriety in America, *Quarterly Journal of Inebriety*, 1, p. 28, cited in Baumohl, J. (1990). Inebriate institutions in North America, 1840–1920. *British Journal of Addiction*, 85(9), 1187-1204.
- Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive Therapy of Substance Abuse*. New York, Guilford Press.
- Best, D. W., Groshkova, T., Sadler, J., Day, E., & White, W. L. (2011). What is recovery? Functioning and recovery stories of self-identified people in recovery in a services user group and their peer networks in Birmingham England. *Alcoholism Treatment Quarterly*, 29(3), 293-313.
- Best, D., Beckwith, M., Haslam, C., Haslam, S. A., Jetten, J., Mawson, E., & Lubman, D. I. (2016). Overcoming alcohol and other drug addiction as a process of social identity transition: The Social Identity Model of Recovery (SIMOR). *Addiction Research & Theory*, 1-13.
- Best, D., Gow, J., Knox, T., Taylor, A., Groshkova, T., & White, W. (2012). Mapping the recovery stories of drinkers and drug users in Glasgow: Quality of life and its associations with measures of recovery capital. *Drug and Alcohol Review*, 31(3), 334-341.
- Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, 33(3), 221-228.
- Biernacki, P. (1986). *Pathways from Heroin Addiction: Recovery without Treatment*. Philadelphia PA, Temple University Press.
- Billings, A. G. & Moos, R. H. (1985). Life stressors and social resources affect posttreatment outcomes among depressed patients. *Journal of Abnormal Psychology*, 94/2, 140.
- Blackburn, S. (1990). Hume and thick connexions. *Philosophy and Phenomenological Research*, 50 (suppl.), 237-250.
- Blonigen, D. M., Timko, C., & Moos, R. H. (2013). Alcoholics Anonymous and reduced impulsivity: a novel mechanism of change. *Substance Abuse*, 34(1), 4-12.
- Bourdieu, P., Wacquant, L.J.D. (1992). *An Invitation to Reflexive Sociology*. Chicago, University of Chicago Press.
- Boyd, R. (2007). Scientific Realism. *Stanford Encyclopedia of Philosophy*, available at: <http://stanford.library.usyd.edu.au/archives/fall2007/entries/scientific-realism> [accessed 14.04.2016]
- Brinberg, D., & McGrath, J. E. (1985). *Validity and the Research Process*. London, Sage.

- Brug, J., Conner, M., Harre, N., Kremers, S., McKellar, S., & Whitelaw, S. (2005). The Transtheoretical Model and stages of change: a critique Observations by five Commentators on the paper by Adams, J. and White, M.(2004) Why don't stage-based activity promotion interventions work?. *Health Education Research*, 20(2), 244-258.
- Bühringer, G. (2000). Testing CBT mechanisms of action: Humans behave in a more complex way than our treatment studies would predict! *Addiction*, 95(11), 1715.
- Bunge, M. (2004). How does it work? The search for explanatory mechanisms. *Philosophy of the Social Sciences*, 34(2), 182-210.
- Bygstad, B. & Munkvold, B. E. (2011). In Search of Mechanisms. Conducting a Critical Realist Data Analysis. 32nd International Conference on Information Systems, Shanghai 2011.
- Carroll, K. M., & Rounsaville, B. J. (1990). Can a technology model of psychotherapy research be applied to cocaine abuse treatment? *Psychotherapy and Counseling in the Treatment of Drug Abuse. National Institute on Drug Abuse Research Monograph*, 104, 91-104.
- Carroll, K. M., & Rounsaville, B. J. (2007). A vision of the next generation of behavioral therapies research in the addictions*. *Addiction*, 102(6), 850-862.
- Carroll, K. M., & Rounsaville, B. J. (2007b). W(h)ither empirically supported therapies (ESTS)? Reply to commentaries. *Addiction*, 102(6), 867-869.
- Cartwright, N., & Hardie, J. (2012). *Evidence-based Policy: Doing it Better. A Practical Guide to Predicting if a Policy Will Work for You*. Oxford, Oxford University Press.
- Chakravarty, A. (2015) "Scientific Realism", from Zalta, E.N. (ed.) *The Stanford Encyclopedia of Philosophy*, available at <http://plato.stanford.edu/archives/fall2015/entries/scientific-realism/> [accessed 14.04.2016]
- Chen, H. T. & Rossi, P. H. (1980). The multi-goal, theory-driven approach to evaluation: A model linking basic and applied social science. *Social Forces*, 59/1, 106-122.
- Chen, H. T. & Rossi, P. H. (1983). Evaluating with sense. *Evaluation Review*, 7/3, 283-302.
- Chen, H. T. & Rossi, P. H. (1987) The theory-driven approach to validity. *Evaluation and Program Planning*, 10/1, 95-103.
- Cloud, W. & Granfield, R. (1994). Terminating addiction naturally: Post-addict identity and the avoidance of treatment. *Clinical Sociology Review*, 12, 159-174.

- Cloud, W. & Granfield, R. (2001). Natural recovery from substance dependency: Lessons for treatment providers. *Journal of Social Work Practice in the Addictions*, 1(1), 83-104
- Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use & Misuse*, 43(12-13), 1971-1986.
- Cochrane, A. L. (1972). *Effectiveness and efficiency: random reflections on health services* (Vol. 900574178). London: Nuffield Provincial Hospitals Trust.
- Collins, L. M., Murphy, S. A., & Bierman, K. L. (2004). A conceptual framework for adaptive preventive interventions. *Prevention Science*, 5(3), 185-196.
- Cook, C. (1988). The Minnesota Model in the Management of Drug and Alcohol Dependency: miracle, method or myth? Part I. The Philosophy and the Programme? *Addiction*, 83/6, 625-634.
- Cook, T. D. & Shadish Jr, W. R. (1986). Program evaluation: The worldly science. *Annual Review of Psychology*, 37/1, 193-232.
- Coviello, D. M., Alterman, A. I., Rutherford, M. J., Cacciola, J. S., McKay, J. R., & Zanis, D. A. (2001). The effectiveness of two intensities of psychosocial treatment for cocaine dependence. *Drug and Alcohol Dependence*, 61(2), 145-154.
- Crits-Christoph, P., Siqueland, L., Blaine, J., Frank, A., Luborsky, L., Onken, L. S., & 16 others (1999). Psychosocial treatments for cocaine dependence: National Institute on Drug Abuse collaborative cocaine treatment study. *Archives of General Psychiatry*, 56(6), 493-502.
- Cronkite, R. C. & Moos, R. H. (1978). Evaluating alcoholism treatment programs: An integrated approach. *Journal of Consulting and Clinical Psychology*, 46/5, 1105.
- Cronkite, R. C. & Moos, R. H. (1980). Determinants of the posttreatment functioning of alcoholic patients: A conceptual framework. *Journal of Consulting and Clinical Psychology*, 48/3, 305.
- Crothers, T. D. (1881). What shall we do with the inebriate? *Alienist and Neurologist*, 2, p. 179, cited in Baumohl, J. (1990). Inebriate institutions in North America, 1840–1920. *British Journal of Addiction*, 85(9).
- Davies, J.B. (1992). *The Myth of Addiction*. London, Harwood Academic.
- Davoli, M., & Amato, L. (2014). Large evidence base, small effects: motivational interviewing for alcohol misuse in young adults. *The Cochrane Database of Systematic Reviews*, 9, ED000088.
- DeLeon, G. (2000). *The Therapeutic Community: Theory, model, and method*. New York, Springer Publishing Co.
- Dole, V. P., & Nyswander, M. E. (1967). Heroin addiction - a metabolic disease. *Archives of Internal Medicine*, 120(1), 19-24.

- Dole, V. P., & Nyswander, M. E. (1976). Methadone maintenance treatment: A ten-year perspective. *Journal of the American Medical Association*, 235(19), 2117-2119.
- Drugs: Breaking the Cycle (2010). Written evidence submitted by RehabGrads (DP141), London, Home Affairs Select Committee, available at <http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/184/184wea23.htm> [accessed 20.01.2017]
- Elster, J. (1998). A plea for mechanisms. Chapter 3 in Hedrom P. & Swedberg R. (eds.) *Social mechanisms: An analytical approach to social theory*, Cambridge, Cambridge University Press, p.45.
- Elster, J. (2007). *Explaining Social Behavior*. Cambridge, Cambridge University Press.
- Elwell-Sutton, T. (2014). *Community-based drug rehabilitation pilot – interim evaluation*. Chelmsford, Essex County Council
- English, C. (2009). The regulatory function of addiction: Maintaining internal cohesion by the drugging of parts of the personality. *Psychodynamic Practice*, 15(4), 341-349.
- English, C. (2011). *Intrapsychic dimensions of addiction: the wearing down of help seeking capacities by cruel and tyrannical objects* (Doctoral dissertation, University of Nottingham).
- Essex CC Organisational Intelligence (2016). *SHARP Community Rehabilitation in Essex, Programme Evaluation*, November 2016, Chelmsford, Essex County Council.
- ESRC (2010). *Framework for Research Ethics*. Swindon: Economic & Social Research Council.
- Etheridge, R. M. & Hubbard, R. L. (2000). Conceptualizing and assessing treatment structure and process in community-based drug dependency treatment programs. *Substance Use & Misuse*, 35/12-14, 1757-1795.
- Finney, J. W. & Moos, R. H. (1986). Matching patients with treatments: Conceptual and methodological issues. *Journal of Studies on Alcohol and Drugs*, 47/02, 122.
- Finney, J. W. & Moos, R. H. (1989). Theory and method in treatment evaluation. *Evaluation and Program Planning*, 12/4, 307-316.
- Finney, J. W. (1995). Enhancing substance abuse treatment evaluations: Examining mediators and moderators of treatment effects. *Journal of Substance Abuse*, 7/1, 135-150.
- Finney, J. W., Moos, R. H. & Humphreys, K. (1999). A Comparative Evaluation of Substance Abuse Treatment: II. Linking Proximal Outcomes of 12-Step and Cognitive-Behavioral Treatment to Substance Use Outcomes. *Alcoholism: Clinical and Experimental Research*, 23/3, 537-544.

