

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

# **Alcohol, Drug, Well-being and Recovery in New Zealand**

A thesis presented in partial fulfilment of the requirements of the  
Master of Philosophy

Massey University, Palmerston North, New Zealand

Dale Smith

2012

## **Abstract**

Addressing dependence on alcohol or drugs involves much more than merely stopping heavy drinking or drug use. National and international literature shows that there are many dimensions to recovering from alcohol or other drug dependence (AOD). Though some of these aspects have previously been explored in detail there is still insight to be gained about what makes recovery from alcohol or other drug dependence possible. One of the fundamental questions that warrants exploration is: what enables people with AOD dependence to achieve and maintain abstinence and improve their well-being, in the first two years, within the New Zealand context?

This thesis explored, in detail, the lifestyle changes of 11 New Zealanders with two years or more of abstinence-based recovery from alcohol and/or other drug dependence. In particular, it examined what they perceived were the necessary lifestyle ingredients to maintaining abstinence and improving their quality of life. These lifestyle changes happened within a recovery community context that supported their need to have belonging, relating, meaning and purpose.

More specifically, the key recovery ingredients for this recovery population were found to be: identifying with other people with AOD, following a structured recovery programme (12-steps), processing challenging emotions, developing high levels of self-honesty, building relationships with other recovering people, serving others, managing alcohol and drug saturated environments, experiencing higher power encounters, and establishing hobbies, interests, and fitness routines.

Involvement in these dynamic recovery communities resulted in a number of behavioural changes and shifts in participants' outlook on life that could otherwise take years of counselling or therapy to achieve.

The treatment field has a lot to learn from these rich community-based alcohol and other drug recovery fellowships; a number of implications and recommendations for alcohol and other drug treatment professionals have been identified.

“it was magical... being part of a really big WE” (study participant)

## **Acknowledgments**

I would like to show my special appreciation to a number of people who made this study possible. Firstly, the study participants who took time out of their busy lives to share their experiences of their first two years of pursuing an abstinence-based recovery lifestyle from alcohol, other drugs or both. I would especially like to show my appreciation to my supervisors Dr Gretchen Good and Dr Marg Gilling of Massey University who continued to support, challenge, and direct me throughout this thesis. I would like to show my appreciation to my wife Michelle, my children Danielle and Ben, my mother, father, and brother for their on-going support throughout my continued educational pursuits. My further appreciation goes to the Trust Board of Capri Hospital who granted me study leave to complete this thesis.

## Table of Contents

Abstract .....	1
Acknowledgments .....	2
<b>Chapter One: Thesis Introduction .....</b>	<b>8</b>
1.1 Introduction.....	8
1.2 Research Aims .....	8
1.3 The Research Question.....	8
1.4 Brief Overview of Research Process Taken.....	8
1.5 Background Information on Alcohol and Drug Use in New Zealand .....	9
1.6 Political Background to AOD Problems .....	10
1.7 Origins of Dependence on Mood Altering Substances.....	11
1.8 Number of People Accessing Alcohol and Drug Services in New Zealand, and Therapeutic Modalities Used In Treatment .....	12
1.9 Current Diagnosis Criteria of Dependence on Mood Altering Substances.....	13
1.10 Researcher's Personal Bias .....	14
1.11 Terms Used .....	14
1.12 Summary and Review of Introduction.....	14
1.13 Structure of this Thesis.....	15
<b>Chapter Two: Literature Review on Alcohol and Other Drug Recovery .....</b>	<b>16</b>
2.1 Introduction.....	16
2.2 Alcohol or Other Drug Dependence (Addiction) .....	16
2.3 Why do people choose to get help or address their AOD problems?.....	17
2.4 Societal Views .....	17
2.5 Alcohol and Drug Treatment.....	18
2.6 Recovery .....	21
2.7 The Ambiguity of the Meaning of Recovery.....	22
2.8 Individual Perspectives of Addiction Vary.....	23

