Overcoming Addiction without Formal Treatment: A Qualitative Study of the Process of Self-Managed Change

Research report submitted in fulfilment of the requirement for the degree

Master of Arts in Community-Based Counselling Psychology

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By

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Abstract

This study explores the narratives of individuals who have overcome an addiction without formal treatment through a process of self-managed change. The research was conducted from a qualitative perspective that was grounded in social constructionist methodology. Six individuals were interviewed and the transcripts formed the texts for analysis. The analysis is divided into two sections. The first section looks at narrative as genre and content. It explores the type of narrative genres utilized by participants and looks at the spheres of meaning within the content of their narratives. The second section of the analysis looks at narrative as social construction and action. It explores participants' constructions of addiction, formal treatment and recovery and it examines the way language is used to distance construction of self in the past from constructions of self in the present. Furthermore, the analysis observes the narratives as social actions embedded in social worlds, raising awareness of the stream of power that flows within the storytelling.

The narratives collected in this study illustrate that overcoming addiction without formal treatment through a process of self-managed change is possible. They demonstrate the power that individuals can have over the substances to which they become addicted. They challenge the presuppositions that formal treatment is necessary. This study thus seeks to mobilize resistance against the dominant narratives of addiction in society.

By contesting these narratives within the social world, this research aims to open up a space for previously marginalized voices to be heard. Investigation indicates that this is most likely the first study on overcoming addiction without formal treatment conducted in South Africa. It is significant therefore in that it serves to break a silence.

Declaration

I declare that this research report is my own unaided work. It is submitted for the degree of MA Community-Based-Counselling-Psychology in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in another university.

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Deborah Pryce

22nd day of December, 2006.

Acknowledgements

I am greatly indebted to the following people:

To those brave men and women who trusted me enough to break their silence and to share their stories on overcoming their addictions without formal treatment through a process of self-managed change. I know that for many of you the courage to do so was borne of the hope that your experiences might help others. I hope that your narratives included in this text might liberate people in the ways you would have wanted.

To my supervisor, Dr. Carol Long, for always managing to illuminate the horizon in ways that not only inspired me, but challenged my thinking about what is possible and shed new light on my sometimes limited perspectives.

To my mother, Jane, for your incredible love and support and for helping me to follow my dreams.

To my fantastic family and very special friends, for your ongoing encouragement, prayers and love. I look forward to spending more time with you all!

To Anthony Craig, for being my love and my rock. Thank you.

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"Is there a limit to the dysfunctional disciplining of the population?

I recently received an announcement for a conference on the latest research and cure for addiction, called "the number one health and social problem facing our country today".

Among the addictions to be discussed were exercise, religion, eating, work and sex. If all these activities when pursued with intensity or gusto, can be defined as illnesses that require cure, there seems little in cultural life that can withstand subjugation to the professions.

Unless we can mount a collective refusal."

(Gergen, 2005, p. 40)

Chapter One: Introduction

1.1 Title

Overcoming addiction without formal treatment: A qualitative study of the process of self-managed change.

1.2 Rationale

Seedat (1997) in his article on The Quest for Liberatory Psychology calls for psychologists in South Africa to include marginalised groups at the level of knowledge production, to put an end to 'containments of critical energy' (Disco, 1979 as cited in Seedat, 1997, p.263) and to break silences. 'Silences' refer to those psychosocial phenomena that have not received any research priority or theoretical attention by the discipline.

This research aims to break a silence.

Investigation indicates that this is most likely the first (and only) study on overcoming addiction without formal treatment conducted in South Africa[1].

It aims to open up a space for the voices of individuals who have overcome an addiction without formal treatment to be heard.

Relying on the actual words and experiences of recovered alcohol and drug addicts this research challenges conventional wisdom concerning how people overcome addiction. Through a process of narrative inquiry, participants in this research were encouraged to 'tell their story' in their own terms, 'with the hope for increased sensitivity and sharing' (Terre Blanche & Durrheim, 1999, p. 97).

[1] A comprehensive literature search reveals no other studies have been conducted on this area in South Africa. Additional confirmation provided by Andreas Plüddemann, Senior Scientist, Alcohol and Drug Abuse Research Unit of the South African Medical Research Council (Plüddemann, Personal Communication, 2006).

The desired outcome of this research is not in the narratives simply as texts awaiting analysis but rather for these narratives to be seen as social actions embedded in social worlds. This narrative research offers 'a more empathic orientation' and thus attempts 'to give voice to the unheard and marginalised in society, to generate understanding through sharing first-hand experience' (Terre Blanche & Durrheim, 1999, p. 97). How does an individual tell his or her story when it challenges dominant cultural narratives? This study explores the phenomenon of counter-narratives (Andrews, 2004) – narratives that run counter to the dominant stories available in the social world - and how they must be understood within the complex set of social conditions and forces that surround an individual.

Dominant narratives of addiction in today's society postulate that individuals with addiction problems cannot recover except through treatment. As a result there has been even internationally limited research conducted on overcoming addiction without formal treatment through a process of self-managed change.

From that limited research, it is emerging that the process of self-managed change is a common route to overcoming addiction. This research is discussed more fully in the literature review. However for the purposes of introduction, some examples of studies are provided here. Overcoming problem drinking without formal help has been found to be the likely route to recovery in two Canadian general population samples with spontaneous remission rates of 75% and 77% respectively (Sobell, Cunningham & Sobell, 1996). Cunningham & Breslin (2004) maintain that only one in three people with alcohol abuse or dependence ever seek treatment. In addition, Cunningham (1999), following research on the service use of former drug users (utilizing data from the 1994 Canadian Alcohol and Drug Survey), concludes that the majority of individuals overcome drug addiction without formal treatment (Cunningham, 1999). Furthermore, it is estimated that 80% to 90% of all those who stop smoking do so without formal treatment (Marlatt, Curry & Gordon, 1988; US Department of Health & Human Services, 1988; Carey et al., 1989; Fiore et al, 1990; Mariezcurrena, 1994; Hughes et al., 1996; as cited in Sobell, Ellingstad & Sobell, 2000).

Findings such as these support Orford's (2001b) perspective that instead of assuming that addictions, like diseases, require formal treatment, we should be assuming on the whole that they do not require treatment and try to understand the real world, everyday processes whereby people make their own changes.

Finally, the majority of research into addiction is quantitative in nature, and is steeped in empiricism and positivism. Qualitative research within the addictions appears to be a minority interest. In 1998, Fountain & Griffiths (as cited in Neale, Allen & Coombes, 2005) conducted a content analysis on papers published during 1995-1996 in three leading international drug publications: *Addiction, Drug and Alcohol Review* and *Addiction Research*. Of the 291 papers scrutinized, only 17 (6%) reported on studies that had wholly or partially used qualitative methods. In 2004, the journal *Addiction* published just 3 qualitative papers i.e. a mere 2% of all reported studies (Neale et al., 2005).

There is thus a dire need for more qualitative research on addictive behaviours. This study is embedded in a qualitative narrative paradigm, with the intention of contributing more nuanced, life-like insight into overcoming addictions without formal treatment.

1.3 Research Focus

Contrary to popular belief, individuals are able to overcome addiction without formal treatment through a process of self-managed change. The aim of this research is to explore the narratives of individuals who have overcome an addiction without formal treatment, and in so doing gain a rich understanding about the process of self-managed change. This includes a focus on how individuals tell their stories as well as how these constructions interact with broader systems of truth.

This research not only aims to break the silence for individuals who have overcome an addiction through a process of self-managed change, but also aims to mobilise resistance - it heeds Gergen's (2005) call for a collective refusal against addiction being constructed as a disease requiring cure through formal treatment.

1.4 Theoretical Framework

A social constructionist perspective is chosen as conceptual grounding for this study. It is based in a qualitative paradigm, using narrative analysis as a research method. This framework is discussed below.

1.4.1 Social Construction as Conceptual Foundation for Research

This research was grounded in social constructionism, which is a 'paradigm of knowledge based on the idea that events, objects and selves do not have a pre-given or essential reality, but are constituted through the language we use to describe them' (Wilbraham, 2004, p.494). At its foundation, a social constructionist approach has one or more of the following key assumptions (Gergen, 1985, as in Burr, 1996):

1. A critical stance towards taken-for-granted knowledge.

Social constructionism challenges the view that conventional knowledge is based upon objective, unbiased observation of the world. It thus opposes positivism and empiricism in traditional science – based on the assumptions that the nature of the world can be observed and that what exists is what we *perceive* to exist. Gergen (2005) proclaims that 'scientific knowledge is nothing but social convention' (p.55). This research aims to challenge the taken-for-granted 'scientific knowledge', the 'truth' that addiction is a disease requiring formal treatment.

2. Historical and Cultural Specificity

To a social constructionist, the way in which people understand the world, the categories and concepts used, are historically and culturally specific. Understanding depends on where and when in the world one lives. The particular forms of knowledge that exist in any culture are therefore artefacts of it, and we should not assume that our ways of understanding are necessarily any better (in terms of being any nearer the truth) than other ways. For instance, using heroin became an acceptable activity for American soldiers fighting in Vietnam. Large numbers of soldiers reported becoming addicted to heroin. However, once they returned from Vietnam to the U.S., the majority of veterans stopped using heroin. Addiction may thus have its roots in social and cultural conditions (Robins, Davis & Goodwin, 1974, as in Granfield & Cloud, 1999).

3. Knowledge is sustained by social processes

It is through interactions between people in the course of social life that versions of knowledge are constructed. Therefore social constructions of all kinds, particularly language, is of great interest to social constructionists. What is regarded as 'truth' varies historically and cross-culturally - the way in which people understand the world, is a product not of objective observation of the world, but of the social processes and interactions in which people are constantly engaging each other. The ideology of Alcoholics Anonymous (AA) is largely based on the social processes and interactions in which members engage. Through the ritual storytelling, people acquire new languages, new associations, new narrative structures and new epistemologies around their alcoholism.

4. Knowledge and social action go together.

These 'negotiated' understandings take a variety of different forms, and thus create numerous different 'social constructions' of the world. Each social construction invites a different kind of action from individuals in the world. An example pertinent to this research relates to alcoholism. Before the Temperance movement, 'drunks' were seen as entirely responsible for their behaviour and therefore blameworthy. A typical response was therefore imprisonment. However, in wider society, there has been a move away from seeing drunkenness as a crime and towards thinking of it as an addictive disease. 'Alcoholics' are not seen as totally responsible for their behaviour, since they are the victims of an affliction. The social action offered by society is thus medical and psychological treatment (not imprisonment). Descriptions of constructions of the world thus sustain some patterns of social action and exclude others (Burr, 1996).

1.4.1.1 Implications of Social Constructionist Approach for Research

From a social constructionist perspective, objectivity in research is an impossibility. The 'objectivity-talk' of scientists becomes just part of the discourse of science through which a particular version of human life is constructed. No human being can step outside of his of her humanity and view the world from an objective position. Researchers must view the research as necessarily a co-construction between themselves and the people they are researching.

Research is therefore a process to understand how meaning is constructed by a process of conversation between researcher and participants. Human life and experience is fundamentally constituted in language and language should therefore be the object of study as it plays a central role in the construction of reality (Terre Blanche & Durrheim, 1999). People construct particular versions of their reality and the researcher tries to understand how that reality is constructed through language and conversation with the participant. The aim of this research is to present the reality of overcoming addiction without formal treatment through a process of self-managed change, and the way that meaning is constructed by participants within their reality. This includes a focus on how individuals tell their stories as well as how these constructions interact with broader systems of truth. Rather than presenting a transparent description of reality, social constructionist research is interested in the context in which the construction of meaning is set. Removing or ignoring the context of an event or social action by the researcher lessens our understanding of social meaning and significance (Neuman, 2003).

In research, the social constructionist position supports a critical agenda. If the social world is seen as constructed then it can be deconstructed. It also has emancipatory implications since it offers the promise of unmasking other taken-for-granted knowledges which proclaim themselves as self-evident truths (Foster, 2004).

Finally, research within a social constructionist approach recognizes that it is not exempt from the critical stance it brings to bear on other theories. The research is in itself a social construction – as a researcher therefore reflexivity is of utmost importance . This issue is explored later in the report.

1.4.2 Qualitative Research

Qualitative and quantitative methodological paradigms differ vastly from one another. Quantitative research paradigms represent positivist, experimental and empiricist schools of thought and take scientific explanation to be nomothetic. The nomothetic characteristics of quantitative research shows its aim to objectively measure the social world, to test hypotheses, and to predict and control human behaviour. Qualitative research paradigms represent constructivist, naturalistic, interpretive, post-positivist or post-modern schools of thought and are idiographic

or holistic in nature. The idiographic characteristic of qualitative research shows its aim to understand the social world and the meaning people attach to their everyday life (Schurink, 1999 as in Van Niekerk, 1999).

A qualitative research paradigm will be used in this study in order to come to an understanding of the narratives of individuals who have overcome an addiction without formal treatment through a process of self-managed change. Neuman (2003, p.145) summarizes the characteristics of quantitative research compared with qualitative research as follows:

Quantitative Research	Qualitative Research
Test hypothesis that the researcher begin with.	Capture and discover meaning once the researcher becomes immersed in the data.
Concepts are in the form of distinct variables	Concepts are in the form of themes, motifs, generalisations and taxonomies.
Measures are systematically created before data collection and are standardized.	Measures are created in an ad hoc manner and are often specific to the individual setting or researcher.
Data are in the form of numbers from precise measurement.	Data are in the form of words and images from documents, observations, and transcripts.
Theory is largely causal and is deductive.	Theory can be causal or noncausal and is often inductive.
Procedures are standard, and replication is assumed.	Research procedures are particular, and replication is very rare.
Analysis proceeds by using statistics, tables, or charts and discussing how what they show relates to hypotheses.	Analysis proceeds by extracting themes or generalisations from evidence and organizing data to present a coherent, consistent picture.

1.4.3 Narrative Analysis

According to Bruner (1986, as cited in Hänninen & Koski-Jännes, 1999, p.1837), one of the leading figures of the cognitive revolution in psychology, “there are two

modes of cognitive functioning, two modes of thought, each providing distinctive ways of ordering experience, of constructing reality". These modes of thought run parallel to the quantitative and qualitative research distinctions made above. One is the paradigmatic or logico-scientific mode of thought, which involves logical arguments, abstraction and deals with general causes of behaviour. The other is the narrative mode of thought which involves stories of particular events. Each of these modes has its own operating principles and procedures of verification. The former can convince by its universality and the latter by its life-likeness.

As mentioned in the introduction, psychological research on addiction has been based mainly on a logico-scientific mode of thought. General techniques of change and ways of influencing behaviour have been studied extensively. The self-managed change movement however relies on good stories, stories of trials and tribulations told by individuals who have been able to quit their addictions. There are numerous narratives coming from organisations like Alcoholics Anonymous (albeit stories often constructed within AA's frame of reference), yet the stories of alcoholics who do not belong to AA and people who have suffered from other addictions have remained relatively unexplored. The study at hand aims to address these areas of neglect.

Orford (2001a) encapsulates the role of narrative analysis in understanding the process of self-managed change when he writes, "I have always thought that psychological research could profitably have done more in the way of asking people directly about their experiences. I therefore welcome the move towards qualitative research methods in psychology. I believe that I am an expert when it comes to my own change processes, and I hope others would treat me as such" (p.14). Narrative inquiry allows the researcher to rightfully treat the participants as experts when it comes to their own change processes.

In recent years, qualitative researchers in psychology and the social sciences have become increasingly interested in narrative forms of inquiry (Bruner, 1990, 2002; Murray, 2003; Polkinghorne, 1988; Sarbin, 1986 as in Smith & Sparkes, 2006). One reason for this interest rests on the premise that human life is itself storied and that narrative is both a method of knowing and an ontological condition of social life. Indeed for narrative psychologists, the stories that people tell and hear from others form the basis of who they are and what they do. They are a cultural

resource that gives significant substance and texture to people's lives. In this sense stories shape identity, guide action, and constitute our mode of being (Smith & Sparkes, 2006). The basic principle of narrative psychology is that individuals understand themselves through the medium of language, through talking and writing, 'and it is through these processes that individuals are constantly engaged in the process of creating themselves' (Crossley, 2000, p. 10 as cited in Smith & Sparkes, 2006, p. 170).

According to narrative psychology people ascribe sense and meaning to their lives by grasping it as a narrative (Polkinghorne, 1996). The self-narrative structures the conception of the past by focusing on the events considered to be essential in shaping the life course. It also provides future orientations. The formation of a self-narrative is particularly important in times of life change when it is essential to maintain the sense of continuity and to create new visions for the future (Hänninen & Koski- Jännes, 1999).

1.5 Limitations

In keeping with the values of qualitative research, it is important to specify some of the limitations regarding this study at the outset. Firstly, I recognise that I am a white middle class researcher who only included white middle class participants from our multiracial and multicultural South African society so my analysis is limited. This was not an active sampling choice but an unexpected result in the context of a difficult-to-access sample. Had my research included narrators of other perspectives, my analysis may well have been very different. In addition, the sample was small and not representative of very many different addiction groups – only drugs and alcohol. However the aim was not to make broad sweeping generalisations but rather to analyse the personal narratives of the participants for depth of understanding.

The research focus is on self-managed change. During the interviews, it emerged that one participant had seen a psychiatrist (albeit for his panic attacks); another had participated in her 12 step church recovery programme (the definition of formal treatment in this study excluded assistance from religious organisations) and yet another participant had once attended an AA meeting (years before his recovery). Each of these instances indicate limited participation of treatment programmes in the recovery process. Some may, however, argue that this study

could have been strengthened if participants had not encountered 'treatment of any kind'. When recruiting participants however, these individuals defined themselves as having overcome an addiction without formal treatment (through a process of self-managed change) and narrated their stories in this manner. In line with the interests of narrative research, I was more interested in the ways in which individuals construed their story of overcoming addiction, than in an objectively defined sample with rigid criteria of absolutely no contact with external treatment systems.

Finally, the invitation to participate probably only appealed to those who felt they had a story to tell, thus limiting the external validity of these findings.

1.6 Language Limitations

Throughout this study, I am cognizant of the fact that there are many times when I have been compelled to use the conventional language of addiction. I am aware of the power of language and its ability to create meaning, to perpetuate ideas that may be harmful. The language used to discuss the world of alcohol and drug problems is at times problematic. For example, the use of words such as alcoholic, addict, alcoholism, and addiction are 'loaded' and are not used without reservation. I wish to resist contributing further to the reinforcement of constructs that are often as destructive for those experiencing alcohol and drug problems as they are useful. These words and the meanings they suggest run counter to the findings of this study. Nevertheless, using such terms to communicate findings could not be avoided.

There is not one agreed upon or standard term for describing overcoming addiction without formal treatment (Stall and Biernacki, 1986). There are a number of terminologies used throughout the literature – natural recovery, spontaneous remission, natural resolution, spontaneous recovery, untreated remission and self change. In this study, Copeland's (1998) term of 'self-managed change' is adopted as it is seen to be the most accurate term - the process of overcoming an addiction is neither natural nor spontaneous as these terms imply effortlessness. Self-managed change adequately describes a process of behaviour change that requires conscious effort.

1.7 Research Questions

The primary research question of this study is as follows:

What are the narratives of individuals who have overcome addiction through a process of self-managed change?

In answering this question, the research focuses on two main areas of analysis. The first section of the analysis explores the **narratives in terms of genre and content**. The focus is on understanding the content and structure of participant's narratives as articulated through social interaction and as mediated by culture.

The research questions are as follows:

- ***What*** types of narrative genre (culture story model) did participants make use of in telling their story?
- ***What*** happens in the story?
- ***What*** are the different spheres of meaning in narratives of overcoming addiction without formal treatment*?*
- ***What*** facilitates the process of self-managed change?