- Finney, J., Noyes, C., Coutts, A. & Moos, R. (1998). Evaluating Substance Abuse Treatment Process Models: I. Changes on Proximal Outcome Variables during 12-Step and Cognitive-Behavioral Treatment. *Journal of Studies on Alcohol*, 59/4.
- Fiorentine, R., Nakashima, J., & Anglin, M. D. (1999). Client engagement in drug treatment. *Journal of Substance Abuse Treatment*, 17(3), 199-206.
- Foucault M. (1973). *The Birth of the Clinic: An Archaeology of Medical Perception*. (trans. Sheridan A.M.), London, Tavistock.
- Foundation 66 (n.d.). Essex Support and Mentoring Service (web page), available at: <http://www.phoenix-futures.org.uk/essex-support-and-mentoring-service> [accessed 19.12.2016]
- Foxcroft, D. R., Coombes, L., Wood, S., Allen, D., & Almeida Santimano, N. M. (2014). Motivational interviewing for alcohol misuse in young adults. *Cochrane Database Systematic Review*, 8.
- Geertz, C. (1973). Thick Description: Toward an Interpretive Theory of Culture, in: *The Interpretation of Cultures: Selected Essays*. New York: Basic Books, pp.3-30
- Georgakis, A. (1995). *Clouds House: An Evaluation of a Residential Alcohol & Drug Dependency Treatment Centre*. Salisbury, Life-Anew Trust.
- Giddens, A. (1992). *The Transformation of Intimacy: Sexuality, Love and Eroticism in Modern Societies*. Chichester, John Wiley & Sons.
- Giddens, A., (1991). *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Cambridge, Polity Press.
- Glesne, C. & Peshkin, A. (1992). *Becoming Qualitative Researchers: an Introduction*. White Plains, NY, Longman.
- Gossop, M., Marsden, J., Stewart, D., & Rolfe, A. (1999). Treatment retention and 1 year outcomes for residential programmes in England. *Drug and Alcohol Dependence*, 57(2), 89-98.
- Granfield, R., & Cloud, W. (2001). Social context and "natural recovery": The role of social capital in the resolution of drug-associated problems. *Substance Use & Misuse*, 36(11), 1543-1570.
- Granovetter, M., Tilly, C. (1988). Inequality and labor processes, In Smelser, N., (Ed.) *Handbook of Sociology*, Newbury Hills, CA, Sage.
- Greener, J. M., Joe, G. W., Simpson, D. D., Rowan-Szal, G. A., & Lehman, W. E. (2007). Influence of organizational functioning on client engagement in treatment. *Journal of Substance Abuse Treatment*, 33(2), 139-147.
- Greenwood, J. D. (1994). *Realism, Identity and Emotion: Reclaiming Social Psychology*. London, Sage Publications.

- Groshkova, T., Best, D., & White, W. (2013). The assessment of recovery capital: Properties and psychometrics of a measure of addiction recovery strengths. *Drug and Alcohol Review*, 32(2), 187-194.
- Hammersley, M. (1987). Some Notes on the Terms 'Validity' and 'Reliability'. *British Educational Research Journal*, 13(1), 73-82.
- Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in Practice* (3rd edition), London, Routledge.
- Harrison, D. (1860). *A Voice from the Washingtonian Home* (Boston, Redding & Co.); *Journal of the American Temperance Union*, April 22, 1858, cited in Blumberg, L. U. (1978) The institutional phase of the Washington Total Abstinence Movement, *Journal of Studies on Alcohol*, 39, p. 1596
- Hazelden-Betty Ford (2016). Master of Arts in Addiction Counseling (web page) available at: http://www.hazelden.org/web/public/master_of_arts.page, [accessed 16.02.2016]
- Holstein, J. A. & Gubrium, J. F. (1995). *The Active Interview*, Thousand Oaks, CA: Sage
- Holstein, J. A. and Gubrium, J. F. (1997). 'Active Interviewing', pp. 113-129 in D. Silverman (ed.) *Qualitative Research: Theory, Method and Practice*, Los Angeles CA, Sage.
- Joe, G. W., Broome, K. M., Rowan-Szal, G. A., & Simpson, D. D. (2002). Measuring patient attributes and engagement in treatment. *Journal of Substance Abuse Treatment*, 22(4), 183-196.
- Johnson, V. E. (1980). *I'll Quit Tomorrow*. San Francisco CA, Harper & Row
- Kaidesoja, T. (2013). *Naturalizing Critical Realist Social Ontology*. London, Routledge.
- Kaskutas, L. A. (1994). What do women get out of self-help? Their reasons for attending Women for Sobriety and Alcoholics Anonymous. *Journal of Substance Abuse Treatment*, 11(3), 185-195.
- Kaskutas, L. A., Bond, J. & Humphreys, K. (2002). Social networks as mediators of the effect of Alcoholics Anonymous. *Addiction*, 97/7, 891-900.
- Kaskutas, L. A., Subbaraman, M. S., Witbrodt, J., & Zemore, S. E. (2009). Effectiveness of making Alcoholics Anonymous easier: A group format 12-step facilitation approach. *Journal of Substance Abuse Treatment*, 37(3), 228-239.
- Kellogg, S. (1993). Identity and Recovery. *Psychotherapy: Theory, Research, Practice, Training*, 30(2), 235.
- Kelly, J. F., & Greene, M. C. (2014). Toward an Enhanced Understanding of the Psychological Mechanisms by which Spirituality Aids Recovery in Alcoholics Anonymous. *Alcoholism Treatment Quarterly*, 32(2-3), 299-318.

- Kelly, J. F., & Hoepfner, B. B. (2012). Does Alcoholics Anonymous work differently for men and women? A moderated multiple-mediation analysis in a large clinical sample. *Drug and Alcohol Dependence*, 130(1), 186-193.
- Kelly, J. F., Hoepfner, B., Stout, R. L. & Pagano, M. (2011a). Determining the relative importance of the mechanisms of behavior change within Alcoholics Anonymous: a multiple mediator analysis. *Addiction*, 107/2, 289-299.
- Kelly, J. F., Magill, M., & Stout, R. L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. *Addiction Research & Theory*, 17(3), 236-259.
- Kelly, J. F., Stout, R. L., Magill, M., Tonigan, J. S., & Pagano, M. E. (2011b). Spirituality in recovery: A lagged mediational analysis of Alcoholics Anonymous' principal theoretical mechanism of behavior change. *Alcoholism: Clinical and Experimental Research*, 35(3), 454-463.
- Kelly, J. F., Stout, R. L., Magill, M., & Tonigan, J. S. (2011c). The role of Alcoholics Anonymous in mobilizing adaptive social network changes: A prospective lagged mediational analysis. *Drug and Alcohol Dependence*, 114(2), 119-126.
- Kelly, J. F., Stout, R. L., Tonigan, J. S., Magill, M., & Pagano, M. E. (2010). Negative affect, relapse, and Alcoholics Anonymous (AA): does AA work by reducing anger? *Journal of Studies on Alcohol and Drugs*, 71(3), 434.
- Klingemann, H. K. H. (2004). Natural recovery from alcohol problems. Chapter 10 in Heather, N. & Stockwell, T. (eds.) *The Essential Handbook of Treatment and Prevention of Alcohol Problems*, Chichester, John Wiley, pp.161-175.
- Klingemann & Gmel (eds.) (2001). *Mapping the Social Consequences of Alcohol Consumption*. Dordrecht, Springer Netherlands.
- Kolden, G. G., Chisholm-Stockard, S. M., Strauman, T. J., Tierney, S. C., Mullen, E. A., & Schneider, K. L. (2006). Universal session-level change processes in an early session of psychotherapy: Path models. *Journal of Consulting and Clinical Psychology*, 74(2), 327.
- Koski-Jännes, A. (1998). Turning points in addiction careers: five case studies. *Journal of Substance Misuse*, 3(4), 226-233.
- Koski-Jännes, A. (2002). Social and personal identity projects in the recovery from addictive behaviours. *Addiction Research and Theory*, 10(2), 183-202.
- Krentzman, A. R., Cranford, J. A., & Robinson, E. A. (2013). Multiple dimensions of spirituality in recovery: A lagged mediational analysis of Alcoholics Anonymous' principal theoretical mechanism of behavior change. *Substance Abuse*, 34(1), 20-32.
- Kurtz, E. (2002). Alcoholics Anonymous and the disease concept of alcoholism. *Alcoholism Treatment Quarterly*, 20(3-4), 5-39.

- Lakoff, G. (1987). *Women, Fire, and Dangerous Things: What categories reveal about the mind*. Chicago: University of Chicago.
- Lart, R. (1992). British medical perception from Rolleston to Brain: Changing images of the addict and addiction. *International Journal on Drug Policy*, 3, 118-118.
- Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment*, 33(3), 243-256.
- Leighton, T. (2004). Interpersonal group therapy in intensive treatment. In: Reading, B. & Weegman, M. (Eds.), *Group Psychotherapy and Addiction* (81-98). London: Whurr.
- Leighton, T. (2013). Counselling in intensive structured day treatment – the co-production of recovery, in Mistral, W. (ed.). *Emerging Perspectives on Substance Misuse*. Chichester, John Wiley & Sons.
- Leighton, T. (2015). The Concept of Recovery, in Pycroft, A. (ed.) *Key Concepts in Substance Misuse*, London, Sage.
- Leighton, T. (2016). SHARP intensive day treatment. In Mistral W. (ed.). *Integrated Approaches to Drug and Alcohol Problems: Action on Addiction*, London, Routledge.
- Leighton, T., & Barton, N. (2005). The origins, arrival and spread of residential Minnesota Model centres across the UK, in Strang, J. and Gossop, M. (eds.) *Heroin addiction and The British System*, Volume 2, pp.175-186, London, Routledge
- Leplin, J. (Ed.). (1984). *Scientific Realism* (Vol. 323). University of California Press.
- Leshner, A. I. (1997). Addiction is a brain disease, and it matters. *Science*, 278(5335), 45-47.
- Li, L., Zhu, S., Tse, N., Tse, S., and Wong, P. (2016). Effectiveness of motivational interviewing to reduce illicit drug use in adolescents: a systematic review and meta-analysis. *Addiction*, 111(5), 795–805.
- Lifestyles Statistics, HSCIC (2014). Statistics on Drug Misuse, England 2014, Health and Social Care Information Centre, available at: <http://content.digital.nhs.uk/catalogue/PUB15943/drug-misu-eng-2014-rep.pdf> [accessed 4 November 2016]
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. London, Sage.
- Litt, M.D., & Hester, R. (1992). *Cognitive-Behavioral Coping Skills Therapy Manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence* (NIAAA Project MATCH Monograph, Vol. 3, DHHS Publication No. ADM 92-1895). Washington, DC: U.S. Government Printing Office.