2.9 The Ministry of Health Perspective of Recovery.....	23
2.10 USA Study Defining Recovery.....	24
2.11 Longitudinal Recovery Study.....	25
2.12 Maintenance Factors in Recovery .....	26
2.13 Recovery-Supportive Groups .....	26
2.14 Spirituality and Identity .....	31
2.15 Higher Power.....	32
2.16 Natural Recovery .....	33
2.17 Fitness .....	33
2.18 Skill Development.....	34
2.19 Challenges of Early Recovery .....	35
2.20 Relapse .....	36
2.21 Well-being.....	37
2.22 Cultural Maori Perspectives.....	37
2.23 Change Theories and Models .....	38
2.24 Theories that Describe the Recovery Process .....	38
2.25 Literature Review Summary and Conclusion .....	39
<b>Chapter Three: Research, Design and Methods.....</b>	<b>43</b>
3.1 Introduction.....	43
3.2 Research Methodology.....	43
3.3 Limitation of Existing Research .....	44
3.4 Brief Research Methods Chosen.....	44
3.5 DSM-IV Dependence Self-Screening Tool for Participants in the Study .....	45
3.6 Participant Questionnaire .....	45
3.7 Focus Groups & Principles of Focused Conversations .....	45
3.8 Journals .....	46
3.9 Photo Voice .....	46
3.10 Audio Recording of the Focus Groups .....	46

3.11 Sample Selection.....	47
3.12 Inclusion and Exclusion Criteria .....	47
3.13 MUHEC Approval .....	47
3.14 Protection of 12-step Group Anonymity.....	47
3.15 Commitment to the Treaty of Waitangi .....	48
3.16 Thematic Analysis .....	48
3.17 Data Analysis.....	49
3.18 DSM-IV AOD Dependence Self-screening Tool Results.....	52
3.19 Characteristics of the Study Participants.....	53
<b>Chapter Four: Research Findings.....</b>	<b>55</b>
4.1 Introduction.....	55
4.2 Focus Group Recovery Areas Identified.....	55
Acceptance of AOD problems & first steps to getting help.....	55
Higher Power and Spirituality.....	57
Recovery Fellowships .....	58
Sponsorship .....	59
Relationships with Others including those still using AOD .....	60
Working a Programme, Addressing One’s Egocentricity .....	61
Helping Others .....	63
Managing Feelings.....	64
Routine, Including Hobbies and Interests.....	66
Impressions from Focus Groups .....	66
4.3 Findings From Photos .....	67
4.4 Findings from the Journals .....	72
<b>Chapter Five: Discussion .....</b>	<b>73</b>
5.1 Introduction.....	73
5.2 Focus Group Findings .....	73
Acceptance of a AOD Problem .....	73

Working a Programme .....	81
Hobbies, Interests, & Exercise .....	87
Other areas of consideration .....	88
5.3 Journals and Cameras .....	89
5.5 ADWRNZ Model .....	89
5.6 Personal Application of Study Findings .....	92
5.7 Benefit of Focus Groups .....	92
5.8 Conclusions .....	92
<b>Chapter Six: Limitations, Conclusions, Implication and Recommendations .....</b>	<b>94</b>
6.1 Introduction .....	94
6.2 Limitations of Study .....	94
6.3 Conclusions .....	95
6.4 Implications of this Study Findings for Treatment Professionals .....	97
Misconceptions and stigma .....	97
Confrontation .....	98
Identification with others with AOD problems .....	98
Education about addictive disease .....	98
Problem recognition .....	98
Spirituality .....	99
Honesty about the realities of early recovery .....	99
Acceptance and surrender .....	99
Cognitions, behaviour, social support and emotions .....	100
Vigorous self-honesty about one's vulnerabilities .....	100
Relapse .....	100
A way of living .....	100
Helping others .....	100
Developing or re-establishing hobbies and interests .....	101
Theoretical understandings and models .....	101

Recovery ingredients.....	101
Training .....	102
Passing on information gained from this study.....	102
Utilising 12 step community resources.....	102
Model of recovery .....	103
6.5 Recommendations.....	104
<b>References .....</b>	<b>107</b>
<b>Appendices .....</b>	<b>121</b>
Appendix A. Glossary of Terms (working definitions).....	121
Appendix B. ADWRNZ Study Pack .....	122
Appendix C. The 12 Steps.....	134
Appendix D. Journal findings.....	135
Appendix E. Example of focus groups A1 sheets.....	141
Appendix F. Supporting Letter .....	142
Appendix G. Confirmation of Ethics Approval .....	144
 <b>List of Tables and Figures</b>	
Table 3.1.....	52
Figure 2.1.....	41
Figure 5.1.....	91