The second section of analysis explores the **narratives as social construction and action.** The focus is on how participants construct key elements of the narratives, how they construct a sense of self and how they make meaning in the social world.

The research questions are as follows:

- ***How*** do participants construct addiction?
- ***How*** do participants construct formal treatment?
- ***How*** do participants construct self?
- ***How*** do participants construct recovery?
- ***How*** do the narrators experience telling their story?
- ***How*** can these narratives bring about social action?

1.8 Structure of Research Report

The current chapter of the report forms the introduction to the study and describes the aims, rationale, research questions and basic outline of the research. In the following chapter, a review of literature around addiction and the process of self-managed change provides the context for the study. The research method is then outlined. The results of the study are reported in the analysis which is divided into two sections- the first section looks at narrative as genre and content. It provides an overview of each participant's narrative and an analysis of the way in which participants structured their stories around spheres of meaning. The second section presents the narratives as social construction and action around 4 main themes: constructions of addiction, constructions of formal treatment, constructions of self and constructions of recovery. The discussion centres on consolidating the analysis, and making practical recommendations for social action in response to the insights attained from this study.

Chapter Two: Literature Review

2.1 Definition of Terms

2.1.1 *Addiction*

Addictions are understood as learned habits that once established become difficult to extinguish even in the face of dramatic and at times, numerous negative consequences. In defining addiction, the critical dimensions are as follows (DiClemente, 2003):

1) The development of a solidly established, problematic pattern of an appetitive – that is pleasurable and reinforcing – behaviour
2) The presence of physiological and psychological components of the behaviour pattern that create dependence, and
3) The interaction of these components in the life of the individual that make the behaviour resistant to change.

Habits most clearly associated with addiction include tobacco dependence, alcohol abuse and dependence, substance abuse, eating, compulsive gambling and sexual activity.

Defining addiction with respect to participants in this study was based on simple criteria: the individual had to have experienced frequent cravings; extended periods of daily use, and serious consequences resulting from such use (Granfield & Cloud, 1999).

2.1.2 Formal Treatment

Based on the work of Stall (1983) and Copeland (1998), 'formal treatment' is defined as interventions by recognised institutions or individuals whose main goal is to treat people with addiction problems. This is inclusive of inpatient and outpatient treatment. Assistance received through friends, family, and religious organisations or in verbal warnings from medical or legal authorities do not constitute formal treatment under this definition.

2.1.3 Self-Managed Change

Self-managed change, the term used to identify the cessation of problematic addictive behaviours without the help of formal treatment, is the focus of this study. Because there is not one agreed upon or standard term for describing recovery without treatment (Stall and Biernacki, 1986), there are a number of terminologies used throughout the literature – natural recovery, spontaneous remission, natural resolution, spontaneous recovery, untreated remission and self change. However, Copeland's (1998) term of 'self-managed change' is seen to be the most correct term as the process of recovery is neither natural nor spontaneous as these terms imply effortlessness. Self-managed change is an appropriate term to describe a process of behaviour change that requires conscious effort.

2.2 Addiction

There are numerous models have been developed to conceptualise addiction – social / environmental models, genetic / physiological models, personality / intrapsychic models, coping / social learning models, conditioning / reinforcement models, biopsychosocial models and compulsive / excessive behaviour models. The scope of this research report does not allow for a comprehensive exploration of all models of addiction.

In conceptualising addiction within this study Orford's (2001a) model of addiction as excessive appetites has formed the theoretical basis. Orford's model considers the process of self-managed change as a viable way of overcoming addiction, and is thus presented in detail below. Before doing so however it is important to present two other significant models of addiction - the disease model and the adaptive model. These models represent a distillation of a number of versions encountered over the years (Peele, 1988).

2.2.1 The Disease Model of Addiction

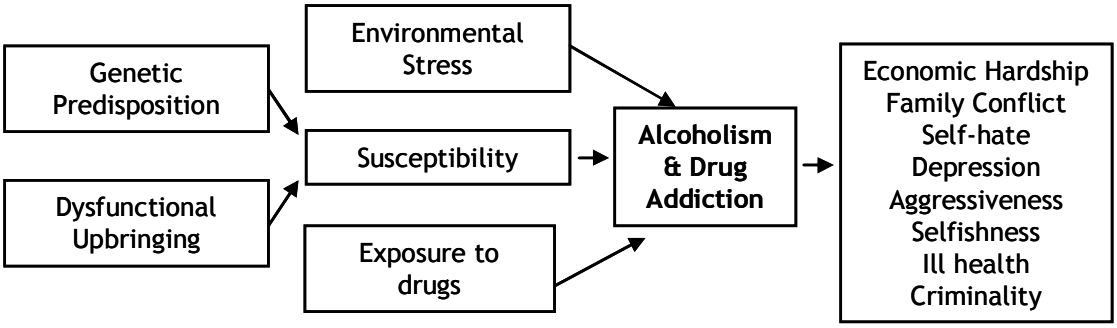

Figure 1: Disease Model of Addiction

The disease model is illustrated in Figure 1 above as a set of causal relationships each represented by an arrow. People first become 'susceptible' to addiction, then 'addicted', and finally self-destructive. The susceptibility could be caused by any disease process, but in contemporary forms of the disease model it is attributed either to a genetic predisposition or to psychological damage that occurred during childhood or both. Susceptible people are seen as vulnerable to drugs much as other people with other genetic defects might be vulnerable to diabetes or people with other kinds of childhood trauma might be vulnerable to psychosis (Peele, 1988).

When a susceptible person is exposed to drugs or alcohol and/or to environmental stress, drug addiction or alcoholism is likely to result, which typically leads to a familiar set of problems: economic hardship, family conflict, self-hate, depression and a host of other problems as illustrated in the figure. In different variations of the disease model, different contributing factors are emphasized. For example, genetic predisposition could be drawn larger and 'dysfunctional upbringing' smaller, indicating that genetic factors are given paramount importance in developing susceptibility (Goodwin, 1985 as cited in Peele, 1988). In another version, 'exposure to drugs' could be drawn bigger and the others correspondingly small, indicating power of the addictive properties of drugs over all factors.

2.2.2 Adaptive Model of Addiction

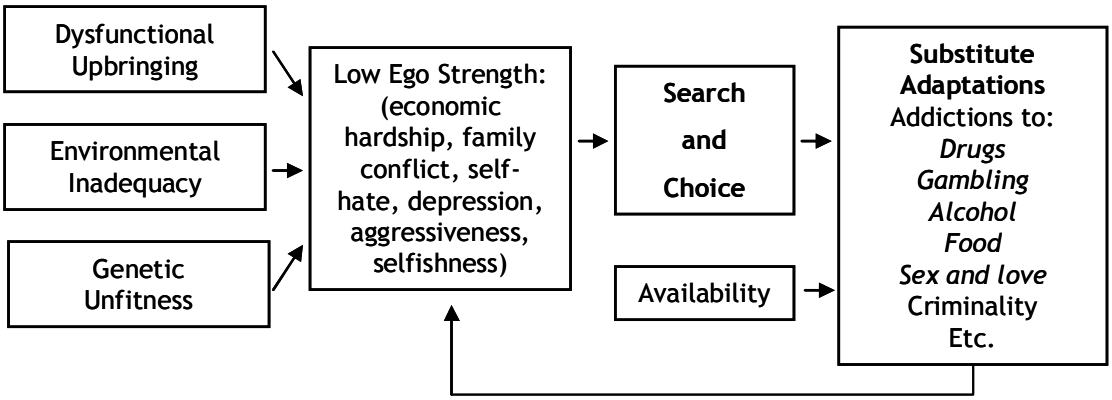

Figure 2: Adaptive Model of Addiction

The adaptive model in Figure 2 above is also depicted as organised set of causal relationships. The process starts with some combination of dysfunctional upbringing, inadequate environmental support and genetic unfitness (i.e. inborn physical or psychological weakness). These problems, and the way the person understands them, result in failure to achieve the levels of self-reliance, competence, social acceptance, self-confidence and so on that are the basic expectations of society. In short, some people fail to maintain adult integration and ego strength (Peele, 1988).

Failure to reach or maintain adult integration can be seen as problematic. It invites social ostracism, despair, mental disintegration etc. It creates an urgent to search out and choose substitute ways to provide meaning, organisation and social support. Various 'substitute adaptations' may be consciously or unconsciously adopted for this purpose. Substitute adaptations do not provide the abiding satisfactions of adult integration but at least provide a means of survival and allow hope for the future. Therefore they are seized and held desperately when their availability is threatened (Peele, 1998).

From an adaptive viewpoint, drug addiction or any other substitute adaptations are 'adaptive' because the alternatives are worse. The substitute adaptations may be harmful, but they provide something essential. For example, the despised identity of a drug user is more bearable than the horrid void of none at all, and deep immersion in a drug culture at least avoids feelings of loneliness and self-hate (Peele, 1998).

2.2.3 Differences between the Models

Although the adaptive model includes many of the same component terms as the disease model, the two differ in a number of significant ways. Most important, the disease model assumes that addicted people are sick, and thus in need of formal treatment. The disease model is utilized by a variety of strongly supported organisations such as Narcotics Anonymous, which describes addiction as "an insidious disease that affects all areas of our lives" (Narcotics Anonymous World Services, 1988, p. 2) and addicts as being "in the grip of a continuing and progressive illness" (Narcotics Anonymous World Services, 1986, p. 1). The adaptive model posits no disease, pathology or disorder and assumes people battling with addictions are responding adaptively within the limitations of their own abilities, perceptions and environments.

Second, a critical cause-and-effect relationship is reversed in the two models. Drug addiction and alcoholism are seen as causing a variety of problems in the disease model, but in the adaptive model they are seen primarily as a result of the same problems (the addiction may well make the problems worse).

Third, similar elements of the two models are constructed differently. For example, environmental stress in the disease model is termed environmental inadequacy in the adaptive model. Likewise, genetic predisposition means something very different from genetic unfitness (Peele, 1998).

Finally there are two central terms that do not translate from one model to the other because they have no corresponding items – these are *susceptibility* in the disease model and *search and choice* in the adaptive model. Susceptibility has deterministic, probabilistic, actuarial connotations that do not fit the adaptive model in which actions are seen as purposive, as suggested by the term *search and choice*. Thus the two models fall on separate sides of the spectrum between mechanistic and purposive explanations of human behaviour (Peele, 1998).

2.2.4 Orford's Model of Addiction as Excessive Appetites

Orford (1986, p. 2 as in Barnes, 2005) reports that Seeley, in 1962, recommended a disease model for the conceptualisation of addictions, but only on a 'trial basis'. It is hardly surprising that drug use and the problems associated with it was originally viewed from the medical perspective, as it was members of the medical profession, trained in the management of disease, who first concerned themselves with the study of drug use (McMurran, 1994 as in Barnes, 2005). Orford (1986, as in Barnes, 2005) however, maintains that this trial period is now over and suggests that, through combining various fragments of knowledge and theory relating to appetitive behaviours (which include drinking, drugs, smoking, eating, gambling etc.), an alternative explanation of appetitive behaviour is clearly identifiable.

From this perspective, Orford (1986, as in Barnes, 2005) attempts to formulate a psychological understanding of appetitive behaviours without recourse to the notion of disease, emphasising rather the use of drugs as a purposeful behaviour. The problem in constructing purposeful behaviour in disease terms concerns the difference between disease symptoms like high temperature or a rash and the symptoms of going into a pub and buying a pint of beer or sticking a needle containing drugs into an arm, which are voluntary actions (McMurran, 1994, as in Barnes, 2005). The disease model of addiction thus confuses the differences between bodily and behavioural abnormalities. Orford (1986, as in Barnes, 2005) holds that an explanation of excessive appetites can be derived from the combination of two theories - the law of proportionate effect and Floyd Allport's theories around the psychology of conformity.

The law of proportionate effect states that the effect of any one influence on behaviour is proportional to the cumulative effect of preceding influences. According to Orford (1986, as in Barnes, 2005), substantial evidence exists suggesting that appetitive behaviour is not determined by a single causal factor, but by a large number of factors which may be biological, sociological and psychological in nature. Also, these factors do not act independently of one another and do not all occur at the same time. They combine in order to have a cumulative effect on the individual (Orford, 1986, as in Barnes, 2005). This understanding of influences on behaviour as being proportional to the cumulative effect of preceding influences is thus viewed from the perspective of this model as an appropriate means for understanding the extent of an individual's indulgence in appetitive behaviours.

The psychology of conformity revolves around the idea that the extent to which an individual conforms to general rules or laws governing a behaviour is indicated by the result of the imposition of conformity processes upon a person's inclination to perform such behaviours which may be considered to be indulgent (Orford, 1986, as in Barnes, 2005). The extent to which a person conforms or indulges is presumed to be result of the opposing tendencies of conformity and indulgence (Orford, 1986, as in Barnes, 2005). The basic idea of forces in opposition, or opposing tendencies towards restraint versus appetitive inclination, is thus taken by Orford as being central to an understanding of appetitive behaviours.

Social learning theory approaches to human behaviour offer significant insight in terms of understanding the opposition of instigating and restraining forces. From this perspective, the outcome of a behavioural choice is the result of the balance of rewards over punishments for participating in rather than avoiding appetitive behaviour (Orford, 1986, as in Barnes, 2005).

Orford extends this social learning perspective, stating that reinforcers can be both non-social and social and that behaviour, whether deviant or conforming, results from greater reinforcement, on balance, over punishing contingencies for the same behaviour and the reinforcing-punishing contingencies for an alternate behaviour. From these theoretical perspectives it is clear that the balance between inclination and restraint and incentive and disincentive are issues of central importance. The importance of the development of increasing intensity in appetite lies in the way this balance is altered as a result (Orford, 1986, as in Barnes, 2005). As inclination increases with the development of appetite, so does the likelihood that increased costs will operate as potential restraints upon future behaviour (Orford, 1986, as in Barnes, 2005).

Orford's view of a comprehensive explanatory model of excessive behaviours takes into account social and cultural context, psychological functions, and development. However, to fully understand the excessive forms of these behaviours, it is essential to examine closely the conflict, ambivalence and social reaction associated with excess (Orford, 1986, as in Barnes, 2005). An issue of importance here is that a significant amount of affective – behavioural – cognitive attachment is likely to develop towards the object of behaviour (Orford, 1986, as in Barnes, 2005). The individual becomes committed to the appetitive behaviour which has

become excessive and these are the circumstances for decisional conflict. This idea resembles the concept of approach – avoidance conflict as discussed by Miller and Rollnick (2002), where a person is both attracted to and repelled by the same object, a situation which is can keep an individual stuck and create a decisional dilemma. Health enhancing decisions may of course be taken before significant attachment is developed, and many individuals do reduce their involvement in appetitive behaviours at various stages and at various levels of attachment. Change in appetitive behaviour in the direction of greater moderation or abstinence is viewed as a naturally occurring response to the ambivalence, conflict or dilemma which accompanies the appetites. These changes are constructed as personal decisions which are influenced by a variety of factors in everyday life (Orford, 1986, as in Barnes, 2005).

Therefore, a lot of the behaviour that is experienced as an excessive appetite can be understood as being a reflection of intense conflict. Feelings of ambivalence are heightened due to the increased attachment to that behaviour and the increased harm that it may be causing the individual. Good intentions are contested by significant attachment, the strength of which may be difficult for the individual to understand, and giving up may be viewed as a consequence of the conflict that arises from the accumulation of the costs of a behaviour consequent upon the development of a strong attachment to a specific activity (Orford, 1986, as in Barnes, 2005). Through the pulling together of existing theories and the addition of new insight, Orford provides a valuable model for understanding appetitive behaviour.

2.2.5 Criticism of Orford's Model

Orford's model is presented here as an alternative to the disease model. However, in the same way Orford calls into question the disease model, one could also challenge his conceptualisation of the use of drugs/alcohol as being a purposeful behaviour. The disease-based model of addiction has facilitated major advances in the field of addiction since its adoption, and continues to be used by a number of strongly supported organizations (NA, AA etc.) Also questionable is Orford's contention that similar principles are applicable to a variety of excessive behaviours such as eating, smoking and gambling. In this regard, it may be more valid to study these behaviours individually and develop conceptualisations and interventions that recognise their uniqueness (Barnes, 2005).

2.2.6 A Social Constructionist View of Addiction

A social constructionist view of addiction posits that while some individuals have problems with alcohol and drugs, the designation and experience of this problem behaviour as a disease is socially generated. In this sense, addiction is a social accomplishment that attributes meaning and moralities to those assigned to the category of alcoholic or 'drug addict' (Schneider, 1972, as cited in Granfield & Cloud, 1999). The construction of alcohol- and drug-dependent people as diseased is not unlike the arbitrary labelling of someone as mentally ill. This is not to suggest that people do not experience problems associated with their use of drugs or alcohol, but that the articulation of the problem as an illness requiring formal treatment is based more on politics and culture than upon medical science. Constructing alcohol and drug addiction as an illness has significant implications for the way 'addicted' individuals conceptualise their experience and for how they are treated in society (Granfield and Cloud, 1999).

Gergen (2005) argues that disciplines such as medicine, psychiatry, sociology etc. (what Foucault would term disciplinary regimes) generate languages of description and explanation – classifications of selves as healthy or unhealthy, normal or abnormal - along with explanations as to why they are so. The regimes also have various research procedures and interventions whereby people are scrutinised and classified, or labelled through language.

When these labels are carried into our everyday life, such as being an 'addict' or an 'alcoholic', people are engaging in power relations – essentially extending the control and power of the disciplinary regimes. As such, disciplines of study begin to have an impact on public policy and practices, as people become further ordered in their terms. Ultimately people participate in their own subjugation (Reith, 2004).

The construction of discourses of 'addiction' and the creation of 'addict identities' is part of the process that Foucault describes as the 'constitution of subjects', whereby the intersection of various types of power, knowledge and authority create new ways of conceiving and 'thinking of' types of person.

Initially, the idea of an 'addict' was constructed as the outcome of an interaction between the properties of specific substances (regarded as dangerous and powerful) and the consumption patterns of certain disruptive social groups. However, together with the development of new techniques of governance associated with the shift to post industrial, neo-liberal societies, 'addict identities' have increasingly come to be defined in terms of subjective, individual evaluations of loss of control. As its subject has shifted from the group to the individual, the field of addiction itself has expanded to include an increasingly large range of commodities and experiences that ever-wider sections of the population fear undermines their sense of personal agency (Reith, 2004).

Gergen (2005) illuminates the way in which "mental disorders" began to mushroom, with the emergence of psychiatry and psychology in the 1930s. Since that time the Diagnostic and Statistic Manual of Mental Disorders has gone through 4 editions and the number of deficit terms has amounted to over 300 – even a number of addictions are now DSM classifiable. As the number of disorders grows, the number of mental health professionals grows and the costs of mental health increase in similar magnitude.

Gergen (2005) describes a cycle of progressive infirmity. This can be adapted to the social construction of addiction:

1. health professionals declare the truth that addiction is a disease
2. as this truth has become disseminated through public policy, education, media, so people come
3. to understand themselves in these terms (e.g. I'm addicted to wine). With such understandings in place they will
4. seek out mental health professionals for a cure. As cure is sought
5. so is the need for mental health professionals expanded (rehab programmes, psychologists etc). and
6. as the professional ranks expand, so does the vocabulary of addiction prosper. This cycle is continuous and ever expanding in its effects.