- Litt, M. D., Kadden, R. M., Kabela-Cormier, E. & Petry, N. M. (2007). Changing network support for drinking: Initial findings from the Network Support Project. *Journal of Consulting and Clinical Psychology, 75*(4), 542.
- Litt, M. D., Kadden, R. M., Kabela-Cormier, E. & Petry, N. M. (2009). Changing network support for drinking: Network Support Project 2-year follow-up. *Journal of Consulting and Clinical Psychology, 77*(2), 229.
- Livingston, W., Baker, M., Jobber, S. and Atkins, B., (2011). A Tale of the Spontaneous Emergence of a Recovery Group and the Characteristics That Are Making It Thrive: Exploring the Politics and Knowledge of Recovery. *Journal of Groups in Addiction & Recovery, 6*(1-2), pp.176-196.
- Longabaugh, R. & Magill, M. (2012). Commentary on Michie et al.(2012): The lid is off the black box. *Addiction, 107*(8), 1441-1442.
- Longabaugh, R., Wirtz, P.W., Zweben, A., & Stout, R. (2001). Network support for drinking. In: Longabaugh, R. AND Wirtz, P.W. (Eds.) *Project MATCH Hypotheses: Results and Causal Chain Analyses. NIAAA Project MATCH Monograph Series, Vol. 8*, NIH Publication No. 01-4238, Washington: Government Printing Office, pp. 260-27.
- Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has won and all must have prizes"? *Archives of General Psychiatry, 32*(8), 995.
- Marlatt, G. A. (1985). Relapse prevention: Theoretical rationale and overview of the model. In G. A. Marlatt & J. R. Gordon (Eds.), *Relapse Prevention* (pp. 250–280). New York: Guilford Press.
- Marlowe, D. B., Kirby, K. C., Festinger, D. S., Merikle, E. P., Tran, G. Q., & Platt, J. J. (2003). Day treatment for cocaine dependence: incremental utility over outpatient counseling and voucher incentives. *Addictive Behaviors, 28*(2), 387-398.
- Maxwell, J. A. (2004). Causal explanation, qualitative research, and scientific inquiry in education. *Educational Researcher, 33*(2), 3-11.
- Maxwell, J. A. (2012). *A Realist Approach for Qualitative Research*. Los Angeles, CA, Sage.
- Maxwell J.A. & Miller B. (2012). Real and virtual relationships in qualitative data analysis, Chapter 7 in Maxwell, J. A., *A Realist Approach for Qualitative Research*. Los Angeles, CA, Sage.
- May, C. (2001). Pathology, identity and the social construction of alcohol dependence. *Sociology, 35*(2), 385-401.
- McAuliffe, W. E., & Ch'ien, J. M. (1986). Recovery training and self help: A relapse-prevention program for treated opiate addicts. *Journal of Substance Abuse Treatment, 3*(1), 9-20.

- McIntosh, J., & McKeganey, N. (2000). Addicts' narratives of recovery from drug use: constructing a non-addict identity. *Social Science & Medicine*, 50(10), 1501-1510.
- McIntosh, J., & McKeganey, N. P. (2002). *Beating the Dragon: The Recovery from Dependent Drug Use*. London, Routledge.
- McMullin, E. (1984). A case for scientific realism, Chapter 2 (pp. 8-40) in Leplin, J. (Ed.). *Scientific Realism* (Vol. 323). University of California Press.
- Meyer, S. B., & Lunnay, B. (2013). The application of abductive and retroductive inference for the design and analysis of theory-driven sociological research. *Sociological Research Online*, 18(1), 12.
- Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implementation Science*, 6(1), 1-11.
- Michie, S., Whittington, C., Hamoudi, Z., Zarnani, F., Tober, G. & West, R. (2012). Identification of behaviour change techniques to reduce excessive alcohol consumption. *Addiction*, 107(8), 1431-1440.
- Miller, W. R., & Harris, R. J. (2000). A simple scale of Gorski's warning signs for relapse. *Journal of Studies on Alcohol*, 61(5), 759-765.
- Miller, W. R., Yahne, C. E., Moyers, T. B., Martinez, J., & Pirritano, M. (2004). A randomized trial of methods to help clinicians learn motivational interviewing. *Journal of Consulting and Clinical Psychology*, 72, 1050-1062.
- Millican, P. (2009). Hume, causal realism, and causal science. *Mind*, 118(471), 647-712.
- Mold, A., & Berridge, V. (2010). *Voluntary Action and Illegal Drugs*. London, Palgrave Macmillan.
- Moos, R. H. *Evaluating Treatment Environments*. New York: Wiley, 1974
- Moos, R. H. (2005). Iatrogenic effects of psychosocial interventions for substance use disorders: prevalence, predictors, prevention. *Addiction*, 100(5), 595-604.
- Moos, R. H. & Finney, J. W. (1983). The Expanding Scope of Alcoholism Treatment Evaluation. *American Psychologist*, 38/10, 1036.
- Moos, R. H., Finney, J. W., Ouimette, P. C. & Suchinsky, R. T. (1999). A Comparative Evaluation of Substance Abuse Treatment: I. Treatment Orientation, Amount of Care, and 1-Year Outcomes. *Alcoholism: Clinical and Experimental Research*, 23/3, 529-536.
- Moos, R. H., Moos, B. S., & Timko, C. (2006). Gender, treatment and self-help in remission from alcohol use disorders. *Clinical Medicine & Research*, 4(3), 163-174.

- Morgenstern, J. & McKay, J. R. (2007) Rethinking the paradigms that inform behavioral treatment research for substance use disorders. *Addiction*, 102/9, 1377-1389.
- Morgenstern, J. (2007a) Perspectives and future directions. *Alcoholism: Clinical and Experimental Research*, 31, 87s-90s.
- Morgenstern, J., & Longabaugh, R. (2000). Cognitive-behavioral treatment for alcohol dependence: A review of evidence for its hypothesized mechanisms of action. *Addiction*, 95(10), 1475-1490.
- Morgenstern, J., Frey, R. M., McCrady, B. S., Labouvie, E. & Neighbors, C. J. (1996) Examining mediators of change in traditional chemical dependency treatment. *Journal of Studies on Alcohol and Drugs*, 57/1, 53.
- Morgenstern, J., Kuerbis, A., Amrhein, P., Hail, L., Lynch, K., & McKay, J. R. (2012). Motivational interviewing: A pilot test of active ingredients and mechanisms of change. *Psychology of Addictive Behaviors*, 26(4), 859.
- Morgenstern, J., Labouvie, E., McCrady, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, 65(5), 768.
- Morgenstern, J., Morgan, T. J., McCrady, B. S., Keller, D. S., & Carroll, K. M. (2001). Manual-guided cognitive-behavioral therapy training: A promising method for disseminating empirically supported substance abuse treatments to the practice community. *Psychology of Addictive Behaviors*, 15(2), 83.
- Moyers, T. B., Miller, W. R., & Hendrickson, S. M. (2005). How does motivational interviewing work? Therapist interpersonal skill predicts client involvement within motivational interviewing sessions. *Journal of Consulting and Clinical Psychology*, 73(4), 590.
- Moyers, T. B., Martin, T., Christopher, P. J., Houck, J. M., Tonigan, J. S., & Amrhein, P. C. (2007). Client language as a mediator of motivational interviewing efficacy: Where is the evidence? *Alcoholism: Clinical and Experimental Research*, 31(s3), 40s-47s.
- National Treatment Agency for Substance Misuse. (2009). *Routes to Recovery: ITEP & BTEI – new approaches to psychosocial interventions*. London: National Treatment Agency
- Neale, J., Nettleton, S., & Pickering, L. (2012). *The Everyday Lives of Recovering Heroin Users*. London: Royal Society of Arts.
- NIHCE. (2008). *Drug misuse: psychosocial interventions* (Clinical Guideline CG51). London: National Institute for Health and Clinical Excellence.

- NIHCE. (2011). *Alcohol-use Disorders - diagnosis, assessment and management of harmful drinking and alcohol dependence* (Clinical Guideline CG115). London: National Institute for Health and Clinical Excellence.
- Nock, M. K. (2007). Conceptual and design essentials for evaluating mechanisms of change. *Alcoholism: Clinical and Experimental Research*, 31(s3), 4s-12s.
- Nutt, D., King, L. A., Saulsbury, W., & Blakemore, C. (2007). Development of a rational scale to assess the harm of drugs of potential misuse. *The Lancet*, 369 (9566), 1047-1053.
- Nutt, D. J., King, L. A., & Phillips, L. D. (2010). Drug harms in the UK: a multicriteria decision analysis. *The Lancet*, 376 (9752), 1558-1565.
- Orford, J. (2008). Asking the right questions in the right way: the need for a shift in research on psychological treatments for addiction. *Addiction*, 103/5.
- Ouimette, P. C., Finney, J. W., Gima, K. & Moos, R. H. (1999) A Comparative Evaluation of Substance Abuse Treatment III. Examining Mechanisms Underlying Patient-Treatment Matching Hypotheses for 12-Step and Cognitive-Behavioral Treatments for substance Abuse. *Alcoholism: Clinical and Experimental Research*, 23/3, 545-551.
- Ouimette, P., Finney, J. & Moos, R. (1997). Twelve-Step and Cognitive-Behavioral Treatment for Substance Abuse: A Comparison of Treatment Effectiveness. *Journal of Consulting and Clinical Psychology*, 65, 230-240.
- Parssinen, T. M., & Kerner, K. (1980). Development of the disease model of drug addiction in Britain, 1870–1926. *Medical History*, 24(03), 275-296.
- Patton, M.Q. (1999). Enhancing the Quality and Credibility of Qualitative Analysis. *Health Services Research*, 34:5 Part II.
- Pawson, R. (1996). Theorizing the interview. *British Journal of Sociology*, 295-314.
- Pawson, R. (2002). Evidence-based policy: in search of a method. *Evaluation*, 8(2), 157-181.
- Pawson, R. (2006). *Evidence-Based Policy: A Realist Perspective*, London, Sage.
- Pawson, R. (2013). *The Science of Evaluation: a realist manifesto*. London, Sage.
- Pawson, R. & Tilley, N. (1997). *Realistic Evaluation*, London, Sage Publications.
- Peele, S. (1989). *The Diseasing of America*. Lexington, MA: Lexington Books.
- Peirce, C. S. (1974). *Collected Papers of Charles Sanders Peirce* (Vol. 4). Cambridge MA, Harvard University Press.