## **Chapter One: Thesis Introduction**

### **1.1 Introduction**

How important is it for people who are dependent on alcohol and/or other drugs to develop a recovery lifestyle, versus merely attempting to abstain from problematic alcohol or other drug use? This thesis explored this and other relevant questions regarding abstinence-based recovery in the New Zealand context.

This chapter includes the aims of the study, the research question, and a brief overview of the process undertaken to answer the research question. It also explores background information about the use of alcohol and other drugs (AOD) in New Zealand, including, but not limited to, the negative impacts of AOD misuse and possible factors in developing AOD problems. It will also outline the number of people in New Zealand accessing help for AOD problems, and the current diagnostic criteria for alcohol and other drug dependence (addiction). Furthermore, it will detail a brief summary of, and conclusions resulting from, the literature review regarding AOD addiction recovery.

### **1.2 Research Aims**

The aim of this study is to help people in recovery from AOD dependence, and the health professionals who work with them, by improving understanding of abstinence-based recovery experiences within the New Zealand context, and by exploring how this improved understanding can inform AOD philosophy, policy, and practice.

### **1.3 The Research Question**

The research questions posed is, what enabled a small group of people with AOD dependence to achieve and maintain abstinence and improve their well-being in the first two years within the New Zealand context?

### **1.4 Brief Overview of Research Process Taken**

A full literature review was completed, then qualitative research methodology and methods were employed to address the research question. These included focus groups, questionnaires, journals, and cameras to retrospectively capture the first two years of study participants' recovery experiences. Thematic research methods were then applied to analyse the data gathered. Finally, the findings were compared and contrasted with existing literature and then recommendations for treatment professionals have been outlined (see Chapter Six).

## 1.5 Background Information on Alcohol and Drug Use in New Zealand

The Alcohol Advisory Council of New Zealand (ALAC), collaborating with the Ministry of Health, New Zealand Police, and the Accident Compensation Corporation (2010), states that eight in 10 adults consumed alcohol at least once in the previous year. Three in five people consumed more than the recommended amount in a single drinking session, with 17.7% of adults 15 years or older drinking in a potentially hazardous manner exceeding ALAC's recommendation of a total of six standard alcoholic drinks for males and four for females on a single drinking occasion, and 14% of New Zealanders meeting the criteria for a substance use disorder (2010). Binge drinking has had a significant amount of attention in the media. Of people aged 16 to 17, 77.2% of women and 65.4% of men had engaged in binge drinking behaviour in the previous year, as did 80.7% of men and 80.5% of women aged 18 to 24, and 77.1% of men and 71.4% of women aged 25 to 34 (2010).

The findings from the Drug Use in New Zealand Survey 2007/8 also showed that the percentages of people using drugs in that 12 month period was: 46.4% used cannabis; party pills 13.5%; hallucinogens 7.3%; amphetamines 7.2 %; kava 6.3%; and ecstasy 6.2% (Mason, Hewitt & Stefanogiannis, 2009).

The negative effects of excessive AOD use are well documented. In July 2011 the National Committee for Addiction Treatment's (2011) position paper stated that one in three people are negatively affected when a person misuses alcohol or other drugs. This includes 62,000 physical assaults and 10,000 sexual assaults each year. Furthermore,

overall, about one in five past-year drug users (18.6%) reported ... harmful effects in the past year due to their drug use. Among past-year drug users, the most commonly reported harmful effects ...[were their] financial position (10.8%), friendships or social life (8.5%) and home life (8.4%). Furthermore, 7.2% of past-year drug users reported having had one or more days off work or school in the past year due to their drug use (Mason, et al. 2009, p. 196).