The professional practice of classifying and curing addictions have the negative effects of inviting us to see normal problems of everyday life – what Orford (2001a, 2001b) would term 'excessive appetites' – as disease diminishing our ability to generate local solutions (believing these are problems for professionals) and

providing us with multiple means of finding fault in ourselves and others (for example, 'I am a chocolate addict', 'he is addicted to work'). Such classifications do not give many people the sense that they are personally responsible for their problems ('I can't help it, I have a disease').

Robertson (1972, as cited in Granfield & Cloud, 1999) highlights an array of consequences of blind acceptance of the disease concept of addiction:

- Conceptual ambiguity of addiction within medicine
- The possibility of defining an ever-increasing range of conditions and behaviours as diseases
- The possibility that medicine gains control over expanded areas of life; and,
- That disease conceptions of addiction would turn responsibility for rehabilitation over to experts and professionals.

In his critique of the disease concept of addiction, Robertson (1972, as cited in Granfield & Cloud, 1999) suggested that by labelling addiction as a disease and placing individuals in 'sick role', the addict comes to believe that the disease can be treated only by outside intervention. No amount of restraint or willpower or 'natural' solutions would suffice to overcome addictive behaviours. The narratives in this research challenge this perspective.

2.3 Addiction in the South African Context

Ninety percent of the American population accept the view that addiction is a disease that must be treated (Peele, 1990). Whilst similar data with regards to the South African population is not available, I believe that the same discourse is dominant in our society. This opinion stems from numerous conversations with a variety of individuals regarding addiction as well as a review of current literature and media coverage. For example, on the 22nd of November, 2006, The Star newspaper included a two page supplement on 'Drugs: The Threats' in South Africa (please see Appendix G). At the centre of the supplement, there is an article entitled 'Addiction: The Disease Concept'. It is stated that recognition of addiction as a disease '*implies several things:*

- *The course of the illness is predictable and progressive.*
- *The disease is primary – it is not just a symptom of some other underlying disorder.*
- *It is permanent.*
- *It is terminal. If left untreated, it results in insanity or premature death.' (The Star, 2006).*

The supplement includes a number of advertisements for a variety of treatment centres in South Africa. The disease concept of addiction is promoted and reinforced by organisations offering addiction treatment which is understandable given that their existence depends on treating 'addicts'.

The South African Community Epidemiology Network on Drug Use (SACENDU) Project is an alcohol and drug sentinel surveillance system operational in and around Cape Town, Durban, the Eastern Cape, Mpumalanga and Gauteng. The system includes about 80% of the country's treatment facilities (Plüddemann, personal communication, 2006) and monitors trends in alcohol and other drug use. Alcohol is the dominant substance of abuse across all SACENDU sites (Parry, Plüddemann, Bhana, Harker, Potgieter, Gerber, Johnson, 2006). As stated in the Global Status Report on Alcohol (WHO, 2004), results from the 1998 South African Demographic Health Survey indicate that 27.6% of males and 9.9% of females reported alcohol dependence. The economic costs associated with alcohol abuse in South Africa are likely to be in excess of $1.7 billion (2% of GNP) per year (WHO, 2004). The rough percentages of the South African population dependent upon drugs and/or other substances (and the associated costs) are not available as they remain unknown (Plüddemann, Personal Communication, 2006).

SACENDU reports that in the first half of 2006, 7542 patients were treated across their 63 treatment centres/programmes. In proportion to the size of the population, it can be inferred from this small figure that the vast majority of individuals facing addiction in South Africa do not benefit from formal treatment, which provides impetus into researching the phenomenon of overcoming addiction without treatment through a process of self-managed change.

2.4 Self-Managed Change

2.4.1 Review of Research on Self-Managed Change

The majority of research in this area has focused on drug, alcohol and tobacco addiction.

A sizable body of epidemiological and longitudinal studies of alcohol problems in the general population has now demonstrated that the prevalence of self-managed change is greater than previously suggested - only a minority of alcohol dependent individuals seek help and that processes of recovery usually take place without formal treatment (Sobell, Cunningham, Sobell, Agrawal, Gavin, Leo & Singh, 1996).

Data from the National Longitudinal Alcohol Epidemiological Survey (NLAES) on a household sample of the US population revealed that only 9.9% of individuals with a current diagnosis of alcohol dependence or alcohol abuse had received treatment during the preceding 12 months (Grant, 1996, as cited in Bischof, Rump, Meyer, Hapke & John, 2005).

Overcoming problem drinking without formal help has been found to be the likely route to recovery in two Canadian general population samples with spontaneous remission rates of 75% and 77% respectively. (Sobell, Cunningham & Sobell, 1996). Cunningham & Breslin (2004) maintain that only one in three people with alcohol abuse or dependence ever seek treatment. In addition, Cunningham (1999), following research on the service use of former drug users (utilizing data from the 1994 Canadian Alcohol and Drug Survey), concludes that, as for smoking and alcohol, the majority of individuals overcome drug addiction without formal treatment (Cunningham, 1999).

These findings were further supported by the outcome of a review by Sobell, Ellingstad & Sobell (2000) of 38 studies that reported data on individuals who recovered from an alcohol or other drug problem without formal help or treatment. In their research, they estimate that 80% to 90% of all those who stop smoking do so without formal treatment (Marlatt, Curry & Gordon, 1988; US Department of Health & Human Services, 1988; Carey et al., 1989; Fiore et al, 1990; Mariezcurrena, 1994; Hughes et al., 1996; as cited in Sobell, Ellingstad & Sobell, 2000).

Self-managed change represents a legitimate avenue to overcoming addiction. It is not a new paradigm - it ultimately remains part of the recovery continuum. Understanding recovery without treatment does not require an anti-treatment stance. The process of self-managed change should be viewed as lying at one end of the treatment or recovery continuum (Granfield & Cloud, 1999).

2.4.2 Critique on Self-Managed Change Research

There are numerous issues worth noting in the research conducted in the area of self-managed change. The definitions of self-managed change/natural recovery/spontaneous remission have not been the same, and the follow up periods for these studies have differed widely. Walters (2000) maintains that the creation of a standardized procedure for identifying natural recovery, use of a large representative sample and repeated follow up would do much to enable replicable results and to advance our understanding of the spontaneous remission process.

The review of 38 studies by Sobell et al. (2000) found that many of the natural recovery studies with alcohol and drug abusers were methodologically weak. They maintain that "studies need to report consistently respondents' demographic characteristics at the time of their recovery. Such information will be useful in identifying variables common among naturally recovered substance abusers. Studies also need to obtain detailed descriptions of respondent's pre-recovery substance abuse history in order to provide a clear picture of the pattern and severity of respondents substance use" (p.755).

The lack of reporting of demographical information at the time of recovery is a serious shortcoming of the current literature – one would expect factors such as marital status, employment and age at time for recovery to be important for identifying factors associated with recovery and for predicting who is more likely to recover naturally (Sobell et al, 2000).

Another issue which appears regularly is the lack of reporting of problem severity. It is logical to expect that problem severity would influence the process of natural recovery, and that less severe addictions may be easier to overcome without treatment (Sobell et al, 2000)

Assessment of co-morbid psychopathology should also occur in natural recovery studies because a number of clinical disorders are highly co-morbid with substance

use disorders (Bischof et al, 2005). Sometimes clients recovering from a cocaine addiction, for example, begin to abuse alcohol. A more prevalent example, would be the high correlation between cigarette smoking and cessation of alcohol/drugs. Tobacco use should be assessed for all naturally recovered substance users.

Last, but not least, the definition of self-managed change rests heavily on a subject's self report – this raises questions about the validity and reliability of several of the studies. However, research shows that self report measures have proven sufficiently reliable and valid to serve as criterion measures in spontaneous remission research (Walters, 2000).

2.4.3 Factors in Overcoming Addiction through Self-Managed Change

In a study with forty samples conducted by Sobell et al. (2000), 62,5% of them offered reasons for recovery. The most recurrent reason put forward by respondents involved health concerns, with 42.5% of the sample reporting these concerns. The next most frequent reasons concerned financial issues and negative personal issues relating to substance use (e.g. negative feelings about self or embarrassment about a specific incident). Each of these reasons was cited in 12 (30%) samples. Other reasons included changes in the way respondents viewed their substance use (i.e. cognitive changes 27.5%), influence from a significant other (25%), family-related reasons (22.5%), social related reasons (20%), legal reasons (20%) and religious reasons (17.5%)(Sobell et al, 2000).

The results of Walter's (2000) review of quantitative studies on spontaneous remission - which included tobacco abuse – also found that health concerns were the primary reason underlying spontaneous remission amongst most subjects. Following health, the concerns that featured most prominently for self-remitting smokers include feelings of disgust and the will to stop. However, alcohol and drug self-remitters were more likely to use changes in values and goals and concerns about related social problems to kick-start their process of natural recovery from substance abuse. Social support, relationship changes, willpower and identity transformation were the most frequently cited maintaining factors for self-remitters as a whole.

Maintenance factors are an integral part to self-managed change. 18 of the 40 studies in Sobell et al (2000)'s review collected data regarding maintenance factors. Of these, the most reported factor (32.5%) involved social support or a change in social group. Significant other or family-related factors were the next most frequently reported maintenance factor with 27.5% samples reporting these. These findings are consistent with the fact that social support is critical to favourable outcomes in studies on treatment (Moos, Finney & Chan, 1982; Billings & Moss, 1983 as cited in Sobell et al, 2000). 20% of respondents reported that nonsubstance related factors had kept them from relapsing, while avoidance of use substances, work-related changes and general lifestyle changes were each reported by 17.5% of the samples. Furthermore, religion, self control or willpower and changes in living arrangements were each reported by 15% of all samples (Sobell et al, 2000).

2.4.4 Theoretical Underpinning for the Process of Self-Managed Change

2.4.4.1 Transtheoretical Model of Change (TTM)

In characterizing the natural process of giving up excess, Prochaska, DiClemente & Norcross's (1992) 'transtheoretical model' of change has been very helpful since it enables us to 'cross the otherwise heavily guarded borders between the separate addiction territories' (Orford, 2001b, p.26). In their model of recovery, an individual progresses from a stage of "precontemplation", where the person is not currently considering change; to "contemplation", when he or she undertakes a serious evaluation of considerations for or against change; and then to "preparation", in which the decision to stop occurs and efforts are made to prepare for stopping – commitment and planning are secured. Successful accomplishment of these initial stage tasks lead to "taking action" to make the specific behavioural change. If successful, action leads to the fifth and final stage of change, "maintenance", in which the person works to maintain and sustain long-term change (DiClemente & Velasquez, 2002; Prochaska et al, 1992).

Multiple studies provide strong support for these stages as well as for a common set of change processes used to progress the stages (Prochaska et al, 1992). Change processes are covert and overt activities and experiences that individuals engage in when they attempt to modify problem behaviours. The change processes were first

identified theoretically in a comparative analysis of the leading systems of psychotherapy. The processes were selected by examining recommended change techniques across different theories, which explains the term *transtheoretical*. The processes include consciousness raising, self-reevaluation, self-liberation, counterconditioning, stimulus control, reinforcement management, helping relationships, dramatic relief, environmental reevaluation and social liberation. The TTM entails a systematic integration of the stages and processes of change.

The identification of factors and processes facilitating self-managed change at each stage of the change model has proved extremely beneficial in many diverse areas (DiClemente & Velasquez, 2002). In particular, the TTM model has played an integral role in the development of motivational interviewing and brief interventions using a motivational approach (Miller & Rollnick, 2002). Interventions can be tailored to where a client is in the change cycle. For example, one could emphasize the health benefits to an alcohol abuser thinking about cutting down his drinking (contemplation), whilst one could encourage a drug abuser in the maintenance phase to develop sources of social support and work on transforming his or her identity.

While there is some disagreement between addiction researchers over the exact number of stages through which an individual may pass during his recovery, one aspect about which there is significant agreement is the importance of an identifiable "turning point" in the individual's addiction history, a point at which the decision to quit is established. This turning point has also been described as a "rock bottom experience" or an "existential crisis" (McIntosh & McKeganey, 2000).

Hunt and Matarazzo (1970, as cited in Orford, 2001b) demonstrated that relapse curves following attempts to change tobacco, alcohol and heroin habits were remarkably similar, with high proportions of people relapsing in the first few weeks, and a flattening out of the curve well below 100%, leaving around 20-30% having made at least medium term changes. This figure of 20-30% recurs in a number of unexpected places. This is not to argue that formal treatment never works, but rather to highlight the fact that treatment operates within a context and against a background of powerful natural processes (Bacon, 1973, as cited in Orford, 2001b).

When treatment does work, we can predict that it does so because of processes that are non-specific. Orford (2001) maintains therefore that research should be reoriented in focus, away from the concentration on specific therapies, and towards basic change processes. It is even more important therefore that research includes individuals who have overcome addiction through a process of self-managed change.

2.4.4.2 Stall & Biernacki's Model of Spontaneous Remission

Stall & Biernacki (1986) propose a model of spontaneous remission behaviour which takes into account many of the common factors identified in the process of natural recovery. The initial stage of the model involves building of resolve or motivation to quit using substances in a problematic manner. In the review by Walters (2000), this is represented by a few initiating factors – medical problems, pressure from family and friends to stop, extraordinary events, financial problems – that account for over half the reasons cited by self-remitting alcohol, tobacco and drug abusers for initially quitting substance abuse. The second stage of the model consists of a public pronouncement to quit. Finding substitute activities, replacing old associations with new ones, developing new recreational and leisure interests, and changing one's place of residence all signify a commitment to change that rests on a public pronouncement to live differently. The third or maintenance stage of the Stall & Biernacki model involves the management of the new identity and an integration into a non-using lifestyle, represented by factors such as ongoing social support, a growing sense of self confidence and willpower, and the discovery of life meaning through religion, education, physical exercise and identity.

2.4.5 A Social Constructionist View of Self-Managed Change

Language plays a central role in the construction of reality (Terre Blanche and Durrheim, 1999). It is note worthy therefore that in our social world language around the phenomenon of self-managed change is limited and not well established, particularly when compared with the deep-seated and oftentimes loaded language of addiction. That a common term for self-managed change / natural recovery / spontaneous remission / natural resolution has not been identified and adopted by social scientists speaks volumes. How can 'the process of self-managed change' become a reality for an individual if the language through which that reality is constructed is not readily available in everyday life?

When discussing the topic of my research, the responses I frequently received from people were either, “what ***is*** self-managed change?”, or “I didn’t think it was possible that anybody ***could*** overcome an addiction without treatment”. One gets therefore that the idea of overcoming an addiction without formal treatment through a process of self-managed change is socially constructed as being somewhat naïve.

Chapter Three: Method

3.1 Participants

Qualitative researchers tend to use nonprobability sampling. This means they rarely determine the sample size in advance and have limited knowledge about the larger group or population from which the sample is taken (Neuman, 2003). I used the nonprobability sampling technique of snowball sampling in this study. Media solicitation was never an option as Rumpf et al (2000) maintain that "media solicitation leads to a sample selection bias in research on natural recovery from alcohol dependence" (p.765). Fellow colleagues and psychologists were asked to forward a recruitment email to potential candidates. Six participants were recruited through snowball sampling - one of the participants supplied the details of two other participants. The other three participants responded directly to the recruitment email.

In qualitative research, the breadth and scale of samples are sacrificed in order to obtain a deeper and more contextualised understanding of people's lives and experiences (Neale et al., 2005). I was thus content with six participants as the focus of my study was not on the sample's representativeness, it was on how the sample could clarify and enhance understanding around overcoming addiction without formal treatment. The narratives obtained from six participants provided a large enough amount of narrative data for saturation to occur and for the analysis to be meaningful.

Participants were eligible for the study if they were over eighteen years of age (so they were able to legally consent to the study) and if they defined themselves as recovered addicts, having overcome their addiction without formal treatment through a process of self-managed change.

Based on the work of Stall (1983) and Copeland (1998), 'formal treatment' was defined as interventions by recognised institutions or individuals whose main goal is to treat people with addiction problems. This is inclusive of inpatient and outpatient treatment. Assistance received through friends, family, and religious

organisations or in verbal warnings from medical or legal authorities do not constitute formal treatment under this definition.

Participants must have been in recovery from an addiction for at least one year. Prior studies have also used the period of one year as a recovery criterion (Copeland, 1998). In terms of defining addiction, participants had to have experienced frequent cravings, extended periods of daily use, and serious consequences resulting from such use (Granfield & Cloud, 1999). All six participants had reported overcoming an addiction without formal treatment through a process of self-managed change.

Half of the sample was male and half was female. Aside from one participant in her early fifties, the other participants ranged between 25 – 30 years in age. Three of the participants were married, one was engaged to be married, one lived with his girlfriend and the other was single. All participants were from a white middle class background, either employed or self-employed in a variety of industries. Details of specific occupations are withheld for the purposes of confidentiality. The highest level of education attained by participants ranged from Grade 11 to a Masters Degree.

3.2 Interviewing Procedure

Planning for the interviews

In preparing for the interview, a semi-structured format was utilized. I wanted participants to 'tell their story' in its entirety but there were also important areas to explore with reference to my research question. A semi-structured format thus allowed for this balance and flexibility. Through familiarising myself with Mishler's ***Research Interviewing: Context and Narrative*** (1986), I remained aware of some of the pitfalls of interviewing and therefore attempted at all times not to suppress stories, 'limit' answers or interrupt narratives.

The interview schedule was constructed to draw upon issues identified in the literature and phrased and structured in order to elicit narratives rather than content areas. It contained questions on life experiences and family background, the participant's perception of the severity of his/her addiction, lifestyle, physical and psychological health, reasons for and factors influencing the process of self-managed change, length of recovery, maintenance factors, reasons for not

accessing formal treatment, and the experience of being interviewed. These questions facilitated participants talking in some depth about their experiences and feelings around overcoming their addiction.

Setting up the Interviews

Once a participant expressed willingness to participate in the research, an individual interview was set up between the participant and myself at a location of their choice – office, home or local church. I ensured that we would have an adequate degree of privacy, and that participants put aside enough time so that they would be able to give their interview undivided attention. Prior to each interview, I made sure that I was fully equipped with tape recorder, consent forms and information sheets packed.

During the Interview

I started each interview thanking each participant for their time and explaining what the research was about. In order to facilitate the generation of reliable data, I reassured each participant that their confidentiality would be respected at all times. Each participant was given and asked to complete (where required) the following:

- An information sheet (see Appendix A) stating that participants could withdraw from the study if they so wished and with telephone number of professional support if needed.
- An informed consent form (refer to Appendix B).
- A form giving consent for the interview to be recorded (see Appendix C).
- A one page demographic questionnaire (see Appendix D).

Mishler (1986) advocates that the role of the interviewer be taken seriously. Similarly, Holstein and Gubrium (1998) also focus on the interaction between the interviewer and interviewee as central to qualitative in-depth interviewing. They stress that conventional approaches to interviewing treat participants like 'passive *vessels of answers'* waiting to be tapped. In contrast, they suggest that the aim of the interviewer should be to stimulate the participant's interpretive capabilities and that the role of the interviewer should be to incite participant's answers, virtually 'activating narrative production' (Holstein & Gubrium, 1998, p. 122). As an active interviewer, I attempted to activate each participant's stock of

knowledge to enrich the topic of overcoming addiction through a process of self-managed change. I aimed to be aware of participants' non-verbal cues and made every effort not to react in ways that could influence their responses (for example, through expressing horror or surprise).

Conceiving of the interviews as active meant attending carefully to the ways in which knowledge was assembled. In other words, understanding ***how*** the meaning-making process unfolds in the interview is as critical as understanding ***what*** is asked and conveyed (Holstein & Gubrium, 1998). The dual interest in the ***whats*** and the ***hows*** of interviewing and analysis is explored in more detail later in this chapter.

Interviews varied from one to one and a half hours. In ending the interview, I asked the participants if there was anything more they would like to say. I made notes about the interview as soon as possible after it was over (Terre Blanche & Kelly, 1999).