- Pernanen, K. (2001). Consequences of drinking to friends and the close social environment. in Klingemann & Gmel (eds.) *Mapping the Social Consequences of Alcohol Consumption* (pp. 53-65). Dordrecht, Springer Netherlands.
- PHE (2014). *Residential Rehabilitation: state of the sector in 2014 Report of a survey of providers and commissioners of residential services*, London, Public Health England.
- Philips, D. C. (1987). *Philosophy, Science and Social Enquiry*. Oxford, Pergamon Press.
- Pittman, D. J. (1967). The Rush to Combine: Sociological Dissimilarities of Alcoholism and Drug Abuse*. *British Journal of Addiction to Alcohol & Other Drugs*, 62(3-4), 337-344.
- Pittman, D. J. (1988). The 'Combined Approach'—a comment on Duncan Raistrick's editorial. *British Journal of Addiction*, 83(8), 871-873.
- Porter, R. (1985). The Drinking Man's Disease: The 'Pre-History' of Alcoholism in Georgian Britain. *British Journal of Addiction*, 80(4), 385-396.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: applications to addictive behaviors. *American Psychologist*, 47(9), 1102.
- Putnam, H. (1975). *Mathematics, Matter and Method*, Cambridge: Cambridge University Press.
- Putnam, H. (1999). *The Threefold Cord: Mind, Body and World*, New York, Columbia University Press.
- Raistrick, D. (1988). The 'Combined Approach' - still an important debate. *British Journal of Addiction*, 83(8), 867-869.
- Rehm, J., & Rossow, I. (2001). The impact of alcohol consumption on work and education. in Klingemann & Gmel (eds.) *Mapping the Social Consequences of Alcohol Consumption*(pp. 67-77). Dordrecht, Springer Netherlands.
- Rossow, I., Pernanen, K., & Rehm, J. (2001). Accidents, suicide and violence. in Klingemann & Gmel (eds.) *Mapping the Social Consequences of Alcohol Consumption* (pp. 93-112). Dordrecht, Springer Netherlands.
- Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: what it is and what it isn't. *BMJ: British Medical Journal*, 312(7023), 71.
- Samaritan Daytop Village (2016). Evidence-based practices (web page), available at <http://samaritanvillage.org/about-good/evidence-based-practices>, [accessed 16.02.2016]
- SAMHSA. (2011). SAMHSA's definition and guiding principles of recovery – Answering the call for feedback. SAMHSA Website, available at: <http://blog.samhsa.gov/2011/12/22/samhsas-definition-and-guiding->

principles-of-recovery-answering-the-call-for-feedback [accessed 07.04.2016]

- Sayer, A. (1992). *Method in Social Science: A Realist Approach*, London, Routledge.
- Schön, D. A. (1983). *The Reflective Practitioner: How professionals think in action*, New York, Basic Books.
- Searle, J. R. (1992). *The Rediscovery of the Mind*. Cambridge MA, MIT Press.
- Senker S. (2015). *A Qualitative Evaluation of SHARP Community Rehabilitation Programme*. Essex County Council.
- Senker S. (2016). *A Qualitative Evaluation of SHARP Community Rehabilitation Programme* [second study]. ADT Research and Consultancy.
- Shadish, W.R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and Quasi-experimental Designs for Generalized Causal Inference*. Boston, Houghton Mifflin.
- Simeons, S., Matheson, C., Inkster, K., Ludbrook, A., & Bond, C. (2002). *The Effectiveness of Treatment for Opiate Dependent Drug Users: An International Systematic Review of the Evidence*. Edinburgh: Scottish Executive Drug Misuse Programme.
- Simpson, D. D. (2004). A Conceptual Framework for Drug Treatment Process And Outcomes. *Journal of Substance Abuse Treatment*, 27/2, 99-121.
- Simpson, D. D., Joe, G. W., & Brown, B. S. (1997). Treatment retention and Follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, 11(4), 294.
- Simpson, D. D., Joe, G. W., & Rowan-Szal, G. A. (1997). Drug abuse treatment retention and process effects on follow-up outcomes. *Drug and Alcohol Dependence*, 47(3), 227-235.
- Simpson, D. D., Joe, G. W., Rowan-Szal, G. A., & Greener, J. M. (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment*, 14(6), 565-572.
- Skills Consortium (2010) The Skills Hub, web page, available at <http://www.skillsconsortium.org.uk/skillshub.aspx> [accessed 24.01.2017]
- Smedslund, G., Berg, R. C., Hammerstrom, K. T., Steiro, A., Leiknes, K. A., Dahl, H. M., & Karlsen, K. (2011). Motivational interviewing for substance abuse. *Cochrane Database of Systematic Reviews*, 5(5).
- Solomon, R. L. (1980). The opponent-process theory of acquired motivation: the costs of pleasure and the benefits of pain. *American Psychologist*, 35(8), 691.
- Sondhi, A., & Day, E. (2015). Factors that predict dissemination of evidence-based practice in one local authority in England: An assessment of

introducing node-link mapping into substance misuse practice. *Drugs: Education, Prevention and Policy*, 22(2), 160-165.

- Stiles, W. B., Barkham, M., Twigg, E., Mellor-Clark, J., & Cooper, M. (2006). Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies as practised in UK National Health Service settings. *Psychological Medicine*, 36(4), 555-566.
- Smith, C. & Elger, T. (2012). *Critical Realism and Interviewing Subjects*, Working Paper Series, School of Management, Royal Holloway, University of London.
- Sutton, S. (2001). Back to the drawing board? A review of applications of the transtheoretical model to substance use. *Addiction*, 96(1), 175-186.
- Tang, T. Z., & Derubeis, R. J. (1999). Sudden gains and critical sessions in cognitive-behavioral therapy for depression. *Journal of Consulting and Clinical Psychology*, 67(6), 894.
- Taylor, C. (1985). *Human Agency and Language*, Cambridge, Cambridge University Press.
- The Anonymous People (2013). [documentary film] dir. G.D. Williams.
- Tiffany, S. T., Friedman, L., Greenfield, S. F., Hasin, D. S., & Jackson, R. (2012). Beyond drug use: a systematic consideration of other outcomes in evaluations of treatments for substance use disorders. *Addiction*, 107(4), 709-718.
- Timko, C., Moos, R. H., Finney, J. W., & Connell, E. G. (2002). Gender differences in help-utilization and the 8-year course of alcohol abuse. *Addiction*, 97(7), 877-889.
- Timko, C., Finney, J. W., & Moos, R. H. (2005). The 8-Year Course of Alcohol Abuse: Gender Differences in Social Context and Coping. *Alcoholism: Clinical and Experimental Research*, 29(4), 612-621.
- Timko, C., DeBenedetti, A., & Billow, R. (2006). Intensive referral to 12-Step self-help groups and 6-month substance use disorder outcomes. *Addiction*, 101(5), 678-688.
- Trochim, W. M. (1985). Pattern matching, validity, and conceptualization in program evaluation. *Evaluation Review*, 9(5), 575-604.
- Tucker, J. A. & Roth, D. L. (2006). Extending the evidence hierarchy to enhance evidence-based practice for substance use disorders. *Addiction*, 101(7), 918-32.
- UKATT Research Team. (2001). United Kingdom alcohol treatment trial (UKATT): hypotheses, design and methods. *Alcohol and Alcoholism*, 36(1), 11-21.
- UKDPC Recovery Consensus Group (2008) *A Vision of Recovery*. London: UK Drug Policy Commission.

- Volkow, N. D., Koob, G. F., & McLellan, A. T. (2016). Neurobiologic Advances from the Brain Disease Model of Addiction. *New England Journal of Medicine*, 374(4), 363-371.
- Vygotsky, L. S. (1978). *Mind in Society: The Development of Higher Psychological Processes*. Cambridge MA, Harvard University Press.
- Wanigaratne, S. (2006). Psychology of Addiction. *Psychiatry*, 5(12), 455-460.
- Weiss, C. H. (1972). *Evaluation research: Methods for Assessing Program Effectiveness*, Englewood Cliffs, NJ, Prentice-Hall.
- Weiss, C. H. (1978). *Using Social Research in Public Policy Making*, Lexington MA, Lexington Books.
- West, R. (2005). Time for a change: putting the Transtheoretical (Stages of Change) Model to rest. *Addiction*, 100(8), 1036-1039.
- West, R. (2005). *Theory of Addiction*. Oxford, Blackwell Publications.
- West (2010a). PRIME theory Pt. 4: Identity and impulses/inhibitions, video lecture, available at <http://www.primetheory.com/summary-prime-motivation.php?watch=motivation&pt=4#vid>
- West (2010b). PRIME theory Pt. 6: Plans & intentions, video lecture, available at <http://www.primetheory.com/summary-prime-motivation.php?watch=motivation&pt=4#vid>
- West, R. (2013). *Models of Addiction*, EMCDDA Insights Series No 14. Luxembourg: Publications Office of the European Union.
- White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor*, 9(5), 22-27.
- White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly*, 23(1), 3-15.
- White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33(3), 229-241.
- White, W. (2008). *Recovery Management and Recovery-Oriented Systems of Care* (Vol. 6). Chicago: Great Lakes Addiction Technology Transfer Center.
- White, W. L., & Miller, W. R. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor*, 8(4), 12-30.
- Wilson W.G. (1971). *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*, 3rd ed., New York, Alcoholics Anonymous World Services Inc.
- Winter, G. (2000). A comparative discussion of the notion of 'validity' in qualitative and quantitative research. *The Qualitative Report*, 4(3), 1-14.
- Wright, J. P. (1983). *The Sceptical Realism of David Hume*. Manchester, M.U.P.

Yalom, I. D., & Leszcz, M. (2005). *Theory and Practice of Group Psychotherapy* (5th Edition). New York, Basic Books.

Zemore, S. E., & Kaskutas, L. A. (2008). 12-step involvement and peer helping in day hospital and residential programs. *Substance Use & Misuse*, 43(12-13), 1882-1903.

Appendix 1a

Transcribed interview with Jason (all names and identifying details changed)

Tim: So I just want to take it from what I have just said and ask you to describe yourself as you see yourself when you come into the programme and what's going on for you and how you see this place helping you to change in whatever way you think you are changing.

Jason: When I first came into the programme, erm, I felt quite lost – within meself – I felt I'd lost . . . some of my . . . some of my identity, erm, I felt vulnerable, although as a precursor to SHARP I'd been at the Brink for I think it was 6 or 7 weeks, which initially gave me, some sort of, a little bit of value, before I came in here. Had I not done the Brink, I would have probably have managed here, because it's totally different but as a precursor I think it's a good idea. The first week was probably a bit of a blur, to be honest, because there was so much going on, and being still in a fragile state of mind, it was a bit fast for me to be quite honest. But the second week I settled down again, leading up to my 'Life Story', which was quite difficult for me to read, very difficult. Although once, through support from the counsellors here, I was able to finish that, and you know actually read it out. I felt a great relief, but what I have found here, since I've been here, not only from the counsellors, but from the community or the group, there's always a great sense of compassion. I mean depending on the numbers, it varies as you know, sometimes there's 16 or it can be 20 people, really, to be quite honest, apart from my first name they really don't know that much about me until I've read my life story aloud. So of course not everything was in that, but I just found this feeling of warmth, of – I mean, if I think of it really I mean – apart from me addiction, which of course we've all got in common, they don't really know you. It just, just – I've never really experienced anything like that in me life. I been quite, you know, I'm 56 years of age, and I've done quite lot of . . . I've worked most of me life, so I've worked with a lot of people in my life, got a lot of, er, life experience, but mm, mm, not only in SHARP but even from ???, I mean I started off in 'Genie in the Gutter' about in October when I was still using, then I went into detox, and I went to 'Art and Soul' though I never really connected, for whatever reason I don't know, I can't really explain it, still can't, erm, went back to 'Genie', and I felt, I felt each step has been a progression. I mean again, going into 'Genie in the Gutter', the compassion I felt, you know the warmth, erm, was amazing, and it did help me open up, a lot of things, it helped me get a lot of things off me chest.

Tim: So when you experienced people that seemed to be interested and compassionate towards you, that really helped you to sort of open up areas of yourself? . . . or?

Jason: Yeah, open up areas of myself, but also to be able to listen, to listen a bit more, I realised 'Hang on, woah! These people really care.' Which I hadn't . . . I've not, er, felt for quite some time. Erm, which is unusual for me - I've not really had anything like this before you know.

Tim: Are you saying it's mutual – that you can sort of care back?

Jason: Yeah that's right – I can feel, I can feel for other people. I mean I have heard other people's life stories, but even interacting in group therapy I find that I can relate to people. I mean if somebody shares something that I can relate to I can relate back. I find that helps, I find it uplifting, I find it helpful, as well.

Tim: What moves you when you hear, er, what do you particularly respond to do you think?

Jason: I can feel, er, I can feel their pain, that's what it feels like to me, so I can, er, I can relate to their pain, so I can sort of feel how they're feeling. And, er, you know if there's anything I can say or do to help them alleviate that, I feel that's good, on a, a two way basis, I mean, if someone who's sharing if I can speak to them or I tell them how I'm feeling, I find that helps – I feel as if that's a two way thing.

Tim: That's sounds important. I know it's sometimes difficult to explain, but I would just like to go back and pick up on something you said earlier. You mentioned that you thought that in a way your identity was under some kind of threat, that you were kind of losing that identity. What was it? What was your identity do you think?

Jason: I lost me sense of worth, I lost me sense of values, in addiction. I lost me goals, me values and me morals, without a shadow of a doubt, and since I've been here, er, I'm listening to the counsellors, and sometimes they put things in a different perspective, although I can relate to it exactly what they mean, in a different light maybe, and I can say 'whooh' and I can see the old me.

Tim : 'This is a person who *did* have values' is that what you are saying?

Jason: Yeah, yeah. And I find them coming back as well. I find a lot of me values are coming back. I am most definitely changing, I mean I've been, as you're aware of, er, not just this weekend, I mean probably since I've been here, I've been here

five weeks and I've had 4 or 5, when I say crises, normally I would have, would have walked out on them. I would have normally, without a shadow of a doubt – there's no ifs or buts – but I do feel as if I've taken on board some of the tools that we learn here. It's reminding me of my old values, of what I am, or who I am. And I've been able to use those.

Tim: That's what I want to hear about – let's explore that a little bit. I mean I came in yesterday, and I mean everything in the team room is completely confidential (yeah), and I heard Krissy describe the situation with, is it your wife? (yeah) and what she'd been doing over the weekend and where she ended up, and I thought 'I need to ask Jason how does he deal with that, because you are obviously dealing with it, you went to visit her in the hospital didn't you? (yeah) but you still stay here, you still come here, you stay engaged . .

Jason: I don't feel, er, I feel as if I've come so far now on this journey of recovery I just feel stronger. See, initially, what happened in the evening time on Friday, she came to my flat about 10 past 12 and she wanted to come in and I, er put barriers, not er, I mean Debby's got an alcohol problem as well as me, and initially what happened was she was living with me. Well the plan was that when I came out of detox, towards the end of January, that she would stop drinking. She said she didn't have a drink problem although I knew she did, and that never stopped. And I stayed three and a half months clean. Inevitably, I relapsed, thinking – I mean I felt as though I'd got stronger, but obviously not strong enough not to relapse! So we put barriers up, I mean I brought it into SHARP and we had a chat and they said you need to put boundaries in place. So that's what I did – I explained to her – I said 'Look, I can't do this while we're living together and you're carrying on drinking. I can't do this.' We both have a home – I have a flat and she has a flat. So she moved back to her flat. But she's noticed the change in me for the better. I'm much more clear in my mind and thoughts, and more aware of what's happening around me, in my home environment. Erm, but on the Friday, I mean normally in the past if she's been drunk or I've been drunk we have confrontation, which we had on Friday, and the confrontation we had on Friday was, er, I'd been to a wedding during the day, which she was invited to go to, but I really didn't want to take her, because of the way the relationship's going, I didn't want to go there where she was back into the fold, kind of thing. So she never went. So what happened first off was that a friend phoned to say she couldn't find her: "I can't find her, she's been drinking and I think she's on her way to you." (meaning to my flat). And when she got there she was absolutely ranting and raving. I live on the

top floor and she was shouting and swearing, and you know abusing me, basically, verbally. So I came out of me flat, I didn't have any footwear I was just in me socks, and I tried to calm her down, but she was having none of it. And then she'd walk away, a hundred yards, and I thought she'd calmed down a bit, but when I went over to her she'd explode again, she . . . again, screaming and shouting. This must have went on for about 20 minutes. And normally, I mean – she took her coat off and she was like swearing at me you know, and I never made any . . . normally I would have . . . it would have led to violence, we would have ended up fighting, but I just felt stronger as a person, to step back from that, “whoah, whoah” – which is massive, for me. If you look at past history, it was a very volatile relationship.

I mean she even said things like “I don't wanna fuckin' – I don't wanna see you any more, I've fuckin' met someone.” I mean normally that would really have got my back up, “what's all that about?” y'know, and she even passed me his number, she gave me his number. And I said “well i don't want that” I just sat on the wall and put it on the side. I must admit I was confused as to what to do, really. And I asked her, I said “Look, get your bags” - she had a couple of bags with her – “get your bags, and you can stay at mine.” I think I thought, initially I thought it was for her safety. And now when she had wanted to stay at my flat at the beginning, and me saying no, at the outset, now she didn't want to stay at my flat, it was, er “Fuck off”, y'know, whatever, and it went from there. Erm, I mean she ran out into the main road, and when I was trying to get closer to her, she was basically saying “Come over here and I'll fuckin' jump in front of a car”, which she did on one occasion and the car swerved. At this point I didn't know what to do and I was going to phone the police, but the more I got ??, the more she quietened down. And I thought maybe if I just back off she'll go home. Because what she had wanted to do was to stay in flat, and she knew . . . I had made it quite clear by this time, whoh! I'm not gonna fight with you. I mean at one point she hit me but I did not fight back . . .

Tim: How do you feel about yourself as you tell this story? Being able to hold your boundaries.

Jason: I feel very proud of it. I am absolutely over the moon, no, because I can feel the changes in myself, I can, I really can. I mean there's been some days it's been really tough here, but they said to me here, or maybe I heard it somewhere before I came: “Your worst days here are your best” and I feel that. But I can feel myself

changing – I feel that I am getting my old values back, erm, I mean for one thing, I mean funnily enough, I met a friend of mine on the train here this morning, I've met him quite a few times, and I can speak to him about meself you know. I can explain what I'm doing, where I am, y'know. And I was chatting to him this morning, he asked me how I was doing and I said "Well I feel as if I'm doing all right", and he said 'Jason you look all right, when I first met you on the train . . .', and for me, he can see a change in me . . . I mean even last night, I mean I went to visit her in hospital (*after the incident described above his wife had thrown herself in the Mersey and had injured her arm and was rescued and sent to the hospital*) even coping with that, because she was basically blaming me. I mean she's never been there for me, I was there for her during her detox, and whenever she got in trouble with the police I was there for her, but she wasn't though, you know Tim, for me. I mean after my detox she met me at home with a couple of bottles of wine. But I didn't bring this up to her. So again after about ten or fifteen minutes of just being slagged off really, I mean normally I would have told her just to fuck off and just walked out, but again I kept calm. I said "Look I'm tired, do you think it would it be ok if I just go?" and she said "Oh, you're tired, are ya?" (*sarcastically*) and I said 'I'll come back in tomorrow, I'll see you tomorrow', and I just got up and went.