Transcribing the interviews

The necessary permission to tape and to transcribe the interviews was obtained from each participant in writing (see Appendix C). The interviews were all tape-recorded and transcribed word-for-word into a word processor. Transcription was a time consuming and lengthy process but enabled the cogs of analysis to start turning.

3.3 Data Analysis: Approach to Narrative Analysis

The initial analysis included two focal areas - one looking at how the narratives were told and the other looking at how the narratives reflected the basic change processes inherent in overcoming addiction. My first round of analysis thus involved a categorical content analysis (Lieblich, Tuval-Mashiach & Zilber, 1998). On the basis of the two areas of research focus, the narratives were read and re-read and major 'content universes' (Lieblich et al, 1998, p. 112) were established. Content categories were defined as they emerged from the reading. (This required a circular procedure of analysis that involved careful reading, suggesting categories, sorting the subtext into categories, generating ideas for additional categories or for

refinement of existing ones, and so on). I finally coded and sorted all the material into categories using a qualitative analysis software package. The definition of categories was heavily influenced however by my second area of research focus and therefore by empiricist theories such as the Transtheoretical Model of Change (and so incorporated categories such as precontemplation, contemplation, action, maintenance etc.) The sentences in each category were tabulated – all in accordance with my aims.

At this stage, it became clear that the epistemological tensions between my two aims were irreconcilable. My results (a list of content areas) neither communicated the lifelikeness and storied nature of the narratives, nor explored the narratives in a social context. I thus decided it would be far more valuable to focus on my primary aim – looking at the narratives and the way in which participants made sense of their stories – and thus abandoned this method of narrative analysis, and 'started from scratch'. This initial analysis facilitated immersion in the data such that I started again knowing each narrative in an intimate way. With this 'intimate knowledge', I added input from my supervisor and from the methods of analysis as suggested by Gergen (2005), Plummer (1995), Hoffman (2003), Parker (1992), Andrews (2004) and Smith & Sparkes (2006). This combination has been instrumental in illumining my path with regards to a rich(er) understanding and analysis of the stories participants told.

Through this process, another key distinction in the analysis emerged. Smith & Sparkes (2006) write about the tension which exists between qualitative researchers regarding what might be labelled the approaches to narrative research – the distinctions and divides between the ***whats*** and the ***hows*** of storytelling. As Denzin (1997, as cited in Smith & Sparkes, 2006, p. 184) notes, 'various versions of narrative theory will go to great lengths to split narrative into two parts: story (what happened) and discourse (how the story is told)'.

There are researchers who work primarily in relation to the questions of ***how*** the story and social reality is constructed. Others, however, are more concerned with the key elements and organisation of the narrative – its plot, characters and content. They emphasize ***what*** questions. Gubrium and Holstein (1998a, in Smith & Sparkes, 2006) call upon researchers to think about working with both the ***whats*** and the ***hows*** in their research projects. Thus rather than prejudicing either the

whats or the ***hows*** of storytelling, they argue that both are equally important in understanding our worlds. "The two approaches complement each other and can be developed in tandem to understanding the complexity of certain phenomenon" (Smith & Sparkes, 2006, p.187).

With this call for action in mind, this study aims to look at both the ***what*** and the ***how*** of participant narratives. The analysis of narratives in this study is thus divided into two sections:

- **Narrative as Content and Genre:** The first section pursues ***what*** questions and thus addresses the content and structure of meaning as articulated through social interaction and as mediated by culture. It aims to answer the following questions:
    - ***What*** types of narrative genre (culture story model) did participants make use of in telling their story?
    - ***What*** happens in the story?
    - ***What*** are the different spheres of meaning in narratives of overcoming addiction without formal treatment***?***
    - ***What*** facilitates the process of self-managed change?

- **Narrative as Social Construction and Action:** The second section of analysis pursues ***how*** questions looking at how participants constructed key narrated elements, a sense of self and meaning making in the social world. It aims to answer questions such as the following**:**
    - ***How*** do participants construct addiction?
    - ***How*** do participants construct formal treatment?
    - ***How*** do participants construct self?
    - ***How*** do participants construct recovery?
    - ***How*** do the narrators experience telling their story?
    - ***How*** can these narratives bring about social action?

More detailed accounts of these two sections of the analysis are provided below.

3.3.1 Narrative as Genre and Content

This first part of the analysis serves to introduce the reader to each of the participants, and to provide a re-authored version of the participant's stories as they were told during the interviews. For the sake of coherence, the re-telling of the stories aims to identify the main storylines in the interview material and to relate them to the 'story types' or '**genres**' inherent in our culture. This section also looks at the way in which the **content** of narratives can be structured around spheres of meaning.

3.3.1.1 Narrative as Genre

Narrative identities should not be understood as free fictions. Rather, they should be seen as the product of an interaction between the cultural discourses which frame and provide structure for the narrative, and the material circumstance and experience of each individual (Bruner 1987, Ezzy, 1997, Gergen 1992, as cited in Elliott, 2005). In other words while each individual has the capacity to produce a narrative about themselves that is creative and original, this narrative will take as its template existing narratives which each individual has learned and internalised. How a narrative is told will depend crucially on the cultural resources available (Kelly and Dickinson, 1997, as in Elliott, 2005). One way of understanding these culturally specific narrative resources is in terms of 'genres'. Genre can be defined as a narrative pattern that has become established through repetition. It is because they are familiar and easily recognized that genres act to shape the expectations of the audience while also providing a template for the author (in this case the participant).

These narrative frameworks may be more or less restrictive and may be managed and maintained in very different ways. For example, Denzin (1989, as in Elliott, 2005) describes how an alcoholic's story about his life can be understood as located within the cultural texts and shared experiences of 'Alcoholics Anonymous'. Other more formal settings may provide even more explicit control of the way in which narratives may be told. Medical consultations, job interviews and research interviews are all examples of occasions where particular types of stories are required, and there may be a variety of procedures in place to ensure that the appropriate narratives are elicited. There are clear links here with the work of authors such as Foucault and Rose on the institutional settings that contribute to the workings of the modern regulated self (Foucault, 1990; Rose, 1989 as in Elliott,

2005). As Foucault has stressed, the west has become a 'singularly confessing society. The confession has spread its effects far and wide. It plays a part in justice, medicine, education, family relationships and love relations - Western man has become a confessing animal' (1990, as in Elliott, 2005, p. 128).

Although some traditional narratives may be maintained and remain stable over time, they also have a capacity for change. Genres of the past are replaced by new genres, stories breed new stories and narrative structures metamorphose into new narrative structures (Todorov, 1990 as in Elliott, 2005). As Plummer (1995) highlights, the rape narratives and coming out stories that were well-recognised in the 1990s would not have been possible just 30 years ago.

As is evident in the results section of this report, there are many different established narrative forms or 'genres', solidified at different depths within a culture to which individuals can turn in order to make sense of their own experience and communicate that experience to others.

3.3.1.2 Narrative as Content

Linde (1993 as cited in Smith & Sparkes, 2006) suggests that as a participant tells his or her story, there is a personal, interpersonal and cultural demand to achieve coherence in the content of the narrative. However, coherence is not an absolute property of the story told, it is created by the participant and the researcher.

Holstein and Gubrium (1998), along with Mishler (1986) suggest that researchers direct their attention towards the artful practices through which storytellers **do** coherence, and examine the complex and differentiated ways that narratives can be organised to serve their meaning-making functions. In so doing, the **content** of the narratives in this study are organised in terms of different spheres of meaning – **emotional, causal/explanatory and ethical**. These spheres make the narratives more than a mere review of one event after another, and facilitate conceptualising coherence across the narratives.

Gergen (1998 as cited in Hänninen & Koski-Jännes, 1999) proposes that the **emotional sphere** of a narrative is related to the goals of the narrator, which in the course of events are threatened, attained or missed. Stories are thus analysed specifically from this emotional point of view – whether they proceed towards or

away from the goals of the narrator, whether they have a happy or tragic ending, and how the high points and low points are located in the narrative.

Narratives typically provide a sense of **explanation** - as narrative theorist Paul Riceour puts it, "Explanation must... be woven into the narrative tissue" (Gergen, 2005, p.69). The explanatory aspect of a narrative is based on its causal meanings i.e. on the way the events are seen to be linked to one another as chains of causes and consequences. Guidelines for narrative explanation often lie within popularised forms of scientific, political, religious or other expert-based beliefs, "coherence systems" or discourses (Linde, 1992, as cited in Hänninen & Koski-Jännes, 1999).

The way the events are explained also has **moral consequences**, since the explanation allocates responsibility for the events: who or what is to be blame for adversity, and who deserves praise for success. In this sense, a narrative can accuse or deny, it can emphasize or deny the power and responsibility of the narrator.

Stories also usually include an **ethical perspective**. The ethical level provides the narrative with a deeper resonance, as the narrative is not only a story about the good and bad times of the narrator, but is also an articulation of his or her social construction of good and bad, worthy and unworthy, right and wrong in human life.

3.3.1.3 The Process of Analysis: Narrative as Genre and Content

The interview transcripts were read and re-read individually. I then summarised and re-authored each narrative focusing on ***what*** happened in the story. I selected those aspects of the story which I felt were most critical based both on content as well as my recollections of the way in which the participant communicated their story (both verbally and non-verbally) in the interview.

With an overview of each story, I then analysed ***what*** type of narrative or culture story model or genre was being told. I also thought about w***hat*** meanings participants attached to their addiction and to their recovery (as described before). For the sake of clarity and coherence in the analysis, I decided to include summary tables as follows:

The Type of Story	
Description of temporal sequence of events – a summary of how the plot unfolded - related to the goals of the narrator (emotional sphere)	
Cultural Story Model (genre)	The connection with prevailing story types in our culture
Construction of addiction (explanatory sphere)	An interpretation of how the participant constructed the reason for their addiction
Construction of recovery (explanatory sphere)	An interpretation of how the participant constructed the reason for their recovery
Moral assessment of self (moral sphere)	The way in which the individual allocates moral responsibility for the events
Evil (ethical sphere)	The participant's construction of evil in narrative
Good(ethical sphere)	The participant's construction of good in narrative

Once these tables of analysis were complete, I rounded off this first section of the analysis by exploring the similarities and differences between each narrative with respect to the spheres of meaning. After having painted a big picture of each narrative, I turned focus to the way in which participants created their pictures, as well as the context within which each painting was constructed. It is clear from this analysis that overcoming addiction, and reconstructing the sense of self, must be understood within a complex set of social conditions that surround each individual.

3.3.2 Narrative as Social Construction and Action

Plummer (1995) argues for an approach to narrative '*that does not stay at the level of textual analysis: it insists that story production and consumption is an empirical social process involving a* ***stream of joint actions in local contexts themselves bound into wider negotiated social worlds'*** (p. 24).

Within this latter part of the analysis - 'Narrative as Social Construction and Action' - two approaches were adopted and combined. First, the **'stream of joint actions in local contexts'** was explored i.e. how participants socially constructed their narratives in relation to others. Second, there was a focus on how their narratives are **'bound into wider negotiated social worlds'.**

Radical social constructionists suggest that no knowledge about a reality that is 'out there' in the social world can be obtained from the interview, because the interview is obviously and exclusively an interaction between interviewer and interview subject in which both participants create and construct narrative versions of the social world (Miller & Glassner, 1998). Social construction theory posits an evolving set of meanings that emerge from the interactions between people (Hoffman, 2003). These meanings are part of a general flow of constantly changing narratives. The development of concepts is a fluid process, socially derived. In shaping our understandings of self, Gergen's (2000) theory of people as relational beings who are defined in and through relationships highlights the role of social, historical and cultural systems of meaning. In this sense, these systems influence processes of meaning making, which function to construct the self differently across cultures. The constructions of the self are sustained by the way in which participants construct meaning.

In looking at how narratives are '***bound into wider negotiated social worlds'***, the work of Plummer (1995) was instrumental. He uses the area of sexual stories e.g. 'coming out' stories, rape stories and 'recovery stories' about sexual issues more generally to explore the social role that stories can play – the functions of such stories in the lives of individuals and within society more generally. In particular, he raises questions about how new genres of stories emerge around a topic that was previously hidden from view. He argues that stories can be used to maintain the status quo, but can also have an emancipatory function transforming individual lives and the wider culture.

It for this reason that the work and ideas of Plummer (1995) have been central in this study. The type of stories that emerge in this research have previously been hidden from view (as discussed in Chapter One, this study may indeed be the first study on overcoming addiction through self-managed change in South Africa). Plummer (1995) sees story telling as a stream of social actions and suggests an array of problems for analysis. Crucial to this analysis, is a concern with power and with capacities to tell stories or to remain silent. This second part of the analysis looks at how participants construct addiction, a sense of self and recovery – bearing in mind the streams of power within which the constructions are embedded.

Plummer (1995) believes that a sociology of stories should be less concerned with analysing the formal structure of stories as narratives (plot, setting, characterization, temporal ordering etc) and more concerned with analysing the social role of stories: the way stories are produced, the ways they are read, the work they perform in the wider social order, how they change and their role in the political process. Plummer (1995) examines how for stories to be 'successful', there needs to be social worlds embodying a strong community of support waiting to receive them. The tales of overcoming addiction through self-managed change generally lack such communities of support and hence are less developed as stories. They are hopefully 'waiting in the wings for their time, their voice, their audience' (Plummer, 1995, p.16).

3.3.2.1 The Process of Analysis: Narrative as Social Construction and Action

The process of analysis in this section goes beyond the narrative text. The narratives were again read and re-read inspecting and marking (using an array of coloured pens) the way in which participants constructed the main concepts emerging from each interview i.e. constructions around addiction, constructions of formal treatment, constructions of self, and constructions around recovery. There was not a formal coding process as by this stage of the analysis, my knowledge of the interviews was intimate enough to easily find examples to support conceptualisations of meanings.

The method for analysis was guided by key questions which Plummer (1995) asks when exploring stories embedded in political flow:

- **The Nature of Narratives:** ***How*** are the narratives produced? Which parts of the narrative empower participants and which degrade, control and dominate?
- **The Making of Narratives:** Which strategies enable stories to be told, how are spaces created for them, and how are voices silenced within narratives? **How** are narratives constructed to fit into the wider networks of routine power? ***How*** do participants construct addiction? ***How*** do participants construct self? ***How*** do participants construct recovery?
- **The Consuming of Narratives:** Who has access to narratives? Where is the reader located within the political spectrum? ***How*** might the consumption of stories be extended?

- **Narratives in the wider world:** ***How*** do narratives fit with the wider frameworks of power in the social world? The story telling process flows through social acts of domination, hierarchy, marginalisation and inequality.

Asking these questions facilitated a process of consciousness-raising with regards to the streams of power that flow through the narratives. In the process of answering these questions and through exploring the ***how*** of the narratives, it became clear that the participants belong to a group 'whose marginality defines the boundaries of the mainstream, whose voice and perspective – whose consciousness – has been suppressed, devalued, and abnormalised" (Delgado, 1995, p.64 as cited in Andrews, 2004, p.2). These narratives are thus examples of counter-narratives and so my analysis was further guided by the work of Andrews (2004).

The final process in the method adopted in this study was to check the analysis, striking 'a critical distance from the text' (Terre Blanche & Durrheim, 1999, p.158). The results were inspected in an attempt to minimise mistakes such as summarising, contesting the text (as if there was a 'truth' to it), psychologising and stating the obvious. Throughout the analysis, an awareness of the dangers of constructionism were kept in mind – the oppression and suffering of the participants was not trivialised as just another text (idealism) and participants' descriptions of reality were not dismissed as merely accounts or constructions (relativism) (Terre Blanche & Durrheim, 1999). The results were also discussed with a number of associates and colleagues who were able to provide fresh perspectives.

3.3.3 Conclusion

Exploring both ***what*** and ***how*** questions through analysing the narratives from both a genre & content perspective, as well as from a social action & construction perspective has contributed towards a much deeper, more nuanced understanding of the data provided by participants. It also allows the reader to become attuned to the real-world political consequences of the narratives. Results of this analysis are presented in the following chapter; but, before continuing, there are two important aspects of the research which demand attention – standards of quality and ethics.

3.4 Ensuring Standards of Quality in Qualitative Research

In quantitative research, the concepts of reliability and validity are useful in addressing the quality or methodological rigour of a study. In qualitative research, standards of good practice refer to the trustworthiness of data (which approximates *reliability*) and the trustworthiness of the conclusions drawn from the data (addressing standards of *validity*) (Stiles, 1993, as in Elliott, Fischer and Rennie, 1999).

Building on a review of existing principles of good practice in qualitative research, Elliott, Fischer and Rennie (1999) used an iterative process of revision and feedback from colleagues who engage in qualitative research, resulting in a set of seven guidelines especially pertinent to qualitative investigations in psychology. These guidelines serve four functions: to contribute to the process of legitimizing qualitative research; to ensure more appropriate and valid scientific reviews of qualitative dissertations; to encourage further developments in approach and method; and, to encourage better self-and other-monitoring.

It is indeed for the purpose of self-monitoring that I considered Elliott, Fischer and Rennie's (1999) guidelines throughout my research process, in an attempt to enhance the quality and methodological rigour of this research. These guidelines – and examples of how they have been applied to my study - are as follows:

1. **Owning one's perspective and reflexivity** – Recognising and stating one's own position as a researcher, both in terms of theoretical orientation and personal values and assumptions is of great importance in attaining validity in qualitative research. Owning one's perspective assists the reader in assessing the interpretive account (Elliot, Fischer & Rennie, 1999). In the context of research methodology, the notion of reflexivity is used to indicate an awareness of the identity, or self of the researcher within the research process (Elliott, 2005). I aimed to maintain a reflexive stance throughout the research process, facilitated through engaging with my supervisor. I attempted to 'bracket' (Kruger, 1990, as in Terre Blanche and Kelly, 1999, p.140) my own values so as to understand and represent participants' experiences and actions more adequately. In the introduction of this report, I stated my own limitations as white, middle class researcher. Throughout the research process, I have remained aware of the

fact that not having overcoming an addiction through a process of self-managed myself may influence the way I make choices regarding what to include and what to exclude.

2. **Situating the sample** - Basic descriptive data (age group, gender, ethnicity, social class) has been provided about the participants and the social location of the sample has been acknowledged.

3. **Grounding in examples** – As is evident in the results section, examples of each theme are provided to illustrate both the analytic procedures used in the study and the understanding developed in the light of them.

4. **Providing credibility checks -** The research process has involved a continual returning to the original data to ensure credibility. My supervisor has served as a sounding board and analytical auditor reviewing the data for any discrepancies. Relevant literature around credibility has been sourced and applied at each stage of this study.

5. **Coherence** – The understanding of narratives represented in a way that achieves coherence and integration while preserving nuances in the data. The results of this study first include an overview of each participant's story, together with a table of analysis summarising the genre and key spheres of meaning within each narrative. These tables are useful in achieving integration and coherence. The second part of the analysis drills down more deeply into the data (and the construction thereof) so as to preserve the nuances and lifelikeness of the data.

6. **Accomplishing general vs. specific research tasks** – If a more *general* understanding of overcoming addiction without formal treatment through a process of self-managed change was intended, this study would have required many more participants. With only 6 participants, it is acknowledged that there are limitations of extending the findings to other contexts and individuals. Furthermore, the limitations of a small white middle class sample were specified in introducing the research at hand.

7. **Resonating with readers** – This research report attempts to stimulate resonance in readers. The material is presented in such a way that readers can first obtain an understanding of and empathy for each participant, before moving onto the analysis of constructs associated with narratives of overcoming addiction without formal treatment.