And I must admit, well, it's about a ten minute walk from the bus stop to the station you know, and walking to the station I felt a bit sad, because of the way . . . probably because of the way she'd spoken to me. But then again I'm thinking, well, I thought about meself, and what I was like, and I thought . . . I mean one of the positive things was that she was seeing a psychiatrist yesterday and she's admitted to a lot of drinking and apparently she has asked for help to come off the drink, but even this morning, I was thinking this morning, I mean they say, 'If you change, the people around you will change', and I think that's a poss . . . that's a real possibility, you know.

Tim: I am going to ask you in minute what particular things you remember counsellors or peers have said that have helped you, but it seems you are not dancing that old dance with her – she's inviting you in . . .

Jason: (*interrupts animatedly*) That's exactly what I said to me sister, because I watch a lot of sport with me two sisters and me brother and I actually said to me sister, as we were sat there Sunday, well because there was so much went on at the

weekend that I was with her, I said “The problem for her is I’m not dancing to her tune any more – and she doesn’t like it!”

What I’m finding here - I really can’t big it up enough, and I’m not just talking about SHARP, I’m talking about from Day 1, from Genie in the Gutter, to going to the Brink, which was a great help, and a good precursor for here, because if I hadn’t done the Brink I wouldn’t have been able to handle this I don’t think. If I’d come straight into here it could have been too much . .

Tim: It could have felt too intense?

Jason: Yeah, quite intense. I found it intense, and the whole honesty thing, being honest with yourself, that comes across to me here you know. In addition you know you lie, you connive, you manipulate – just the fuckin’ sheer honesty coming back you know – ‘come on, look at this, look at this in the right frame of mind’ really – and that’s helped a lot. You know: ‘Look at things for what they are!’ You know that’s something, you know.

Tim: You are obviously ready to do some of that. Can you think of some examples? You mentioned that sometimes the counsellors would put something, they would frame something in a new way, and you’ll go ‘OK I might think of it like that too’. Can you think of any examples of that?

Jason: (*pause*) Ooh that’s a bit hard, that’s a bit difficult! Some of the things Krissy says – Krissy talks about running things past the committee in your head and that’s exactly what I’m doing really – you’re judging yourself, you’re judging straight away before you’re thinking, you know. That was one thing that stuck with me. Keeping it in the day, to keep it unimportant, to keep it in the day – I think that’s massive. There’s probably quite a bit of other stuff but . .

Tim: So just to check that out to make sure I have understood - there’s an idea here that you have become aware that you have a conversation going on with yourself – there’s a critical part of yourself?

Jason: Even if it’s subconscious, maybe it’s there subconsciously, but maybe when somebody talks about that, maybe it’s your subconscious that hears, I don’t know.

Even phrases like, erm, I’m trying to think – you know sometimes when we go into a conversation – a confrontation, y’know - and somebody says something and you think, you know ‘That’s landed!’ And the other thing is, “hang on, whoh! that’s

not mine, that's yours!" That's not mine, but in the past you'd deal with it in the old way. You'd just take it as said, and you know you would just take it from there and react, and you're off. It lands and it seems to stick with you.

Tim: That seems to be what's happening with your wife too. In a sense you are recognising her stuff and not allowing it to land on you.

Jason: Yeah, "That's not mine! You own that!" I'm learning a lot from that and not just with me partner, me wife, you know. I've been in other conversations and situations and I've thought "hey that's not mine – and I'm not even going to rise to that – that's just going straight over", but in the past it could have landed, it could have got to me. And then, do you know, I'm taking a drink! And I think for me personally, I can't speak for other people, things like that, there's one where she goes "???" That one it gets you on the back foot straight away. And I think it is all thoughts, I mean if you listen to people – I mean listening's a big thing isn't it? – how many times have you, er, - I mean I've always liked to think that I'm a good listener anyway, but how many times do we not listen properly, and we act out on what we thought we've heard? You know, and even arguments, I've even thought about that an' all: "you fuckin' said . . . ! blah blah" "But I never fuckin' said that, what I said was . ." But if you were listening in the first place you'd avoid that confrontation in the first place. You know if you just sit down and listen, not just to the counsellors, listen to what the group are saying, and take on board and if, you know, you look and you listen hard, you can see, see the way people are feeling, you know. But I think this stuff that lands on you and ouches you, and the way you react to that, I think that's a big one for me. And again, instead of running it through your own (*internal*) committee run it past the committee here (*the group*), and instead think, think logically – think that's helped me an awful lot. I mean even in the situation at the weekend, where the confrontation had come in – in the past I would've – I mean I probably would have done the whole thing – I would have ended up drunk, I would have ended up fighting with her, she would probably have phoned the police or the police would have been called, and all that was avoided – and I was in a bad place, I was in a bad place and I felt in a bad place, you know, but, er, I sat in the feeling . .

Tim: You know I can't claim to know you, I met you yesterday, but I do pick up that this is kind of a unique experience for you . .

Jason: It's absolutely – if I said it was absolutely amazing . . But I must reiterate, right, I mean, starting off from 'Genie', which was really low key, but again feeling the

compassion, feeling . . . one of the things I really loved in 'Genie', I actually loved the drama class – I felt the teachers there were absolutely superb! But relating things not so much – as in drama, as in drama where you could relate, you could use that outside . . . absolutely brilliant!

Tim: I can see you that you connect this journey to the things you visited before you came here, and you see them as a piece – like stepping stones . . .

Jason: Yeah, at one point I felt as if, as if I had dissed them all a little bit, and as I say I went along to 'Art & Soul'. I didn't really connect with 'Art & Soul' maybe as much at the time. I went back to 'Genie' – they allowed me to come back. But I'd been abstinent for quite a while, and some of the people there haven't stopped using, and if it was just me not using and everyone else using that could be dangerous for me, and I could start using again, so I moved on and I lost my drama which was unfortunate. But even now, like this afternoon, on a Tuesday, I'll nip along for half an hour and say hello to the staff. And I even say to the staff "It started here for me". It has felt like a stepping stone for me 'Genie', not so much 'Art & Soul', and I self referred here – I spoke to my key worker there and he said "I can phone them but you'd be better going along yourself for an assessment, which I did. And as In said the precursor to coming here was to go the Brink, which again I think is a fabulous place. It's just a pity there isn't more of them.

Appendix 1b

Sample analysis.

The interview transcribed above produced an enormous amount of rich data as did they all. The following pages present a very abbreviated illustration of the first phase analytical process. Almost every phrase uttered by Jason contributed to the analysis. This appendix offers a glimpse into the process, which was repeated through several iterations and comparisons with the other interviews. The analytical process on paper was supplemented by repeated listening to the audio recording to check for meaning and nuance.

The verbatim quotes are presented in the order in which they appear in the interview. In the actual research process I attempted to select everything that had any relevance to change, problematic behaviours that had led in the past to negative consequences including drinking or using drugs, examples of reflection and self-awareness, any description of how things were changing, and finally how these changes were being activated by experiences in treatment.

Annotated and categorised material

<p><i>I felt quite lost – within meself – I felt I'd lost . . . some of my . . . some of my identity</i></p> <p><i>I felt vulnerable</i></p> <p><i>being still in a fragile state of mind</i></p>	<p>These three quotes are examples of emotional/identity deterioration with a hint of reflexivity</p>
<p><i>support from the counsellors here</i></p> <p><i>not only from the counsellors, but from the community or the group, there's always a great sense of compassion.</i></p> <p><i>the compassion I felt, you know the warmth, erm, was amazing, and it did help me open up, a lot of things, it helped me get a lot of things off me chest</i></p> <p><i>open up areas of myself, but also to be able to listen, to listen a bit more</i></p>	<p>A compassionate context, very important for Jason, mentioned again at the end of the interview. This led to trust and opening up as well as engagement with others.</p>
<p><i>I realised 'Hang on, woah! These people really care.'</i></p>	<p>Internal conversation, 'woah!' used several times as though to convey that reflexivity is a way of slowing down or managing emotional reactions.</p>
<p><i>I can feel, I can feel for other people. I mean I have heard other people's life stories, but even interacting in group therapy I find that I can relate to people. I mean if somebody shares something that I can relate to I can relate back. I find that helps, I find it uplifting, I find it helpful, as well.</i></p>	<p>Caring about others, reciprocity. Leads to feeling better (increased self-worth, feeling uplifted)</p>
<p><i>I lost me sense of worth, I lost me sense of values, in addiction. I lost me goals, me values and me morals, without a shadow of a doubt.</i></p>	<p>More about deterioration during period of addiction, with reference to his values/identity</p>