3.5 Ethics

This research fulfilled the University of Witwatersrand's standard of ethics set for research. Formal ethics approval was obtained from the university's Human Research Ethics Committee (Non-Medical). Ethical considerations included the guarantee of confidentiality to the participants, issues of informed consent and consideration of the benefits and harm of participating in this research.

Although anonymity cannot be ensured, confidentiality was ensured by the use of codes instead of names on all consent forms, questionnaires, and other paperwork. The raw materials will be destroyed at the completion of the research. I am the only individual with access to the audiotapes. Names of respondents, names of family members, place names and so on have been removed from the dialogue in the interview transcripts to protect the identity of the respondents.

Participants were required to give their informed consent to participate in the study. Informed consent was also required to audiotape the interviews. Subjects were informed that they can withdraw from the study at any time and that they can decline to answer any question.

At times, the interviews elicited difficult emotions and memories – participants were made aware of this risk prior to participating and were provided with referral contact numbers of organisations that offer counselling should they wish to speak to someone after participating in the research.

Chapter Four: Results

4.1 Narrative as Genre and Content

The first section of 'Results' serves to introduce each of the narrators, and to provide a re-authored version of the participant's stories as they were told during the interviews.

The re-telling of the stories aims to identify the main storylines in the interview material and to relate them to the genres/story types and belief systems inherent in our culture. The work of Hänninen and Koski-Jännes (1999) on the narratives of recovery from addictive behaviours was particularly helpful in this regard.

As discussed, each type of narrative was analysed in terms of its emotional, explanatory, moral and ethical meanings. Regarding the emotional plot, the different story types shared a relatively common pattern. In Gergen's (2005) view, they could be termed progressive narratives in which the end point is positive (recovery from addiction) and the story is all about the narrative events that lead up to achieving this valued state. This uniformity results from the definition of the sample – the participants regarded themselves as having overcoming addiction (without formal treatment) through a process of self-managed change. However, with regards to the other spheres of meaning, different types of stories emerged.

At the end of each participant's narrative presented, I have included a summary table which looks at the type of story or genre, and key spheres of meaning, used to construct the individual's narrative. The stories were not told in such a neat, coherent way – I realise these tables may be an oversimplification of the sequence of events. Their value however lies in the clarity and coherence which they bring to the reader as an outsider, looking in at the narratives of overcoming addiction without formal treatment through a process of self-managed change.

"Winning the Lotto"
Introducing Jeff

Jeff is in his early thirties, and runs his own business in the construction industry. He started drinking and taking drugs recreationally at school. Over the years he progressively drank and used more and more – every single night and every weekend. His life was '*like a rollercoaster'*. Jeff's mother died when he was twenty. His father goes out every night – drinking and gambling. There was thus no one to go home to. Jeff would leave work and find someone to go out with until the early hours of the morning

During his interview, Jeff told many stories about different incidents that took place when he was addicted to drugs and alcohol. He recalled vivid memories of one weekend (about 3 months before he stopped) where he thought he was going to die. He started drinking with friends after work one Friday evening and much later went to get some drugs. They had *"the biggest binge"* from Friday night through to Sunday. They spent about "*20 grand on drugs that night*".

> *About Sunday morning, it must have been about 9 o'clock, I actually get a knot in my stomach when I think about it, I started feeling like jas I didn't know what was going on, it felt like more than ever that I was dying that everything was just packing up.*

Jeff felt like he had to see a doctor so he called 911. They sent an ambulance and when the ambulance arrived, he decided he didn't need the ambulance and landed up hiding in the complex. The police then arrived (standard practice if someone calls an ambulance for an overdose) and Jeff managed to hide from them too. Jeff phoned his father who fetched him and took him to the doctor.

> *I guess that whole weekend taught me a lot. I had a bad car accident about 2 years before and I managed to stop drinking for about 6 months. I actually hit a guy, we were also smoked up, and this guy - I still don't know if he tried to hijack us, or what was going on but we weren't going fast - and this guy was in the road and he hit the windscreen and the windscreen cracked and we drove off. And that's like a hit and run. We could have gone to jail hey. I stopped drinking then and then that last incident [the weekend] was just* ***the final straw*** *I think.*

Jeff continued to drink and take drugs after this weekend but he soon realised that his body couldn't handle it anymore. He started having panic attacks on a regular basis, resulting in his going to hospital every time he drank for Valium injections to help calm him down.

Around this time, Jeff met a girl whom he really liked. In addition, his business was doing well. He says, *'it was all lined up ready to be taken or to be thrown away'*. He said to himself that if he lasted without drugs or drinking for seven days, he could stop. And he did. During this week of '*cold turkey'*, he was *'so sick and so miserable'*. His body was '*just craving everything so badly, craving the booze, craving the drugs, craving the chaos'*.

Jeff claims he never sought formal treatment because a lot of his friends had been in rehabilitation and '*it never worked'*. He also felt that he could not leave his business for '*28 days or whatever it is'*. *'I just don't have any hope in the system'* reports Jeff, '*no one knows me better than me'*, going on to question how anyone could tell him how best to change.

In addition to running his own business, Jeff attributes the main reason for maintaining his recovery to falling in love with the woman of his dreams. ***'It's almost like a fairytale'***. His girlfriend - '*she's just perfect'*- whom he now lives with, provides for him the home (and love and care) that he never had. Jeff says for him the main thing in his recovery is 'having someone to answer to, to go home to'. He now looks forward to going home at the end of a day, instead of escaping the loneliness by '*booze and drugs and stuff*'. He honestly thinks he's '*one in a million'*. If he looks at how bad things were and how good things are now, he compares it to ***'winning the lotto'***.

The Love Story	
lack of love – compensation by addiction – love received- recovery	
Cultural story model	Love story
Explanation	Addiction is compensation for the lack of love
Cure	Receiving love
Moral assessment of self	Addiction is justified as compensation
Evil	Indifference
Good	Loving care

"What are you doing to yourself?"

Introducing Beth

Wife and mother to two sons, fifty something Beth, tells a story of how she became an alcoholic over many years. She started drinking at university and '*was quite a social drinker'*. She would drink two beers and three or four glasses of wine every evening but felt '*totally in control and totally fine'*. Her husband would occasionally complain but it did not lead her to sobering up. She didn't think her drinking was affecting anybody until one day her son (when he was about 12 years old) said to her,

> ***"What chance have I got in life? You are an alcoholic and Dad is a gambler."***

That was Beth's first 'wake-up call'. She became more conscious of her drinking patterns. When she started having to have drinks before she went out, she realised she '*was on a road to nowhere'* and that she had a problem. She tried to give up entirely on her own but was unsuccessful. She was on a '*slippery slope'* and went '*downhill'* very quickly. Beth reached a stage of hitting rock bottom, during which time she spoke to a friend who said to her,

> ***'What are you doing to yourself?'***

Beth proclaims that these were *"the most amazing words", a 'revelation'* which had a huge impact on her life. She realized that change was needed, but she could not do it on her own. She thus decided to take responsibility, to humble herself and to attend a programme (12 step type) at her church for members battling with addictions. Beth talks about the internal battle she faced using a powerful metaphor of figures sitting on her shoulder '*literally fighting across her'*:

> *When I used to go to the fridge, I could actually feel God sitting here and the devil sitting here. They were sitting having this huge argument, through me, saying "You don't need that drink" – and the other one saying, "You do". At times the devil would win and I would take one and at times the Lord would win and I would say I don't need it. Eventually, the devil disappeared.*

Beth realised at the heart of her addiction was anger:

> *Once I dealt with the anger it just kind of …the needing to drink went away.*

Beth's story illustrates how the way in which society constructs addiction has had a large influence on the way Beth constructs her own meaningful story. Beth believes that she has an addictive personality and that alcoholism is a disease. She has not touched alcohol for six years now. Beth finds meaning in life through her involvement with the church in helping others to overcome their addictions.

The 12 Step Story	
Excessive drinking-isolation-hitting bottom-experimentation- joining RAP -recovery and 'decent' life – gratitude	
Cultural story model	A story of grace/The 12 step story
Explanation	Disease
Cure	Growing humble, identification with other alcoholics
Moral assessment of self	Not guilty but victim of a disease
Evil	Individual hubris
Good	Communion

"One of us had to be stronger"

Introducing Anna

In telling her story, I became aware that there were large parts of Anna's narrative that was being left out. There were references to '*skeletons in her closet*' which remained unspoken throughout our interaction.

Anna's road to addiction started when she was 19 years old. She started taking drugs because she thought '*it would be fun*'. From marijuana, she progressed to ecstasy so she could '*dance forever*'. Then she started taking thins. Whilst living overseas for a few years, the ecstasy didn't agree with her anymore so then she took speed. It was when she returned to South Africa that Anna moved onto cocaine.

When Anna's addiction reached an all time high, she was using cocaine 2-3 times a week and smoking weed every single day. For about seven years, her entire life focus would be on when she was next getting high.

Anna's brother is also an ex-addict. They shared a flat - Anna describes their relationship as being '*co-dependent*'. Anna contemplated giving up because she knew her brother was going down a much worse road then she was. He would '*stick anything up his nose*':

> *I didn't want to carry on using because of that and I knew…we had almost a co-dependent relationship so one of us had to be stronger*'.

The turning point for Anna in overcoming her drug addiction took place when her brother got arrested, with drugs in his possession. She admits that quitting one addiction was followed by becoming hooked on another.

> *I stopped using drugs and became an alcie for quite a long time so for the rest of that year I was drunk. I took the one addiction and traded it in for another*.

Anna claims that being strong for her brother was instrumental in helping her to stay clean, as was meeting regularly with a friend from church with whom she could be open and honest, and who helped her to deal with her '*depressed and*

suicidal' past. Anna is now in her late twenties (she has been clean for over two years), and is engaged to be married.

To facilitate maintaining her recovery, Anna surrounds herself with '*the right people'*.

> *I have got so many friends now, its ridiculous. People who really genuinely care. Um, so I think I didn't find it [recovery] that hard. I had the right support structure. I think if had not had a good support structure it would have been completely different but I had a brilliant support structure. So I didn't find it that difficult.*

The Co-dependent Story	
Gloomy secrets in childhood family – denial of negative feelings – chain of addiction – becoming conscious of the nature of dependence-breaking the chain	
Cultural story model	Co-dependence theory & depression
Explanation	Addiction is caused by secrecy and repression
Cure	Becoming conscious, unveiling shameful secrets
Moral assessment of self	Not guilty but victim of a victim
Evil	Repression of truth
Good	Openness and awareness

"I found God in Jail"

Introducing Don

Don tells the story of how his brother was killed in an accident when he was growing up. Since the accident, he always felt like he was not good enough for his parents and that they compared him to his brother. He was insecure and had a low self esteem. Drugs helped him socially - he started using for social reasons – "*going to clubs, just having a party*". His habit of using became significantly worse when he entered the hairdressing world. *'I just tumbled from there'*. He claims he would spend around 'fourteen grand a month on crack'. He would use every day (staying awake for four or five days at a time) except on his day off when he would sleep all day. Don described himself as a 'pusher'. For example, he acknowledges that he had a big part in his sister's taking of drugs -

> *…which is a very bad thing but, you know, you got to go down the road with somebody, or else you end up on the streets or worse. I'm glad I had somebody who I could travel with - it was somebody to recover with as well, which was helpful and I wouldn't have wanted to do it any other way.*

Don's turning point on his way to recovery was when he got arrested by a group of policemen and put into jail for about 4-5 days. Don describes being locked up:

> *Oh it was shit, it was horrible. You got too much time to think. You locked in a cell that's probably as big as this dining room, lounge whatever, about 12 other guys. You sleep on the floor on a stinky old mattress, I mean stinky old blankets, and you don't even have a mattress. The food is terrible I didn't eat once; I had bread, that's all I had. It's a terrible place, horrible. Way too much time to think.*
>
> *Deborah:*
>
> *What were you thinking?*
>
> *Don:*
>
> *Why I'm here really, why do I do the things that I do to myself? I came to a realization that it's not really worth it. All the shit you put yourself through. I thought a lot about my family and obviously my wife that I gave a lot of hassles to. Just what does it all boil down to really? Has it been that much fun? So then after that I thought no, not for me.*

Don, feeling desperate about the state of his life, claims that he 'found God in jail' which has influenced his recovery.

> *I decided that if He is the only one going to get me out of this, then it's worth trying it out to see what it's like. So I've been going to church ever since and that helps.*

Don has been clean for over two years. He now has his own business and is married with a baby. Don's final court case took place during the course of this research project.

> *We were found not guilty because none of the cops pitched up or anything. But I think a three-year trial is enough to put you off anything really. It was so horrible I hated it. But anyway it's over now. It cost us a stupid amount of money. So that was a lesson well learnt.*

The Turning Point Story	
Emotional pain from childhood – low self esteem - compensates by being self-important and cool - addictive behaviour – disregard for wellbeing of others – hit rock bottom experience - turning point – core change of identity	
Cultural story model	Rock-bottom to epiphany, critical, transforming moment in life
Explanation	Addiction stems from low self esteem and false pride
Cure	Crystallisation of discontent with current life
Moral assessment of self	Old self guilty but now new self
Evil	Egocentrism and false pride
Good	Realisation and awareness, acceptance of higher power greater than him.

"Having that hole filled"

Introducing Tessa

Tessa says that her upbringing *'was not a very normal upbringing'* and *'played a huge part in her addiction'*. She grew up in a home where there was a lot of abuse. Her mother was an *'alcoholic'* and her father was an *'excessive gambler'*. She grew up very young, leaving home at fifteen to get married. She soon after got divorced and *'returned back to normal life'*.

Tessa started taking drugs when she waitressed *'just for fun'*. When she moved jobs to work in a club, she met her boyfriend who was a drug dealer. She lived with him and he provided her with drugs so things started to get *'more extreme'*. Tessa openly admits ***'you know if I wanted to be with him, I would need to use'***. Tessa's drug addiction started with marijuana, LSD and ecstasy *'and stuff'* and eventually got to cocaine and heroin. She would use on a daily basis.

Her addiction reached an all time high when she was living with her boyfriend in a commune with 5 others – they would just *'sit around getting high'*. Eventually her boyfriend decided to go and live overseas. He never asked her to go with which was exceptionally hard but forced her to make a choice:

> *I could either turn to drugs and die if I continued doing drugs, or I could decide to make a difference and make a choice. And ultimately I think with any drug addiction, um it's a choice that you have to make.*

Tessa shares her resolution to stop taking drugs:

> *And, I made that decision the day **after saying good bye to my boyfriend** at the airport and um **that was the turning point**.*

It's almost like his leaving signified her being able to break free from a cocoon.

Tessa has been clean now for over 4 years. She speaks about the road she traveled in pursuit of finding meaning in life and a sense of personal fulfillment:

> *I was searching spiritually that year. I knew that I couldn't find happiness in the world. I tried drugs, I tried alcohol, I tried getting lost in exercise, I tried to be successful and make money in the corporate environment, I moved up the ranks, I bought my own house, all those things and I was still unfulfilled, you know I wasn't happy.*

Tessa finally took time out from the corporate world and worked in a rehab centre for a year. It was there that she experienced tremendous personal growth – particularly from a spiritual perspective. Tessa believes that her relationship with God has been the most important thing in helping her to overcome her addiction without formal treatment.

> *Um, you know I was brought up in a non-Christian home. I have never really been open to the Bible um you know those sort of things always freaked me out. And I think since I became a Christian I have that* ***very strong sense of having that hole filled*** *and I have no desire, no craving no need for any of that. And I think that has been a very strong point in a sense of um, being content, do you understand?*

The Personal Growth Story	
Dysfunctional upbringing – attempts to please others – unhealthy relationships- addictive behaviour – gradual emancipation –finding oneself	
Cultural story model	Butterfly breaks out of a cocoon and finds freedom (spiritually, the hole is finally filled).
Explanation	Addiction stems from oppressive relationships
Cure	Breaking loose, listening to one's own needs
Moral assessment of self	Not guilty but victim
Evil	Oppression, submission
Good	Agency and authenticity

“Floating along on that happy buzz…”

Introducing Max

For Max, starting to smoke weed during his high school years meant a transition from the world of childhood to the world of adults. Since smoking was forbidden, it carried danger and suspension, and declared independence of the norms and prohibitions of adults, and his traditional school world. He reports being ‘*Interested in new experiences and interested in experiences that maybe go against the grain of the mill’*.

As he progressed into adulthood, smoking marijuana and taking drugs served as a buffer alleviating the pressures of adult life. In this sense it increased his sense of mastery.

For Max, his turning point on his road to recovery was not ‘*like the light switching on’*. He says, *‘I think it was more than one single experience; it was a progression over some time’*. The meaning of taking drugs changed when he became aware that his dependence was becoming an obstacle to achieving his life goals in terms of career and marriage.

> *In terms of how it stopped, I basically reached a point in my life where I saw a lot of the people who I had started with um, being either hooked on heroin or in rehab in formal rehab programmes. And that was a wake up call, I guess. Probably more importantly I reached a point where I was advancing in terms of studies and academics and I saw the side that some of the other people were going down and I saw the side that I wanted to go down and decided that I was going to make my choice for the side that I believed was more proactive and more meaningful for me in terms of my life and followed that route. I think my relationship was also probably another big factor. Um, I had somebody who came from a similar background to me in terms of using and she also reached a point in her life where she also needed to make the same decision that I needed to make.*

Max made the decision to stop – he selected a date – and stopped. Overcoming his addiction demanded willpower and cognitive resolution.

> *It's a question of weighing up the pros and cons, and recognising the costs and the benefits. I had come to a point where I was very certain about those costs and those benefits…*
> *I had a very clear idea of why I wanted to stop what I was doing and a clear idea of what I would use both internally and externally as resources to help me in doing that and I did.*

In this story, Max is the hero, the protagonist, who defeats the enemy. As in hero stories in general the hero wins many kinds of goods, but the most important is respect and meaning.

> *I certainly found a lot of meaning in my relationship and a lot of meaning in my work or the work that I was working towards doing. And aah, certainly I would say that the meaning that come from those spheres were big factors in my recovery.*

Mastery Story	
Youth: smoking & drugs=autonomy – young adulthood: smoking and drugs as a buffer=adulthood: smoking and drugs as a dependence is an obstacle to mature responsibility and advancement – decision to quit- actual cessation –self-respect	
Cultural story model	Hero story, the triumph of reason
Explanation	Smoking/drugs first support then threaten one's agency
Cure	Willpower and techniques
Moral assessment	Weak self: guilty; strong self: not guilty
Evil	Weakness
Good	Self- control, responsibility, meaning.

Preliminary Conclusion

Focusing on the genres adopted in the narratives facilitated the process of discerning how a participant wishes the events and experiences that were recounted to be co-constructed. In concluding, it is useful to analyse the commonalities (or lack thereof) between the narratives. Every story resonated a resounding difference and distance between the participant's past (as an 'addict') and their present – the story of their former life is constructed as problematic whereas the story of their new life is constructed as valuable. This is strongly echoed in moral evaluations of self as previously guilty, victimized or weak in contrast to a current self who is more aware, strengthened or humbled. It seems that these constructions of self-managed change are accomplished through a break between past and present.

Every story also described a change in the narrator's relationship with other people. Participants produce meaning in concert with others. Jeff receives the love and acceptance he has longed for, Beth finds a way of sharing deeply with others and communicating anger, Tessa breaks free from her oppressive relationship with her boyfriend, Anna ceases to co-depend on her brother and learns to open up to others regarding her past, Don gains a newfound respect for his wife and family, and in Max's story, defiance gives way to responsibility. This suggests that narratives of self-managed change are peopled with characters who either fuel the addiction or support the change. These are not individualized narratives of change and this suggests the importance of human relationships in both maintenance and self-recovery from addiction.