<p><i>I'm listening to the counsellors, and sometimes they put things in a different perspective, although I can relate to it exactly what they mean, in a different light maybe, and I can say 'whooh' and I can see the old me.</i></p>	<p>This is an example of being influenced by people Jason is beginning to trust and admire. He is impressed by a new perspective. Once more he explicitly refers to an internal conversation.</p>
<p><i>I find a lot of me values are coming back. I am most definitely changing, I mean I've been, as you're aware of, er, not just this weekend, I mean probably since I've been here, I've been here five weeks and I've had 4 or 5, when I say crises, normally I would have, would have walked out on them. I would have normally, without a shadow of a doubt – there's no ifs or buts – but I do feel as if I've taken on board some of the tools that we learn here. It's reminding me of me old values, of what I am, or who I am. And I've been able to use those.</i></p>	<p>Jason refers to a change within himself, specifically to do with his values. He refers to old patterns which would have had negative consequences but says he has new tools, which seems to be connected to his new emerging values.</p>
<p><i>And normally, I mean – she took her coat off and she was like swearing at me you know, and I never made any . . normally I would have . . it would have led to violence, we would have ended up fighting, but I just felt stronger as a person, to step back from that, "whoah, whoah" – which is massive, for me. If you look at past history, it was a very volatile relationship.</i></p>	<p>Jason describes the old pattern leading to conflict, but he describes himself as changed (stronger as a person) and he uses his internal conversation to slow down and intercept his aggressive response</p>
<p><i>I had made it quite clear by this time, whoh! I'm not gonna fight with you. I mean at one point she hit me but I did not fight back . .</i></p>	<p>More detail about changing his reaction</p>
<p><i>But I can feel myself changing – I feel that I am getting my old values back</i></p>	<p>Emphasising his change, connecting this to his values returning.</p>
<p><i>And I must admit, well, it's about a ten minute walk from the bus stop to the station you know, and walking to the station I felt a bit sad, because of the way . . probably because of the way she'd spoken to me. But then again I'm thinking, well, I thought about meself, and what I was like, and I thought .</i></p>	<p>Quite a bit of reflection described here, evaluating his self-state, and couched in terms of an internal conversation</p>
<p><i>I feel very proud of it. I am absolutely over the moon, no, because I can feel the changes in myself, I can, I really can.</i></p>	<p>Second order emotional response of pride appears in the internal conversation. Again emphasising his awareness of change</p>
<p><i>Yeah, quite intense. I found it intense, and the whole honesty thing, being honest with yourself, that comes across to me here you know. In addition you know you lie, you connive, you manipulate – just the fuckin' sheer honesty coming back you know – 'come on, look at this, look at this in the right frame of mind' really – and that's helped a lot. You know: 'Look at things for what they are!' You know that's something, you know.</i></p>	<p>Impressed by the importance of honesty. Reference to old pattern. Honesty leads to a new way of thinking.</p>

<p>Krissy <i>talks about running things past the committee in your head and that's exactly what I'm doing really – you're judging yourself, you're judging straight away before you're thinking, you know. That was one thing that stuck with me. Keeping it in the day, to keep it unimportant, to keep it in the day – I think that's massive.</i></p>	<p>How the old internal conversation reinforces old patterns of critical self-judgement</p> <p>Reference to thinking intervening in the reactive process</p> <p>New ways of thinking.</p>
<p><i>Even if it's subconscious, maybe it's there subconsciously, but maybe when somebody talks about that, maybe it's your subconscious that hears, I don't know.</i></p>	<p>Jason is mulling over the internal process. How does he internalise the influence of others?</p>
<p><i>Even phrases like, erm, I'm trying to think – you know sometimes when we go into a conversation – a confrontation, y'know - and somebody says something and you think, you know 'That's landed!' And the other thing is, "hang on, whoh! that's not mine, that's yours!" That's not mine, but in the past you'd deal with it in the old way. You'd just take it as said, and you know you would just take it from there and react, and you're off. It lands and it seems to stick with you.</i></p>	<p>More about the internal conversation when he is hurt by someone's communication.</p> <p>He describes how this used to go before SHARP.</p>
<p><i>Yeah, "That's not mine! You own that!" I'm learning a lot from that and not just with me partner, me wife, you know. I've been in other conversations and situations and I've thought "hey that's not mine – and I'm not even going to rise to that – that's just going straight over", but in the past it could have landed, it could have got to me. And then, do you know, I'm taking a drink!</i></p>	<p>A detailed description of how his internal conversation helps control his behaviour, once more contrasting this with the old pattern, leading to drinking.</p>
<p><i>But I think this stuff that lands on you and ouches you, and the way you react to that, I think that's a big one for me. And again, instead of running it through your own (internal) committee run it past the committee here (the group), and instead think, think logically – think that's helped me an awful lot. I mean even in the situation at the weekend, where the confrontation had come in – in the past I would've – I mean I probably would have done the whole thing – I would have ended up drunk, I would have ended up fighting with her, she would probably have phoned the police or the police would have been called, and all that was avoided – and I was in a bad place, I was in a bad place and I felt in a bad place, you know, but, er, I sat in the feeling . .</i></p>	<p>Revising the internal conversation by internalising conversation with others.</p> <p>Has proved helpful to change his behaviour</p> <p>A further contrast between how he manages feelings now and changes the pattern compared to previously.</p>

Appendix 2: ethical approval, information sheets and consent form**University of Bath****Department of Education****MPHIL OR PHD PROGRAMME: ETHICAL IMPLICATIONS OF PROPOSED RESEARCH**

To be completed by the student and supervisor(s) and approved by the Director of Studies

before any data collection takes place

Introduction

1. Name(s) of researcher(s)

TIM LEIGHTON

2. Provisional title of your research

Inside the Black Box: a critical realist study of drug rehabilitation

3. Justification of Research

The development of a significant model of rehabilitation for people with alcohol and drug dependence requires an explanatory model that includes the relationship of contexts, mechanisms and outcomes. The evidence base derived from conventional experimental research is sparse and unsatisfactory. An understanding of mechanisms and the contexts for their activation will facilitate the establishment and development of such programmes in diverse areas of need.

Consent

4. Who are the main participants in your research (interviewees, respondents, raconteurs and so forth)?

Interviewees and participants in a brief ethnographic study:

1. Counsellors and related workers in community based intensive day treatment programmes in Liverpool and Bournemouth (first stage) and Worcester and Essex (second stage).
2. Participants (clients) in the programmes.

5. How will you find and contact these participants?

I have various senior roles with the charitable organisation that runs these programmes (senior executive team member, clinical supervisor, head of training). I have the support of the organisation to access the programmes and complete the research. The staff teams involved are enthusiastic about involvement. I will not (and have not for two years) conduct clinical supervision or training while the research is being carried out.

6. How will you obtain consent? From whom?

The senior executive and board of trustees of Action on Addiction will give consent for the study. Individual participants will have the purpose of the study explained to them in plain English and will each give consent to their participation.

Deception

7. How will you present the purpose of your research? Do you foresee any problems including presenting yourself as the researcher?

The research is entirely transparent and does not require any covert activity or deceptive representation of myself. The design is not compromised by honest and clear responses to any participant's questions.

The staff teams and the clients I have met during the preliminary stages of designing this research have understood and welcomed research designed to understand and facilitate improvement of the programmes they are involved in. Plain English explanations and opportunities to question the researcher will be consistently provided.

Explaining that my role as an 'authority figure' within the organisation is suspended for the purpose of the research is a serious concern, but I am known to the staff teams as a trustworthy person and an independent voice. I am not and have not been in any direct disciplinary relationship with any of the staff. The confidentiality of the research process will be explained and reiterated, and I believe will be trusted.

8. In what ways might your research cause harm (physical or psychological distress or discomfort) to yourself or others? What will you do to minimise this?

The research will not involve any physical interventions that could lead to pain, distress or discomfort. My presence as observer in the ethnographic phase might cause anxiety or suspicion in some participants. Careful and explicit explanation of the purpose of my study and an opportunity to debrief individually should mitigate this risk. In my experience the clients of these programmes are not afraid to voice concerns. Of course participants may opt out of the research process temporarily or permanently and I will make it clear that I am willing to leave situations where participants are uncomfortable with my presence. I would be willing to show and explain my field notes to anyone worried about what is being written down.

Early stage interviews about how the programme works and later 'theory-driven' interviews in which participants help me to build theory are unlikely in my opinion to cause psychological distress. I am an experienced counsellor and psychotherapist and am used to providing a safe and confidential space. However if any personal material is spoken of which might provoke distress I will monitor this and check the interviewee's mood and concerns. If required, clients have access to a skilled counselling team to help them. Staff team members will be similarly treated with care and any issues may be either dealt with in further conversation with me or with colleagues. I believe such problems to be rather unlikely to arise, except possibly where a client is not doing well in the programme. Even in such cases, my previous experience has been that an opportunity to speak to a trustworthy researcher can be helpful more often than not.

Confidentiality

9. What measures are in place to safeguard the identity of participants and locations?

The identities and locations of the programmes do not need to be protected as their existence and business is public knowledge. However within documents that may be published or adapted for publication, locations will be disguised by phrases such as 'a city centre location in a large port city in the North-west' i.e. limited to descriptions which provide necessary context.

The confidentiality of individual participants will be assured by encoding names in notes, and secure storage of notes and recordings by electronic encryption. Ensuring understanding of the confidential nature of interviews and observations will be an essential part of obtaining informed consent for participation.

No participant will be identifiable in the dissertation. Transcribed verbal data will have identifying features removed while preserving the integrity of the data.

Accuracy

10. How will you record information faithfully and accurately?

I will be taking field notes and recording interviews with audio recording technology of course with the full knowledge and consent of participants. It is possible that I will have opportunities to make video recordings. These notes and recordings will be promptly reviewed, transcribed and elaborated. Notes will be dated and timed and have the context clearly described.

11. At what stages of your research, and in what ways will participants be involved?

Staff teams and client groups engaged in sessions and informal interactions will be observed and conversed with in visits of 4 or 5 days repeated 3 times over three months. Counsellors and a small cohort of clients will be interviewed (semi-structured – 30-40 minutes) during this phase. In a later phase the same counsellors but different groups of clients will be invited to participate in 'theory-driven' interviews (Pawson 1996) preceded by a specially constructed questionnaire.

12. Have you considered how to share your findings with participants and how to thank them for their participation?

All participants will be offered the opportunity to receive a plain English summary of the research findings. Thanks for participation will be offered at recruitment and following interviews and observational visits.

Additional Information

13. Have you approached any other body or organisation for permission to conduct this research?

The charity Action on Addiction, which runs the projects involved in stage 1. Permission to study the Stage 2 projects will be sought from Essex DAT (Drug Action Team) and the organisations that run the programmes in Essex and Worcester.

14. Who will supervise this research?

Dr Seth Chaiklin

15. Any other relevant information.

Student: Tim Leighton	Signature: Tim Leighton Date: 17 September 2012.
Supervising Member(s) of Staff:	Signature(s): Seth Chaiklin Date:
Director of Studies	Signature:  Date: Retrospective signature for former DoS

A copy of this form to be placed in [1] the student file, and [2] an Ethics Approval File held by the Director of Studies. The Director of Studies will report annually to the Department's Research Students Committee (white paper business) on ethical issues of particular interest that have been raised during the year.

Plain English Information Sheet: PhD Research Study into change processes in treatment. (Version for phase 1)

Thank you for considering helping me by participating in my research project.

My name is Tim Leighton, and I have worked for Action on Addiction and before that, Clouds, for over 25 years. I have been a counsellor, a supervisor and for many years have directed and taught the training degrees that many of the counsellors at SHARP have taken.

My research is about trying to understand just how different people change while in treatment, how the treatment programme helps people to achieve those changes, and how the changes relate to the aims people have to stop using drugs/alcohol and improve their lives.

I will be focusing on the treatment process itself rather than following people up after they leave, as I am trying to understand what I am calling the 'mechanisms' of change. If you agree to participate I will be able to explain more about this and answer any questions you have.

I will be doing my research by making some observations while I visit the centre, meeting you informally and listening to how clients and counsellors talk about what is going on. I will observe groups and possibly one-to-one counselling sessions, if both counsellor and client give their permission. Everything I do will put your confidentiality as the top priority: nothing will be written down or discussed by me with anyone, that could possibly identify you or affect you in any way. Everything will be kept anonymous.

I will also ask people (both counsellors and clients) to volunteer to be interviewed privately. These interviews will be recorded with your permission, and again these recordings will be kept completely confidential. Their only purpose is to help me remember accurately what people have said. The early interviews will be quite simple: I will be asking you what you think is going on in treatment that helps with change, and what you think are the important processes.

You might think it is already understood how 'treatment works'! But in fact there are lots of unanswered questions. Some people respond well to treatment, others do not. Some people seem to need several goes at it. It is probably not just because a client is 'not ready' or 'does not want recovery' that treatment somehow does not seem to stick sometimes, and likewise, someone who may not feel very ready when they start treatment can often do really well! Counsellors, while working well as a team, may have individual ways of working which may help some people better than others. And it is even possible that treatment may be a bit different in different places, even when the programme seems the same, which is why I am doing research both in Bournemouth and Liverpool.

After I have finished the first stage of my research described above, I will do some work to identify the themes that have come out of my observations and interviews. I will then ask for more volunteers (counsellors and clients) to answer a questionnaire and to participate in a special interview where we talk in detail about how you answered the questions and to discuss more about how the programme helps and hinders change. If you are still in the programme, or have left it and are still in the local area, you are welcome to participate in both stages of the research (i.e. be interviewed twice.)

All this is designed to result in a better understanding of how treatment helps people. My main job is to teach people how to be counsellors, and I hope this research will make me a better teacher, and help those who are training to be more effective counsellors.

I will be coming to the agencies where I am going to do the research (SHARP Liverpool and SHARP Bournemouth and Poole) in the next few weeks so that the counsellors and clients can meet me, and I will invite people to volunteer to participate.

Plain English Information Sheet: PhD Research Study into change processes in treatment. (revised version for Phase 2)

Thank you for considering helping me by participating in my research project.

My name is Tim Leighton, and I have worked for Action on Addiction and before that, Clouds, for over 25 years. I have been a counsellor, a supervisor and for many years have directed and taught the training degrees that many of the counsellors at SHARP have taken.

My research is about trying to understand just how different people change while in treatment, how the treatment programme helps people to achieve those changes, and how the changes relate to the aims people have to stop using drugs/alcohol and improve their lives.

I will be focusing on the treatment process itself rather than following people up after they leave, as I am trying to understand what I am calling the 'mechanisms' of change. If you agree to participate I will be able to explain more about this and answer any questions you have.

I started my research by making some observations at the SHARP programmes in Liverpool and Bournemouth, meeting clients informally and listening to how clients and counsellors talk about what is going on. I observed groups and workshops, with the permission of the group. Everything I did and will do at Essex will put your confidentiality as the top priority: nothing will be written down or discussed by me with anyone, that could identify you or affect you in any way. Details such as names, and exact ages will be changed. Everything will be kept anonymous.

I also asked people (both counsellors and clients) to volunteer to be interviewed privately. These interviews were recorded with permission, and again these recordings were kept completely confidential. Their only purpose was to help me remember accurately what people have said. The early interviews were quite simple: I asked people what they thought goes on in treatment that helps with change, and what they thought are the important processes.

Now I have finished the first stage of my research described above, I have done some work to identify the themes that have come out of my observations and interviews. **I am now asking for more volunteers from the client group at SHARP Essex to answer a questionnaire and to participate in a special interview where we talk privately in detail about how you answered the questions and to discuss more about how the programme helps and hinders change.** If you are still in the programme, or have left it and are still in the local area, you are welcome to participate in this stage of the research.

With your permission I will record the interview on my phone, and transfer it to confidential storage when I return home. All the recordings will be erased after the research is complete.

You might think it is already understood how 'treatment works'! But in fact there are lots of unanswered questions. Some people respond well to treatment, others do not. Some people seem to need several goes at it. It is probably not just because a client is 'not ready' or 'does not want recovery' that treatment somehow does not seem to stick sometimes, and likewise, someone who may not feel very ready when they start treatment can often do really well! Counsellors, while working well as a team, may have individual ways of working which may help some people better than others. And it is even possible that treatment may be a bit different in different places, even when the programme seems the same, which is why I am doing research in Bournemouth, Liverpool and Essex.

All this is designed to result in a better understanding of how treatment helps people. My main job is to teach people how to be counsellors, and I hope this research will make me a better teacher, and help those who are training to be more effective counsellors.

CONSENT FORM**Research title****An exploration of change mechanisms in drug/alcohol rehabilitation projects**

Tim Leighton

Please tick each statement as appropriate:

- I have read and understand the plain English summary of Tim's research []
- I have been given the opportunity to ask questions about the study []
- I have had my questions answered satisfactorily []
- I understand that I can withdraw from the study at any time without having to give an explanation []
- I understand that participating or not participating will not affect my treatment in any way. []
- I understand my questionnaire and interview are confidential. SHARP staff will not see or hear what I write or say in the research. []
- I agree to the interview being audio taped and securely stored []
- I understand that some of my comments may be recorded in the final written report, however, they will not be attributable to me and I will not be identified by such comments in any way []
- I agree that the final written report (in line with the conditions outlined above) may be shared with others who have a legitimate interest in the subject matter []
- I am 18 years of age or older []
- I agree to participate in the study as outlined to me []

Name (capital letters) _____

Signature _____

Date _____

Appendix 3: Phase 2 questionnaire

How am I changing? A questionnaire

Instructions

According to some previous research I have done with people in a similar treatment programme I have begun to develop a theory of how people change in treatment. If you are willing to complete this questionnaire and spend around 30-40 minutes talking privately to me about how you answered it, you can help me make the theory better.

According to this theory whether someone changes might depend on situations that affect them, so the first part of the questionnaire asks about those.

The second section is about how the changes you are experiencing are actually happening.

The third section is how you are turning out as a result of these changes (in-treatment outcomes).

Please answer as honestly as possible. How you answer the questionnaire and what you say in the interview afterwards will be kept confidential to me, and will not affect your treatment in any way. You will have read an explanation of my research and signed a consent form. If you have not done so please ask Obi for these. When you have answered please put your questionnaire in an envelope and seal it. Please write your first name on the envelope. This is to keep your answers confidential until you and I look at them together.

Please answer how important each item is to you in terms of how you stuck with the treatment, how you got involved with it, and how you are making changes currently.

This is on a scale of 0-9. There are no right answers. You can have as many important or not important factors as you like.

Please put an X over the number that you choose for each item.

Then after reflecting on your answers please rank order **your most important three items in each section (1, 2 and 3)** in the right hand column.

Questionnaire on next page.

First name.....

Date.....

Section 1: Contexts		
How important is each of the items to you responding to the treatment programme?	not at all important ←————→ extremely important	RANK
1. Members of my family helped or encouraged me to come here.	① ② ③ ④ ⑤ ⑥	
2. I had little alternative to coming here as I was in such a bad way.	① ② ③ ④ ⑤ ⑥	
3. Criminal justice involvement made me come here.	① ② ③ ④ ⑤ ⑥	
4. I went to recovery activities (meetings, recovery café etc.) before I came here.	① ② ③ ④ ⑤ ⑥	
5. I found the treatment programme accepting and welcoming	① ② ③ ④ ⑤ ⑥	
6. The programme here felt well structured.	① ② ③ ④ ⑤ ⑥	
7. The treatment programme felt like a safe place.	① ② ③ ④ ⑤ ⑥	
Section 2: What creates the change process		
8. The staff/peers helped me focus and not get distracted by outside issues.	① ② ③ ④ ⑤ ⑥	
9. I began to see the counsellors and the group cared about me.	① ② ③ ④ ⑤ ⑥	
10. I began to identify with others in my group.	① ② ③ ④ ⑤ ⑥	
11. The honesty and courage of others has helped me open up.	① ② ③ ④ ⑤ ⑥	
12. My perspective on myself was challenged by counsellor(s).	① ② ③ ④ ⑤ ⑥	
13. My perspective on myself was challenged by my peer group.	① ② ③ ④ ⑤ ⑥	
14. The way I think about myself is changing as a result of challenge.	① ② ③ ④ ⑤ ⑥	
Section 3: Outcomes		
15. I have new priorities in my life, what and who I care about is changing.	① ② ③ ④ ⑤ ⑥	
16. I feel my values are changing as a result of this programme.	① ② ③ ④ ⑤ ⑥	
17. I have more self-esteem as a result of participating in this programme.	① ② ③ ④ ⑤ ⑥	
18. I am more confident I can live an alcohol/drug free life.	① ② ③ ④ ⑤ ⑥	
19. I feel more confident about myself amongst people.	① ② ③ ④ ⑤ ⑥	
20. I am making new friendships and connections.	① ② ③ ④ ⑤ ⑥	
21. My relationships outside the programme are improving.	① ② ③ ④ ⑤ ⑥	
22. I am clearer about the kind of life I want	① ② ③ ④ ⑤ ⑥	