Within each story, there appears to be a turning point of some kind - a point at which the decision to quit is established. This turning point has also been described as a "rock bottom experience" or an "existential crisis" (McIntosh & McKeganey, 2000). The turning points in the narratives in this study do not all reflect a single experience – they do however reflect a heightened awareness and a cognitive-emotional shift, in which the participant's regular pattern of seeing, interpreting and approaching things is changed. These experiences are characterised by internal conflict resolution, a confrontation with reality or commitment to a decision. Turning points give rise to clear memories that guide later decision making and behaviour. They are likely to serve important functions in the narrating of the self. For example, they serve as a means of highlighting the moral of the story (Koski-

Jännes, 1998). They also help to delineate the past from the present. Often dramatic, they almost serve as a signal reminder to the narrator that the past should be kept separate from the present, and that their failure to change would have been dire and that their consequent success is therefore all the more meaningful.

The stories all in their own unique way show how narrators draw on cultural "toolkits" and ideas prevalent in culture, for the reconstruction and interpretation of their own lives. It is particularly in relation to this point that "spheres of meaning" begins to adhere (Hänninen & Koski-Jännes, 1999). Narrators are selective about what is included in their story and what is left out. They craft their story – influenced by different genres presented in culture and society (Burr, 1996). The narratives of how participants construe change are both socially constructed and rooted in real-life experience.

The differences between the narratives in this study indicate that addictive behaviours can stem from all kinds of problems and that there are many ways to overcome addiction without formal treatment. This suggests that the dominant discourse that 'addiction must be treated' might not only be futile but even harmful in repressing the deviant voices. People should be free to create and express a story that fits their own experience. After looking at content - the ***whats*** of the narratives - and the intricate ways in which elements of culture and society are woven into the way stories are told, it is now appropriate to focus on the **hows** and look at the narratives as social action and construction.

4.2 Narrative as Social Action and Construction

Throughout each narrative there flows a stream of power (Plummer, 1995). This stream flows in starkly different ways. It is both empowering and creative, as well as oppressing and repressing. There is a tension between these two forms of power, best embodied in participants' describing the experience of telling their story during the interviews.

When asked **"What was it like talking to me about your story today?"** many of the participants made comments around how liberating the experience had been. Opening up a safe space that allowed participants to speak about how they had

managed to overcome their addictions without formal treatment elicited a sense of pride and self-respect. The opportunity to tell their story was indeed empowering. The experience of empowerment was magnified since opportunities to speak out are limited. This is where the repressing power flows - there are few spaces where their stories can be told. Their voices are silenced in most arenas of life.

There is something about their narratives that keeps them deeply ashamed. The undercurrents within the stream of power are strong. There is a tension – a push and a pull - between participants being empowered through having the opportunity to proclaim their private victory of overcoming addiction (without formal treatment) and between participants being oppressed by the public shame of ever having being an addict, a societal 'other', a marginalised identity.

Jeff reports that *'There are not many people that I can talk to about it* (his story). *I mean my girlfriend – I could never sit and tell her all the stories of things that happened and stuff'* and later on he says, *'I could never tell my dad exactly what happened'*. And immediately after that he says, *'Ja, it just brings back memories, hey. Good memories because of all that good has happened'*. In one sphere, you get a sense of personal power as he refers to *'all that good has happened'*. Yet in another sphere, there is a sense of social power that closes down the space for Jeff to voice his stories to his girlfriend and his father – the two people that he is most intimate with are not even able to hear his story because he is afraid of the way in which they may respond.

'Do you know it is actually good for me to be able to get it out?' remarks Beth towards the end of the interview – conveying a sense of empowerment. She also comments however that telling her story was, *'Incredibly emotional - amazing - because I never thought it would be'*. Plummer (1995) writes about how power is strongly connected to emotion. The telling of stories is usually accompanied by strong feelings – as was the case with Beth:

> *'But I think, I think, I know the emotion comes because it has been an incredibly difficult thing for me to admit that* ***I am an alcoholic****. That has been the biggest thing in my life to admit. That is why for years I just said I drink too much. Now I am prepared to admit it and to share it. That has been the hardest part (begins to cry). That is what upsets me.'*

It is in Beth's comments and her emotion that we capture the deep sense of shame that society instils in individuals facing addiction. The meta-narrative around being an alcoholic and what that means is infused with a power that is oppressing and repressing, and yet productive of certain kinds of identity. Because Beth's concept of herself as an 'alcoholic' with a disease – as shameful as it is for her - is more 'in line' with societal discourse on addiction, she ironically appears to be more able and politically 'free' to tell her story than the other participants.

When interviewing Max, I felt as if I was stepping on sacred territory. There are very few people in the world who know what he has been through. He reports that his immediate family do not know that he was addicted to drugs, and therefore remain oblivious to his recovery. When asked what it was like to tell his story, he replied, *'Hard. Um, liberating at the same time.'*

> *I don't think it will ever be easy to talk about what I did, but I suppose it might become easier as I grow older. And maybe I will find the chance to talk about it to an audience that might benefit from hearing it.*

We see Max expressing a hope that one day, as recovery stories ooze through the stream of power in the social world, the space to tell his story and be accepted will open up.

Caught in the currents of the power stream, Anna refers to telling her story as being *'A bit uncomfortable'*. These words of shame are balanced by her positive words that follow, *'I am very happy that I am better, that I am recovered'*.

Don also battles to articulate the conflicting tension. He deals with this discomfort by further re-emphasizing that his identity has changed, he is no longer the person he used to be.

> *I don't know, it's different* ***I'm not used to talking about it so much any more*** *it brings back a lot of old memories and feelings. I don't really think about it that much any more. It makes me realize what sort of a person I used to be and what sort of person I am today, so I suppose it's a good thing.*

Don does not like to be reminded of the sort of person he was, and is not accustomed to talking about this, but feels pulled to reflect because "I suppose" it would be good for him.

Tessa is the only participant who did not seem powerless to tell her story to others and who answered the question 'What was it like talking to me about your story today?' in a positive way. We can see from her answer that a personal sense of satisfaction arises from being able to tell her story to others. This openness seems to facilitate her recovery process.

> *I think it was good. I definitely do think that **it is an important part of recovery is to speak to people about it**. Um, I have always been open about my drug addiction and very open about my recovery. Um, I often try to speak to people about it. I find I don't have a counselor, I don't have somebody that I go to. Um, I have a lot of emotional baggage that has come through the years and I just find that just speaking to people, um, telling people the truth, being honest and open really helps in the recovery process. That's something I have just thought about that really helped in my recovery just speaking to people, saying you know I have made this decision, this is what my life used to be like and I want to make it different. Um, just versing it and **telling people it's very important**. So ja I found today very cool.*

The importance of 'finding a voice' and 'telling one's story' has been well recognized in the politics of the new social movements over the last decade (Plummer, 1995) and it is an important backdrop to this research. As bell hooks (1989, as cited in Plummer, 1995, p.30) has remarked: "oppressed people resist by identifying themselves as subjects, by defining their reality, shaping their new identity, naming their history, **telling their story**".

This tension within power dynamics is not only evident in the theme explored above, it ultimately flows through each narrative, and each theme presented here, articulated through the kinds of subjects spoken about, the language (terms, phrases and metaphors) used and through the presentation of concepts in a contrasting way (as illustrated in the table below). By identifying these binary oppositions, one becomes aware of the kinds of discourses at play in the narratives. Often these binary opposites are implicit in the texts, as only one side is explicitly mentioned (Terre Blanche & Durrheim, 1999).

Binary Oppositions Employed in the Interviews	
Self-respect	Shame
Constraint and willpower	Excessive consumption
Sense of agency	Loss of control
Calm, content	Chaos
Empowerment	Oppression
Autonomy	Loss of freedom
Good	Evil
Openness	Repression of truth
Acceptance of higher power	Egocentrism
Intimacy	Being alone

4.2.1 Constructions around Addiction

In narrative analysis, it is important to look not only at the stories participants tell, but also to look at the stories participants choose **not to tell.** In reviewing the research material, one becomes aware that there is a striking lack of narrative around how each participant's addiction actually started.

The participants comment very briefly on how their addictive behaviour began: Beth started drinking alcohol for social acceptance at first. Max prides himself on the reasons for starting to smoke marijuana, attributing it to being adventurous, and a way in which to declare his independence of the norms and prohibition of his school environment. Jeff also reports starting at school - ***"since Std 6/Std 7 we started going to these parties, drinking…*** *it wasn't so hectic… we started smoking weed in std 6/std 7 but like hard drugs, I think* ***the first time doing hard drugs was like in Std 8 when the raves started"***. Anna claims she started taking drugs because she thought it would be fun and because it helped her to dance 'forever'. Similarly, when Don was asked how he started taking drugs, he replied, ***"Oh it was recreational. Going to clubs, just having a party"***. Tessa describes that '*in the beginning* ***it was more an experimental thing, it was fun'***. Each participant provides a starting point for taking drugs or drinking – mostly for social and recreational reasons - but they do not provide an explanation on how their level of use escalated to being a problem. There seems to be a common resistance around constructing that part of the narrative which describes the road to addiction.

Why do participants resist constructing that part of their narrative which describes the road to addiction?

Although participants did not elaborate on why they became addicted, they all mentioned difficult experiences which could have been used to explain their addiction but were either not linked at all or linked only tentatively.

In other types of narratives, the start of the story is usually a key feature, with participants setting the scene in an often detailed way. For example, in her research involving interviewing individuals with HIV, Long (2005) reports what a pivotal role the story of how participants came to be infected with HIV plays in the narratives. Plummer (1995), on the genre of sexual recovery tales, claims that after defining a problem, individuals focus on the diagnosis and how their problem started. Most stories, Plummer (1995) maintains, "converge into a childhood tale of dysfunctionality and abuse connected to a lost childhood and a world of hidden shame and secrets. The stories return to the childhood of the teller where something traumatic happens" (p. 107).

In reviewing the narratives presented in this study, it is interesting to note that during each interview there was indeed mention of a painful story of some kind - alcoholic parents, the death of a sibling or childhood abuse. These stories are mentioned ever so briefly, yet, lying in the unspoken words, one becomes aware of the devastating impact these life events must have had on each participant.

For example, Tessa talks about growing up with an alcoholic mother and father who gambled excessively. She later briefly mentions that she was abused as a child, and that she left home and married (and subsequently divorced) at the age of 15:

> *…Um, I grew up in a home where I had two brothers.* ***We all got on very well****. Um, we had, two of us,* ***two of us have been abused physically and sexually****.*
> *Deborah:*
> *I'm sorry.*
> *Tessa:*
> ***It's one of those things in life that happens****.*

The way in which 'we all got on very well' is juxtaposed with 'two of us have been abused physically and sexually' serves to minimize the importance of the abuse in the narrative. Tessa further downplays being abused by commenting that ***'It's one of those things in life that happens'*** – there is no link made here between her past and the onset of her addiction. It is interesting how Tessa minimizes what happened to her in her childhood, yet later on in her narrative, she almost contradicts herself by constructing her past as ***'very important'*** and ***'a lot to deal with':***

> *In people's lives,* ***the past is very important but it's something that's difficult****. Because you will always battle with those issues right through life. But ja,* ***generally I had a lot of love from my family****. I was never pressured into doing things. I had freedom to do my own thing, to make something of my life. Um I grew up very young. I left home when I was fifteen and got married. I was engaged for a year and a half. I got married um, I got divorced and then returned back to normal life after that.* ***My past experience of life and my upbringing has been a lot to deal with****.*

Looking back, she tells herself that generally she had a '*lot of love from her family*' - Tessa becomes subject to the discourse of the 'family' where love is represented as the foundation for family life. Dominant 'family' discourse provides a means of constructing her life, and representing it to herself in a way that masks dysfunctional, inequitable social arrangements. Through her syntax, it appears that Tessa constructs the meaning of love to be '*the freedom to do my own thing*'. Freedom comes with both privileges as well as responsibility. Perhaps the burden of such responsibility compelled Tessa to use any drugs, *"anything really, anything that would take me away, to escape reality"*.

The notion of using drugs to escape reality is repeated in Jeff's narrative. He tells the tale of the trauma he experienced growing up:

> *My Mom's side of the family all died. Her brother committed suicide, and her mom and dad died at the same time as my Mom. They all died within one year of my mom. It was quite freaky.*
>
> *Deborah:*
>
> *No! May I ask what she died of?*

Jeff:

She died in an accident and then her mother and father died of a heart attack and then her brother committed suicide.

In expressing all the deaths (and how they died) in the family in a list-like way, Jeff detaches himself from the painful reality that surrounds the passing away of people close to you. His detachment is intensified by the phrase, '*It was **quite** freaky*'. For him, it was out of the ordinary realm of everyday life. When I reflected on how painful this time must have been, Jeff comments:

Ja, I never thought it was that painful. You think back and you think it wasn't too bad, but I am sure it was bad at the time.

In a similar way, Max minimizes the influence of painful events in his life. He says '***I don't think I have ever suffered in my life***'. Yet, towards the end of the interview, Max mentions some of what he has experienced in his life – the heartache of his parents divorce and the ramifications thereof.

***They divorced when I was about 12**. I always stayed with my mom. They have gone through a **couple of remarriages**. Um, **my dad's first one was difficult for all of us**, including him. It didn't last very long. I suppose it's meant we have **moved around a lot** and all the rest of the things that come with a separated family certainly apply to me.*

This repression of the representation of pain and suffering seems even more paradoxical since Max perceives that his friends who are still addicts are sad – and goes on to admit that he too experienced this sadness when using drugs:

Floating along on that happy buzz not quite sure what lies around the corner. Aah, I don't know. Just feeling that that they are lacking something I guess. I think that they are sad in a way. I think they are sad in a way. But struggle to find a way to express their sadness. And struggle to find anything to replace it with.

Deborah:

Do you think the same could be said for you when you were using?

Max:

***Absolutely**.*

Deborah:

Do you think there was a kind of a sadness which sustained the addiction?

Max:

Definitely. Without a shadow of a doubt.

Through the phrase '*without a shadow of a doubt',* Max emphatically confirms that a sadness sustained his addiction, yet fails to make the link between this sadness and his life experiences – his parents divorce, a '*couple of remarriages'* (the word *couple* makes light of the significance of remarriages), moving around and everything else that comes with a separated family.

Contrary to Max and Jeff, Beth admits that there is '*stuff that happened in her life*' that she hadn't dealt with. She uses a powerful metaphor of a little man, who files this '*stuff*' away. At this point in the interview she becomes quite tearful.

*He [*her minister at church*] gave a wonderful sermon on Jonah, where he spoke about issues in our lives that we don't deal with that we put into our subconscious, and down in our subconscious we have a little man who files away stuff that's happened. And the stuff you haven't dealt with is hidden away. It's hot, it can't be touched, but it keeps bothering you and popping up into your conscious. And causes turmoil (tearful). Why am I so emotional? This is crazy.*

There is an irony here that this *'stuff'* that is so '*hot'* that it can't be touched, pops up into her awareness as she tells her story causing her to cry. Beth's tears illustrate the emotional turmoil that she aims to communicate. This part of the interview highlights the power of narrative as performance. The performance is made even more intriguing as Beth asks *'why am I so emotional? S*he does not realize that the 'hot stuff' is popping up in the moment. The power of the little man makes her cry.

In interviewing Anna and Don, one can sense there is also 'stuff' in their backgrounds, stuff that is so 'hot', it can't be touched. There are many secrets that are kept within the family. Both siblings paint an almost too perfect picture of their parents and family background. Don comments:

We are a very close family, very good relationships with each other. We could sit and talk about anything really, which is good I suppose. Just a good family.

We only catch glimpses of that which lies beneath the surface. Anna speaks about the trauma associated with her brothers:

> *Um, I've got a great family. My folks are still together. I lost a brother when I was 11, he died in a hit and run. My other brother had meningitis and got very sick. My timing is really off - I don't know whether it was before or after. So he nearly died. So we went through* ***a bit of a rough patch****.*

The minimization of the negative is evident in the choice of her words '***a bit of a rough patch'***. Don provides some insight into this rough patch the family faced:

> *My brother passed away when I was little and I used to tell my dad he compared me to my brother, which he never did. I was never good enough, because I wasn't my brother…*

Don never felt good enough and this caused his folks to '*feel like "shit" you know*'. In the interview, the discomfort which Don expressed in talking about this issue was evident as he squeezed his hands tightly together. Similarly, Anna did not feel comfortable sharing the more negative aspects of her life in the interview. She speaks briefly about her background:

> *I also have a* ***depressed and suicidal background*** *and I was the most depressed and suicidal I have ever been after the first time I used cocaine. It didn't stop me though…*

When Anna was asked what it was like telling her story, she replied:

> *A bit uncomfortable. Um, I think the drug addiction was only one facet of a whole lot of other stuff so it seems very one sided.*

Despite these stories of the tremendous pain and suffering that was experienced, participants rarely acknowledged a link between these factors and the onset of their addictive behaviour. One could speculate that such a link would serve only to reinforce the shame already associated with their addictive past and is therefore minimized within the narrative. Or perhaps, the 'power of denial' becomes so firmly entrenched during addiction that it lingers on in other areas of life even after recovery. If it is a type of denial operating, then this 'denial' almost flies in the face of prevailing psychological discourse – that it is through acknowledging emotional pain and through dealing with it, that one is healed and set free from afflictions such as addictions.

Is the minimization of childhood suffering exclusive to narratives of overcoming addiction without formal treatment through a process of self-managed change? Or is it evident in the majority of narratives on recovery from addiction? The narratives presented here seem to be very different from the recovery narratives that Plummer (1995) explores in his work on telling sexual stories. For example, Plummer (1995) maintains that in terms of sexual (addiction) recovery tales, significant changes have happened in the last quarter century:

"In fits and starts, with uneven development, a shift is identifiable:

The private pains increasingly become public ones;

The personal sufferings become collective participations;

The pathological languages turn to political ones.

Stories of private, pathological pain have becomes stories of public, political participation. The 'old worlds' of course remain, but progressively the late twentieth century experience of being gay, being a rape victim, or being a relationship addict have all become very different stories" (Plummer, 1995, p.110).

The question needs to be asked: Why are such shifts not happening within the stories of overcoming addiction without formal treatment? Which kinds of narratives work to empower people and which degrade, control and dominate? It seems that stories of overcoming addiction without formal treatment are silenced - they are becoming more private, more pathological and more painful. The power to tell a story, or indeed not to tell story, is part of the political process (Plummer, 1995). Are these stories hidden from our gaze because they do not fit into dominant discourses around addiction being a disease that requires formal treatment? What were the reasons participants gave for circumventing formal treatment? It is to this question that the analysis now turns.

4.2.2 Constructions around Formal Treatment

Andrews (2004) explores the phenomenon of counter-narratives – the stories which people tell and live which offer resistance, either implicitly or explicitly, to dominant cultural narratives. The dominant cultural narrative in our society is that formal treatment is required to overcome an addiction. It is thus useful to look at these counter-narratives presented in this research and look at why participants did not seek formal treatment.

Anna insinuated that the Narcotics Anonymous (NA) assaulted her own sense of self by defining the individual as essentially an addict.

> *Deborah:*
> *And were there any reasons that you didn't seek formal treatment? For example, rehab.*
> *Anna:*
> *Because* ***I didn't think I was a proper drug addict****.*

Anna preferred not to think of herself as 'a ***proper drug addict'***, and even resisted associating herself with people attending NA. She expressed the negative impressions she holds of the NA, claiming they '*take one addiction for another. People become addicted to NA as opposed to drugs. They have no life and it's sad'.*

Anna may be referring to the way in which most addiction treatment and self-help groups are premised on discourses of dependency and powerlessness - they encourage people to accept that they are 'powerless' and have lost control of their lives.

Don also attributed negative qualities to people attending NA, refusing to identify with them, referring to them as *"all whacked in the head':*

> *I went to NA once, long before I stopped using. It just wasn't for me, didn't like the people, didn't like their stories. I just thought that they were all whacked in the head, so didn't want to seek help.*

Like Don and Anna, Jeff did not think that formal treatment was successful in helping individuals to overcome addictions, reporting knowing people who had undergone formal rehabilitation with little success - '*a lot of my friends had been in rehabs and it never worked'*. He went onto say that *'I just don't have any hope in the system'.*

Ultimately, the majority of participants did not feel as if they needed formal treatment, expressing a sense of confidence in themselves to manage the change process.

Jeff illustrates his personal sense of agency through questioning how anyone could tell him how best to change when ***'no one knows me better than me'***. He didn't see the point of '*spending 30 odd thousand rand, when* ***I had the will power to do it myself, even though it was difficult'***.

Adopting a similar self-deterministic stance, Max stated outright, *'I never considered formal treatment. I always had* ***absolute faith*** *in my ability to do it on my own'*. The use of the words '***absolute faith'*** indicates the strong belief that he had the resources to change. He goes on to say:

> *I had a very clear idea of why I wanted to stop what I was doing and a clear idea of what I would use both internally and externally as resources to help me in doing that and I did.*

In concluding the interview, Anna emphasizes that '*you CAN OVERCOME it (addiction) on your own'*. She goes on to say *'I don't think you need rehab and all that jazz'*. The use of the words 'all that jazz' trivializes the concept of 'rehab'.

Beth is the only participant who maintains that if '*you catch'* your addiction in time, *'if you come to your senses in time'* then recovery programmes or AA type programmes work. However, if you continue to deny your addiction, she says, *'it gets to your roots. That is when the rehab centre is your only way out, because there is absolutely no control'*.

Aside from Beth, by not choosing treatment or self-help programmes, the participants resisted the dominant narrative to see addiction as a disease requiring formal treatment. In a sense by emphasizing their own ability to overcome their addictions they were 'demedicalising' and normalizing their excessive alcohol and drug use. The words contained in their choice of language reflected elements of resistance in that they refused to see themselves as victims of a disease over which they had little control. In many ways they were tapping into discourses of agency, self-determination and perseverance which contrast with the victimization implicit in dominant societal views of addiction. Often people who construct stories which go against the social grain, do so with a consciousness of being a member of an outside group. In this sense, narrative analysis has a particular attraction for those whose voice has been silenced, member of 'outgroups'. The stories which participants tell to themselves and others, helps "to document and even validate a

'counter-reality'" (Delgado, 1995, p. 64 as in Andrews, 2004, p. 2). In this sense, counter-narratives, like the dominant cultural narratives they challenge might be experienced and articulated individually, but nonetheless they have common meanings (Andrews, 2004).

The way in which participants construct their identities in relation to their past addictions naturally follows from a decision to reject formal treatment.

4.2.3 Constructions of Self: From Past to Present

Identities are formed out of and in the institutions and roles in which individuals are embedded. We are not born with identities, our identities are social in that they form and change over time through the course of interaction with others. "An individual's story has the power to tie together past, present and future in his or her life. It is a story which is able to provide unity and purpose… individual identities may be classified in the manner of stories. Identity stability is longitudinal consistency in the life story. Identity transformation – identity crisis, identity change – is story revision" (McAdams, 1985 as cited in Plummer, 1995, p.172).

We tell stories about ourselves in order to constitute ourselves. A major focus within the social constructionist view of the self is the emphasis on the role of language as the medium for self-construction. In terms of this approach, the self is seen as being constituted through the ongoing meaning-making processes involved in social interaction (Gergen, 2000).

Narratives lay down routes to a past, mark off boundaries and contrasts in the present and provide both a channel and a shelter for the future. In telling their stories, participants assembled a sense of self and identity.

In this research, it is fascinating to note how participants construct a sense of self in the past (battling with an addiction) in relation to how they construct a sense of self in the present, having overcome their addiction. Each participant sets up a strong contrast, and the stream of power trickles through these constructions and through the oppositions.

The Past: Constructions of Self as Other

Every version of an "other"…is also the construction of a "self".

James Clifford, *Writing Culture* (as cited in Gergen, 2005, p.106)

Using language, embedded in notions of control and agency, participants paint a picture of who they were as 'addicts'. They create an 'other', an identity which carries a stigma, and which may well keep their narrative steeped in shame.

Excessive Consumption

One might expect that individuals who have overcome an addiction through a process of self-managed change may have been able to do so because their addictions were 'not **that** bad', and the use of drugs and alcohol was not excessive.

However, participants go to great lengths to convey the extent to which they were addicted. Their consumption of alcohol and/or drugs is constructed as both excessive and disordered.

For example, Don in talking about the amounts of drugs he used says, *"Too many - **plenty, plenty**. Probably spending about **fourteen grand a month on crack"***. Note the repetition of the word 'plenty', and the quite shocking example of monthly expenditure on drugs. Similarly, Jeff recalls how he *used to '**drink every single night'***. Max exclaims at one point in the interview that *"the only time I would not be under the influence was when I was at work"*. For a couple of years he smoked marijuana on a daily basis, '***and more often than not several times a day***'. He consumed additional drugs on weekends. Anna, who was 'a *cocaine and weed addict',* says her focus in life would be "*on when I was next getting high"*. She reported that '***I wouldn't go a day without smoking a joint, or five'***. She uses humour - 'a joint, or five' - to highlight her excessive smoking of joints.

So while all participants started their use of drugs and/or drinking in a controlled fashion for mainly social reasons, their patterns of excessive consumption eventually led them to serious addictions – using on a daily basis, being solely focused on the next high and spending large amount of money on drugs. Addiction can be seen as a discursive device that conveys the concept of disordered consumption and that expresses a loss of control – a subordination of personal

agency to some external or unwilled mechanism (Reith, 2004). Loss of control is constructed as a crucial element in each narrative and thus warrants being analysed in greater detail.

Control

A primary theme emerging from the analysis revolves around the articulation of a sense of loss of control. During the course of the interview, Jeff declares several times '*my life was just way out of control'*. He characterizes this loss of control as chaos:

> *That's the problem with drugs. There's always another mission, there's always …it's just chaos.* ***Your life is chaos****.*

Jeff elaborates further as he describes one of his drug binges:

> *Well, you see, still then that was bad, but we still carried on until my body didn't want to carry on. But that weekend was hectic I mean I remember I was trying to phone a helicopter****, I was so out of control****. I thought I was dying it felt like we had taken pills with too much rat poison or something and it was just going into my body and slowly I was dying.*

The thought of '*pills with too much rat poison'* slowly annihilating Jeff's body is a powerful metaphor. The image of 'addiction' is underpinned by what can be described as a 'deification of the commodity', whereby a substance – drugs or alcohol – is attributed with controlling powers – no less than the ability to overwhelm the sovereign individual and transform them into something else, something out of control, an 'addict'. 'As the bearer of these addictive properties, the commodity appears to take on a demonic life of its own and swallows up everything' (Reith, 2004, p.286) – reason, choice and control – it comes into contact with.

Beth also uses a linguistic technique to convey the 'battle of control' through her expression of addiction as ***'winning'***. The implicit meaning is that she as the person in battle was 'losing'.

> *At the time I thought I was great. But you do you have it together. No, you're not weak. You have got this thing under control. Maybe occasionally you'll let it slip but nothing serious. But that is what I found. That is what addiction is all about. Until you realise that* ***it is winning****, you don't do*

anything about it because you actually do feel that you have it completely under your control and that it is not ruining your life, it is not controlling your life.

Beth's construction around 'being in control' is implicit, but communicates a hidden message that 'to be in control means you are winning and that you are a good person'. The binary opposite of this construction of self in moral terms appears later in the interview when she associates having 'zilch willpower' (no control or constraint) with being 'useless'.

*And I tried to do it totally on my own, but **I have got zilch willpower** dieting, **anything I just am useless** (laughs).*

Societal discourse expects of individuals to act in a controlled, disciplined, rational way. If this is not the case, there is an assumption that the individual is flawed and 'useless' in some way.

Tessa speaks about her relationship with her boyfriend and how their 'out-of-control' drug-using habits impacted on their relationship:

*Ja, but as soon as it started getting out of control, we'd sit down together because it influenced our relationship and I think that was one of the reasons why we'd sit down and say okay well you know **maybe its getting out of control, lets try and control it but it was never really under control**.*

A close look at these narratives begins to illuminate how participants, using a range of linguistic and paralinguistic devices, construct and re-construct a non-addict identity for themselves. The past is narrated as being so out of control (and it probably was) to maintain the order and willpower of the present. It is striking how this individualizes the process and makes it a matter of individual and personal moral strength. The problem with individualism is that it allows social problems to be de-politicised by locating them at the level of the individual (Burr, 1996).

Construction of Self as an 'Addict'

The influence of others – and society at large - has had a considerable influence on the way in which Beth constructs her sense of self. Having participated in a 12 step treatment programme, Beth's narrative supports the suggestion by Peele (1988)

that individuals might become addicts, that is, assume the identity of an addict, only through their participation in recovery interventions that teach them that they are addicts. From this perspective, the identity of addict is mediated by their participation in institutions which label them as addicted. The extracts from Beth's interview transcripts below clearly illustrate some of the narratives around the disease model of addiction.

> *But you see they [drinking, alcohol and drugs] are all addictive. I am sure if I allowed myself to gamble I would become addicted to it…I now keep away from anything that is addictive, even prescription drugs. If they are addictive, don't give them to me.*

Beth, as the victim of a disease, has no belief in her sense of self control – she believes that she could become addicted to anything - even chocolate she proclaims later in the interview!

> *I would love there to be like a questionnaire (tearful)…(sighs) why does it effect me so much still?*
>
> *Deborah:*
>
> *Mmm.(long pause). A questionnaire to?*
>
> *Beth:*
>
> *To tell, where do I lie from 1 to 10? [in terms of being an addictive personality]*
>
> *Deborah:*
>
> *I guess you have to think what difference would it make if you did know. Would it make much difference?"*
>
> *Beth:*
>
> *I think it would because I suppose it is what people perceive in their minds. That's why a lot of my friends don't perceive me as being* ***an alcoholic*** *because I don't fit the mould.* ***And yet deep down I know I do - you see that's what hurts me.***

In this extract we see how Beth draws on broader discourse to explain herself to herself. Beth has become a subject of discourse – that she fits the mould of being an 'alcoholic' has a stamp of 'the truth' on it, despite it being so painful. She even goes so far as to express that she would like to be able to measure how addictive her personality is in a scientific way, on a scale from 1- 10 so she could 'legitimise' her identity as an alcoholic to her skeptical friends.

Beth's construction of addiction as disease extends to the idea of genetic predisposition. Beth claims her father was an alcoholic and that's why she has become one – she is thus not guilty, she is the victim of a disease. Her somewhat deterministic belief in hereditary conditions is clear in her words of warning to her children (an example of positive power):

> *I've told my kids, "You know what I did, you know the problems I had, don't you drink!" And I have also told them that they have a* ***good chance of being alcoholics because it's in the genes****.*

The emotion which Beth showed during the interview whilst narrating her identity as an alcoholic exemplified the shame associated with such a social construction. She comments '*addiction isn't easy to acknowledge – I think that as an addict what you try and fight is that you are not actually an addict. You have it under control. You can stop if you want to'.*

Implicit in Beth's words is the message she believes you have to acknowledge to overcome an addiction – 'you **are** actually an addict, you do **not** have it under control. You **cannot** stop if you want to'. The explicit words are of encouragement but the implicit message is one of prohibition. The individual is paradoxically stripped of a sense of self- control and agency. The shame may well be heightened by the disease narrative of addiction that maintains "once an addict, always an addict; once an alcoholic, always an alcoholic".

Construction of Self in Relation to Others

Participants share stories of the way in which their past self interacted socially with others. The construction of self is in relation to others. Others and interaction with others are frequently interpreted in a negative light.

Don illustrates this in the extract below:

> *I wasn't a very nice person. I become a, if I can use the word, "asshole". I just wasn't nice to anybody, my wife and me broke up for almost a year, I was horrible to my sister and she's my best friend. I didn't get along with any of my family. The only people I spoke to were the people I did drugs with.*

The conflict which arises between self and others may facilitate the process of overcoming addiction as illustrated below. Anna narrates how the experience of telling her old 'best friend' that her brother had been arrested helped her to stop using drugs:

> *The moment I found out, she said, "come and we'll have some coke". So it was also like* ***it made me realize how sick and fake and pretentious and just evil drugs are****. 'You know, come and have some coke and you can solve all your problems! Your brother will sit in jail but you will be fine'. Well, that helped*

Anna uses exceptionally strong words to describe drugs – sick, fake, pretentious and evil. They resonate strongly with the way in which societal discourse constructs drugs. As her past 'self' revolved around drugs, these words implicitly lurk in her sense of self in the past. The undercurrents of social power come to the surface, and one wonders about the ripples which must impact on her current sense of self.

Contrasting the Constructions of Self: The Past vs The Present

Participants validate their claim to a new identity and a new life by reflecting upon their past life in a highly critical fashion. At times, the contrast between the self in the past and the self in the present is made explicit.

When Don was asked what was most important in helping him to overcome his addiction without formal treatment, he replied: :

> *Just realizing what sort of a person you were, when you were doing it, because you really don't end up being a nice person.* ***I was a horrid hard person. Once you realize who you were when you were doing it, and who you are now, you know it's not worth going back****. Because I am quite a nice guy, and when I was using, I wasn't a nice person at all.*
>
> *Deborah:*
>
> *It's almost like your whole identity has change?*
>
> *Don:*
>
> *Ja, absolutely,* ***I was a pig. Treated everybody badly****. Used, manipulated, just did everything I could to get a next fix…*
>
> *Deborah:*
>
> *And now, how do you see yourself?*

Don:

*Ja, happy. Now is much better. I've never been happier, it's just **I'm a good person now**. Got a solid structure. I've got a family, my whole life to stand up to, like I said happy which is something I didn't have before.*

Don remarks how he is a '*good person now*' as opposed to the '*horrid, hard person*', the '*pig*' he was as an addict. The extreme differences in these constructions help him to situate his narrative – and his self – in the present, safe from the past.

Aside from psychological self, the narratives also often involved a re-interpretation of physical health in the past and the present:

Don:

In the past, I don't think I was very healthy, I didn't eat I didn't sleep now I think I'm pretty healthy … obviously I cant be very healthy the way I used to suffer, such bad headaches, my whole face would be sore, my back would be sore from my kidneys. I wouldn't be able to stand up properly but I would still carry on. Now I'm fine I don't get headaches anymore and I'm pretty healthy.

It is clear that much of the reconstruction of self involves narrating the individual as he or she was in the past in a negative light. This phenomenon is illustrated in the extracts below where Max introduces a binarism - his past sense of wellbeing was '*false*' whereas now he is fulfilled in a way that's '*real and genuine*'.

*Um, **in the past** I was growing up, made a lot of mistakes I was young. **Very insecure**. **Very lonely**. Um, certainly I wouldn't say naïve but um my wellbeing was entirely dependent on a source that was extrinsic. And an extrinsic source that was **essentially very bad**. Physiologically bad for me, socially bad for me, um, now aah I am able to find that sense of wellbeing certainly from extrinsic sources but they have just changed now to extrinsic sources that make me happy and fulfilled in a way that's real and genuine, **that's not false**.*

There is also a contrast between the way in which the effects of drugs are constructed from past to present. Max posits that his new self has become aware of the '*true*' nature of using drugs. In describing the effect of drug use as Max used to

see it - as something positive - he exclaims it was like 'floating ***along on that happy buzz not quite sure what lies around the corner'*** but reports coming to an awareness that drug users are actually ***'lacking something'***, that they ***'are sad in a way but struggle to find a way to express their sadness. And struggle to find anything to replace it with'***.

A similar awareness is expressed in the extract below where Beth discusses her psychological health in the past (as a '*weak'* alcoholic) compared with the present ('*self-confident'*):

> *I think I am far better now. Yes, far more self confident. I think I have overcome (begins to cry)… those weaknesses - I don't know why I am crying it is crazy I don't know why I am doing it- I know I have overcome them and that in itself has given me a lot of self confidence.* ***And yet when I was drinking, I never thought of myself as weak anyway. It is only in retrospect I look back now and think of myself as weak****. But at the time I thought I had it very much together. I suppose that is your way of saying I am in control. This hasn't got the better of me. It was only in that last period of time that I realised that it [the drinking] had won.*

Through labeling, and diminishing, people in the drug world into **'horrible people',** Tessa is able to weave power into the construction of her new self as '*not horrible'* but rather as '*more real'* and as a '*real friend'* **.**

> *And as the years went on it just became easier. You know I think also you start making real friends. Because in the drug world, you have so many friends that you don't know so you know them but like you don't know them. So you know as you* ***become more real*** *and you start to do more things* ***you start dissociating with horrible people****.*

It is clear that by reconstructing aspects of the self, participants can be seen to be distancing themselves from their past, from their world of addiction. They create themselves as belonging to an 'us' as opposed to a 'them'. The message that is constructed is loud and clear: "I am no longer one of them".

This distancing from the past is important in order to make space in the narrative for the introduction of the participant's new identity.

The Present: Constructions of a New Self

Within each narrative, participants construct a new reality where they are able to resume control of their lives. They communicate having developed a sense of agency, and seem to have negotiated the transition from victim self to agentic self. Tessa for example speaks about no longer being afraid of that *'loss of control'* that she experienced when using drugs:

> *You know just as soon as you think you have got everything going, you've got everything under control, something hits you in life and you just feel that you're just so out of control. And I think that's probably where that wholeness comes into it - **I am at peace with it now. I don't fear that, that loss of control**, that loss of what happens now? I would say those are very important factors.*

She further describes the positive aspects of her new identity compared with her old identity in terms of being more emotionally literate:

> *I also now have **the ability to actually experience emotions** to be able to be sad and to be able to be happy, and to know that I am going through an emotion. Whereas when you are on drugs, you are so used to not being in control of your emotions, you just don't know how you are feeling most of the time.*

In speaking about his new sense of self, Max narrates agency and an ability to handle the struggles of life:

> *To be able to live a life that I respect, to be able to be real with myself and the people that I love. Um, to know that life is not always about getting high and having a cool time, you know, that life is about the struggles sometimes, and it's in the struggles and the sadness that we can learn our greatest lessons.*

The central theme of Max's narrative revolves around his gaining mastery of his behaviour as he illustrates above. The ethos of the mastery story emphasizes the individual's ability to control his nature by the use of reason ((Hänninen & Koski-Jännes, 1999) – Max reasons that through struggles and sadness we learn our greatest lessons. He taps into the idea that there is purpose in suffering which thus makes it bearable. The way in which participants construct and reconstruct their experiences facilitates the making of meaning in their lives.

4.2.4 Constructions around Recovery: Meaning Making

The constructions of the self are sustained by the way in which participants construct meaning. Social constructionist theory posits an evolving set of meanings that emerge from the interactions between people (Hoffman, 2003). These meanings are part of a general flow of constantly changing narratives. The development of concepts is a fluid process that is socially derived.

The search for meaning is an integral part of Max's narrative. He speaks about the sources of his meaning playing a large role in his recovery.

> *I certainly found a lot of meaning in my relationship and a lot of meaning in my work or the work that I was working towards doing. And aah, certainly I would say that the meaning that came from those spheres were big factors in my recovery.*

Jeff too finds meaning in the relationship he has developed with his girlfriend. He depicts his addiction as a justified way of striving for the feeling of security and love of which he had been deprived. Through constructing his love story, he releases himself from the guilt of the addiction and highlights his intimate relationship as a basis of the meaning in life.

In four out of the six participants, religion emerges as a very strong dimension of their narratives. In each case, reference was made to Christianity. The narrators felt that their relationship with God was key in the process of self-managed change.

Spirituality can be construed as a narrative strategy that ties in with the way in which narrators make use of 'absolutes', and is thus similar to other narrative strategies such as speaking in binary opposites or hyperbolic exaggerated metaphors. These absolutes and contrasts help to tell their story in a more powerful way.

Beth weaves a thread of her faith in God throughout her narrative – she believes that God was actually working in her life throughout her addiction. He was prompting and guiding her – she joined the church group just at the right time. It was 'absolutely perfect', 'just amazing'.

The Lord works because I came here (to the church group) not knowing anything just knowing I had to come. I joined at the beginning of the whole session.
Deborah:
Right at the beginning?
Beth:
Absolutely.
Deborah:
The timing….
Beth:
*Was **absolutely perfect**, ja. Because if it had been later, they don't let people join later, because you can't, it aborts the whole journey. **It was just amazing**.*

Beth borrows heavily from AA discourse in terms of making meaning of her story. She constructs her identity as an alcoholic, and sees that she was extremely 'weak'. As an alcoholic, she received help from others who have been through a similar experience, and is now giving it in turn to others (through volunteering for the church). Like many AA narratives, Beth's story is clearly rooted in Christian tradition: the prodigal son returns home and is accepted into the congregation and afforded grace and salvation if only he grows humble and abandons his false pride (Hänninen & Koski-Jännes, 1999). To recover from the 'disease', Beth had to hit rock bottom, admit her helplessness with regard to alcohol, and rely on the help of recovered addicts.

In the moral sense, her story absolves her from guilt since it does not blame anyone for her drinking. After joining the church group however, she portrays herself as the responsible protagonist who pursued sobriety with the help of others around her. However, the humility she expresses in her narrative implies that her recovery is conceived essentially as a gift and that she is not to be praised for her success.

*I am (proud of what I have done). But I still say it's **by the grace of God** and I really do. I could never have done it on my own – never.*

Beth believes that if it were not for the grace of God, '*I would have relapsed. You know I would have gone back, I would have had moments of trials and tribulations and I haven't'*.

In a state of complete desperation when arrested in jail, Don turned to God:

> *I found God in jail. I decided that if He is the only one going to get me out of this, then it's worth trying it out to see what it's like. So I've been going to church ever since and that helps.*

As a result, Don developed a relationship with God and with other believers too:

> *The people at church are good people. They talk to you about it, obviously pray with you about it. They just good solid people, and if I ever have slip ups I will talk to them before I speak to any of my friends.*

Plummer maintains that stories come out into the open when communities are willing to hear such stories. "For stories to flourish there must be social worlds waiting to hear" (Plummer, 1995, p. 121). We can assume that for Don, his church community are obviously open to hearing his narrative and provide the space for healing and recovery.

Anna believes that her recovery is now dependent on the fact that she is a Christian, citing '*Jesus'* as the most important factor in helping her to overcome her addiction without formal treatment. Later in the interview, she again perceives God to be instrumental in her recovery:

> *Deborah:*
> *What other things made recovery even harder?*
> *Anna:*
> *Um. I don't think I found it that hard.*
> *Deborah:*
> *Okay. That's great.*
> *Anna:*
> *Because ja my opinion is just that* ***God was completely instrumental in it****, and um even to go from the drugs to alcohol was all part of it, and it was part of me coming clean completely and through that He bought me here to this church. I have got so many friends now, its ridiculous. People who really genuinely care.*

In terms of overcoming her addiction and finding meaning in life, Tessa also talks about how her life has changed since she '*became a Christian*' and how her recovery has become easier:

> *So its 4 years because the first year I relapsed so I don't count that. But I try not to think about the years and count the days I just know that it's a formal decision that I made. I do know that drugs always had a hold on me and* ***the moment that I became a Christian in Feb 2005****, when I go through my bad times or when I go out and have fun and enjoy myself* ***I don't have that nagging voice in the back of my head saying you know, 'to go buy some cocaine would be nice'****. You know I always had that in my head even though I had stopped I had made a decision to stop, I always had that nagging voice. So I would think to go out and get high would be nice but* ***since I became a Christian last year its like I still get depressed and go through times when life is just so overwhelming but I don't have that desire to ever want to go down that road um, I turn to God now so my life has really changed from that perspective****.*

In describing her relationship with God, Tessa says ***"I don't need, I don't feel the need to fill something… It's like it's been filled"***. She believes that her relationship with God has filled the hole that the drugs filled before. Narratively, she indicates an absolute replacement of drugs with Christianity. Tessa says that '***having that hole filled***' has been ***'a very strong point in a sense of um, being content'***.

The use of the words '*being content*' stands in binary opposition to the *'discontent'* and chaos she describes as being entrenched in her addiction.

In reviewing the power relations at play, perhaps participants draw on sets of Christian discourse in an attempt to move away from the oppositional set of discourses embedded within society – discourse which constructs shame, ideas of excessive, disordered consumption, sin and even 'evil' around the concept of 'addiction'.

Discourses of Christianity stand in contrast to the condemnation perceived to be in dominant modernist narratives. Christianity discourse offers notions of grace, forgiveness and the opportunity to be 'a new creation in Christ'. The 'old self' and

the stigma of the past dies with Christ on the cross and so individuals can be freed from its negative power. Tessa articulates this construction in the following extract when she speaks about God giving her '*a new life*':

> *I realized for the first time that Jesus had died for me on the cross and that He had paid for my sins and that He would accept me just the way I was. And all I had to do was turn to Him and ask for forgiveness and that He would give* ***me a new life and He did. So ja. It was an amazing path****. I would definitely recommend it. It doesn't take away the problems, any problems in life are still there.*

Victor Frankl, in his seminal book, Man's Search for Meaning (1984), maintains that addiction is due to what he calls "the existential vacuum", a feeling of emptiness and meaninglessness. Whether it is through spirituality, work or love, each participant narrated a story of finding new meaning in his or her life that could well have played a role in curtailing "the existential vacuum", and overcoming addiction.

Chapter Five: Discussion and Conclusions

"The point is not a set of answers, but making possible a different practice"

Susanne Kappeler, The Pornography of Representation (in Gergen, 2005, p. 227)

The discussion attempts to consolidate the narrative analysis. It also aims to explore how these narratives can be seen as social actions embedded in social worlds.

5.1 Narrative as Genre and Content: Conclusion

This study explored both the **whats** and the **hows** of the way in which narratives of self-managed change were told. The first section of the analysis looked at the content and structure of meaning as articulated through social interaction and mediated by culture. It aimed to answer the following questions:

- What type of narrative genre (or culture story models) were utilized by participants?
- What happens in the story? What are the spheres of meaning in narratives of overcoming addiction without formal treatment?
- What facilitates the process of self-managed change?

The analysis revealed that each participant drew upon a very different cultural story. In each case, the cultural story provides a focus around which coherence and a sense of continuity can be built (despite the clear divisions between past and present). Jeff's story is a love story in which love conquers all; Max is the hero with the tragic flaw who manages to conquer his weakness through his own inner strength. Both of these stories are highly individual yet resonate clearly with strongly entrenched cultural genres. Tessa finds spirituality in order to fill the hole inside herself and Beth receives grace through a church recovery programme. Although different, Tessa and Beth draw upon genres of religion and of salvation (through recovery or through saviour from self). The genres employed by Anna and Don seem to relate more to modern genres of psychology and science: stories of co-dependence and depression or of crisis and turning-point.

In considering what the deployment of these genres offer us in terms of understanding the process of self-managed change, it becomes clear that each person is drawing upon well-established and readily available genres to sustain their stories, but that happy-ending is crucial. This suggests the richness of opportunity around which narratives of self-managed change may be constructed.
The spheres of meaning offered by the genres employed by participants clearly enable the maintenance of narratives of change and constructions of self. It is also clear, however, that the genres offer particular spheres of meaning as well as particular rules. For example, in the causal sphere, participants constructed the meaning of addiction in a variety of ways: as compensation for the lack of love; as a disease; or, as a phenomenon caused by secrecy and repression in childhood; or, low self esteem and insecurity; or by oppressive relations. The genres offered by participants are strong and include clear moral assessments.

In exploring what facilitates the process of self-managed change, three main characteristics related to overcoming addiction emerged. First, participants made a concerted effort to avoid drugs and/or alcohol as well as related social cues that stimulate the desire to use or drink. Secondly, although most participants proclaimed they were ultimately responsible for their own process of self-managed change, they did acknowledge the importance of support received from others (partners, family or friends). These relationships seemed crucial to constructions of a new self. Such constructions evolved as a result of interactions with others through which participants created new meaning. This point brings me to the final factor that seems to facilitate self-managed change – that participants discover a sense of meaning in their lives. For Max, meaning came from pursuing his career and marriage, for Jeff meaning came from his new girlfriend and the home they created together, for Don, meaning came from being a husband and father, as well as from his church friends. Beth, Anna and Tessa attribute their sustained recovery to their religion, and belief in God.

The second part of the analysis – narrative as social construction and action – demonstrated that these meanings and the related process of self-managed change occurs interactionally within a stream of power and complex social relations.

5.2 Narrative as Social Construction and Action: Conclusion

The second section of the analysis pursued ***how*** questions emphasizing how participants constructed key narrated elements, a sense of self and meaning making in the social world. It aimed to answer questions such as the following:

- ***How*** do participants construct addiction?
- ***How*** do participants construct formal treatment?
- ***How*** do participants construct self?
- ***How*** do participants construct recovery?
- ***How*** do the narrators experience telling their story?
- ***How*** can these narratives bring about social action?

Consolidating the analysis on how participants constructed the different themes that emerged from the narratives is a difficult task, as constructions are varied and richly nuanced. This is the valuable nature of qualitative research within a social constructionist perspective. There are however a few broader reflections worthy of consideration. Each participant mentioned briefly how they started drinking or taking drugs – mainly for social reasons – yet there was a conspicuous absence of narrative around how their drinking and drug-using habits moved from being recreational to addictive. The narratives included some kind of a turning point which acted as a 'wake-up call' and kick-started the process of self-managed change. Most participants avoided seeking formal treatment as they lacked faith that it would indeed help them, or because they believed they had the resources (personal and social) to overcome their addiction on their own. Beth attended a 12 step course at her church (a religious organisation and therefore not classified as formal treatment in this study). It was fascinating to contrast her narrative and her recovery process with that of the others. For the 12 step programme to be effective, it required that Beth come to terms with the fact that she has a disease, that she is powerless and that she is an alcoholic for life – incorporating this into her sense of self has clearly been a painful and shameful process. The fact that the other participants maintained an identity that distanced them from their previous excessive use raises some compelling questions about the possible damaging effects of treatment programmes on an individual's self concept.

Language played a critical role in how participants constructed their sense of self in the past and in the present. Constructions of a new self resonated with an

increased sense of self efficacy, agency and empowerment. A set of binary oppositions operated in a powerful way in the narratives, for example, between good/bad, structure/chaos, autonomy/loss of control, real/false and secrecy/openness. Perhaps the dualism which was the most striking of all arose from the tension between empowerment and shame.

Each narrative flows within a stream of power. The stream of power is both empowering and repressing. This was most clear in exploring how the narrators experienced telling their story. Through opening up a safe space that allowed participants to speak about how they had managed to overcome their addictions without formal treatment elicited a sense of pride and self-respect. The opportunity to tell their story was indeed empowering.

The experience of empowerment was magnified since opportunities to speak out are limited. This is where the shame flows - there are few spaces where participants' stories can be told. Their voices are silenced in most arenas of life. Because of the grand narratives that dominate conventional views on addiction in our social world, the counter-narratives of individuals overcoming addiction without formal treatment don't seem to fit. Through succeeding in overcoming their addictions, the participants gain the kudos of having done it alone, yet these individuals are viewed as being deviant from the norm (albeit a special deviance). Their narratives are thus marginalized. Through contesting discourses, this research (both in the literature review and the analysis) has attempted to expose some of the pillars upon which the shame and marginalisation rests.

Overall, this study seeks to mobilize resistance against the dominant narratives of addiction. It challenges the presuppositions that formal treatment is necessary. It demonstrates the power that individuals can have over the substances to which they become addicted. In overcoming addiction, a process of self-managed change is possible, and it is worthy of broader societal consideration.

5.3 Final Comments

It seems that as there are multiple pathways into addiction, so there are multiple pathways out of addiction. The narratives in this study illustrate that the process of self-managed change is indeed a pathway to overcoming addiction.

The results of the analysis show that there are a plethora of possibilities with regards to the type of narratives available on the process of social-managed change. The different genres provide individuals overcoming addiction without formal treatment with tools to constitute themselves and their stories in a positive way. They provide support, and give individuals a sense of superiority and pride that 'they've done it on their own'.

However, the process of self-managed change, as demonstrated by participants, does not occur in isolation. Instead personal transformation is a social product that is greatly influenced by the situational social world in which an individual is located. As discussed in this report, these counter-narratives challenge the dominant discourse that addiction requires cure through formal treatment and thus the voices of those who have managed to do it 'on their own' are silenced.

This research broke a silence. It is recommended that further research is conducted to shed light on the betwixt-and-between place that those overcoming addiction through self-managed change find themselves. The findings of such research should be made available in professional and public forums. For example, I hope to present this research at a SACENDU meeting and aim to have it published in leading journals in the addiction field. Addiction journals (*Addiction, Drug and Alcohol Review, Addiction Research and Addiction)* should be encouraged to adopt policies and practices that will encourage more qualitative submissions on the whole but particularly around overcoming addiction without formal treatment.

Through opening up dialogue around this topic, it is hoped that a language will emerge around the phenomenon of self-managed change. It is through language that overcoming addiction without formal treatment will become a possibility for many more individuals.

Increasing the possibility and therefore the likelihood of individuals overcoming addiction without formal treatment in South Africa stands to benefit our society in a number of ways. For instance, there are **lower costs** associated with overcoming addiction without formal treatment. The process of self-managed change facilitates an **increased sense of self efficacy** that is associated with solving problems unaided by conventional interventions. The strategies used by individuals and the results of their efforts to overcome their addictions without entering treatment personify many of the elements of **individual empowerment**. This sense of empowerment is accompanied by an increased sense of agency and control. Furthermore, it seems that by circumventing formal treatment, individuals are more protected from being subjected to 'addict' identities (Granfield and Cloud, 1999).

On a broader scale, benefits such as these and the reality of overcoming addiction without formal treatment calls for a reappraisal of current drug and alcohol strategies in South Africa that are more supportive of the self-managed change process[2].

Strategies of this nature would heed Gergen's call and thus facilitate the mounting of ***'a collective refusal'*** against the domination of narratives around addiction as disease that requires cure through formal treatment (Gergen, 2005, p. 40).

In conclusion, I agree with Gergen (2005, p. 40) when he writes the ***'dysfunctional disciplining of the population must end'***. For individuals who have overcome an addiction without formal treatment through a process of self-managed change, it is hoped that their voices will no longer be silenced and that…

> **Their private pains will increasingly become public ones;**
> **Their personal sufferings will become collective participations;**
> **Their pathological languages will turn to political ones.**
>
> **(Plummer, 1995).**

[2] It should be pointed out that since the sample of participants in this study probably does not represent the larger 'overcoming-addiction-through-self-managed-change' population, my conclusions are speculative. However while this data lacks the breadth of larger statistically based investigations, like other qualitative studies its strength lies in its ability to capture the deeper meaning and context of human experience. Because of the depth associated with qualitative studies like this one, consideration of broader implications is a legitimate and valuable exercise.

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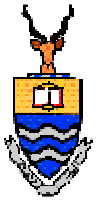
Appendices

Appendix A

Participant Information Sheet



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My name is Deborah Pryce, and I am conducting research for the purposes of obtaining a Psychology Masters Degree at the University of the Witwatersrand. I am interested in finding out more about overcoming addiction without formal treatment. I therefore wish to invite you to participate in this study.

Participation in this research will entail being interviewed by myself, at a time and place that is convenient for you. The interview will last between one and a half and two hours. With your permission this interview will be recorded in order to ensure accuracy.

Participation is voluntary, and no person will be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. All of your responses will be kept confidential, and no information that could identify you would be included in the research report. The interview material (tapes and transcripts) will not be seen or heard by any person in this organisation at any time, and will only be processed by myself. You may refuse to answer any questions you would prefer not to, and you may choose to withdraw from the study at any point.

Telling me your story may elicit emotions, so should you require someone to talk to after participating in the study, please make use of Life Line on 011 725 1347 or 0861 322 322 (toll free).

If you choose to participate in the study please fill in your details on the form below and email it back to me at deb@pryce.com. If you would like to participate, I will contact you within two weeks in order to discuss your participation. If you have any questions regarding the research, please feel free to call me on 082 452 0117.

Kind regards

Deborah Pryce

Appendix B

Interview Consent Form

I have read and understood what the above-mentioned research project is about. I consent to being interviewed by Deborah Pryce for her study on overcoming addiction without formal treatment. I have stopped (*relevant addictive behaviour e.g. using alcohol or drugs*) without treatment for at least one year.

I understand that:

- Participation in this interview is voluntary.
- That I may refuse to answer any questions I would prefer not to.
- I may withdraw from the study at any time.

No information that may identify me will be included in the research report, and my responses will remain confidential.

Participant Code: _____

Signature: _____

Date: _____

Name of Researcher: _____

Signature: _____

Date: _____

Appendix C

Audiotape Consent Form

I have signed the consent form agreeing to participate in the above-mentioned research project.

I understand that the researcher, Deborah Pryce, has asked my permission to record the interview on to audiotape. This is to aid transcription of the interview.

I understand that:

- The tapes and transcripts will not be seen or heard by any person in this organisation at any time, and will only be processed by the researcher.
- All tape recordings will be destroyed after the research is complete.
- No identifying information will be used in the transcripts or the research report.

I hereby give my permission for my interview with the researcher to be recorded on audiotape.

Participant Code: _____

Signature: _____

Date: _____

Name of Researcher: _____

Signature: _____

Date: _____

Appendix D

Questionnaire: Demographic Information

Participant Code:		
Age in years:		
Gender:		
Racial Group:		
Level of Education Reached:		
Marital Status:	Single:	
	Married:	
	Divorced:	
	Separated:	
	Living together:	
	Other (specify):	
Employment Status:	Employed:	
	Unemployed:	
	Self-employed:	
	Retired:	
	Part-time work:	
	Student:	
	Other (specify):	
Occupation:		

Appendix E

Basic Interview Schedule

1. Would you like to tell me about your experience in overcoming your addiction?

The following questions will be used as prompts when necessary if the participant does not freely offer the information in the course of telling their story. They will not be asked in any particular order, but will follow the structure of how the participant tells their story:

2. Could you tell me more about your family background?
3. Can you describe your addiction to me.
4. How dependent would you say you were on (*addictive behaviour*)?
5. May I ask you to describe why you think you became addicted to *(addictive behaviour)* in the first place?
6. Was there a significant "turning point" on your road to recovery?
7. What were the reasons for and factors influencing your recovery?
8. Would you like to tell me some more about your recovery as you see it?
9. What are some of the things you have found helpful to maintain your recovery?
10. What made recovery even harder?
11. What were your reasons for not seeking formal treatment?
12. Do you participate in (*addictive behaviour*) at the moment? (Explore)
13. How would you describe your physical health both now and in the past?
14. How would you describe your psychological wellbeing both now and in the past?