ALAC adds that "the New Zealand Health Survey [2007/8] found that 17.7% of us are hazardous drinkers... at least 31% of recorded offences were committed in circumstances where the offender had consumed alcohol prior to committing the offence. (NZ Police, 2009, p. 24)" (Alcohol Advisory Council of New Zealand, 2011, p. 1).

Use of alcohol and/or other drugs was a factor in 103 fatal car accidents and 441 car accidents causing serious injury in 2008 (Alcohol Advisory Council of New Zealand, et al., 2010).

Furthermore, ALAC states “In the analysis of mortality, we estimated that 3.9% of all deaths in New Zealand in 2000 were attributable to alcohol consumption (approximately 1040 deaths)...[with] 17,200 years of [New Zealanders’] life estimated to be lost as a result of alcohol misuse” (Alcohol Advisory Council of New Zealand, 2005, p. 6).

The estimated costs of alcohol and other drug related harm vary. Slack, Nana, Webster, Stokes and Wu (2009), reporting to the Ministry of Health and ACC, estimate the total social cost of harmful drug use in New Zealand in 2005/06 to be \$6,525 million, with the cost of diverted resources for harmful alcohol use estimated to be \$4,437 million. Slack et al. (2009) estimated that harmful alcohol use from 2005/6 alone cost the nation \$4.9 billion. What can be concluded is that the cost of AOD misuse is significant to the New Zealand community.

## **1.6 Political Background to AOD Problems**

The dominant approach in the treatment of AOD problems in New Zealand is harm minimisation (Ridder, Mohr & Health Research Council of New Zealand, 2003). This means that the focus of interventions is to reduce the harms caused by AOD use. The New Zealand Minister of Health stated that the purpose of the National Drug Policy 2007-2012 “is to prevent and reduce the health, social and economic harms that are linked to tobacco, alcohol, illegal and other drug use” (Ministry of Health, 2007, p.1). However,

A harm minimisation approach does not condone harmful or illegal drug use. The most effective way to minimise harm from drugs is not to use them. The harm minimisation approach does recognise that where eliminating high-risk behaviours is not possible, it remains important to minimise the personal, social and economic costs associated with those behaviours. Harm minimisation encompasses a wide range of approaches, including abstinence-oriented strategies and initiatives for people who use drugs. It also considers the impact of the illegal status of some drugs on the people who use them (Ministry of Health, 2007, p. 6).

There is debate about the effectiveness of harm minimisation as the dominant approach to dealing with AOD problems. Gardiner (2006) writes “if harm minimisation, which has been the only approach for the past 20 years, is working so well – why are we one of the

highest drug-using nations in the world?” (p. 1). Community Alcohol and Drug Services (CADS) who utilise a harm minimisation approach state that they do not oppose abstinence-based approaches to AOD problems, but that for many people reducing and better managing their AOD use is a more appropriate intervention (Community Alcohol and Drug Services, 2011). The harm minimisation versus abstinence of problem-causing substances debate is also an international one. McLennan (2011), reported on a working group instigated by the Betty Ford Center consisting of clinicians, policy makers, family members, and recovery advocates convened to define the term ‘recovery’ in the AOD setting. After much debate, the consensus was that harm reduction approaches were not a valid form of AOD recovery, and that only those who were abstinent could be viewed as in recovery from AOD dependence (McLennan, 2011). Further discussion of what ‘recovery’ is and involves is explored in Chapter Two of this thesis.

### **1.7 Origins of Dependence on Mood Altering Substances**

The literature is inconsistent in understanding why people develop AOD dependence (addiction). Galanter and Kleber (2008) explain that “It is generally understood [that dependence is] a disease with genetic, psychosocial, and environmental underpinnings” (p. 29). Hester and Miller (2003) dispute the disease model and point out that there is still much debate about the disease concept of abuse and dependence.

They further state that there are a number of alternative perspectives regarding the cause and best treatment of these disorders. These include moral, temperance, spiritual, educational, character logical, conditioning, social learning, cognitive, systemic, socio-cultural and public health theories and models. Chan, Cardoso and Chronister (2009) concur that all theory is limited in explaining the complexities that are involved in the phenomena called substance abuse or dependence both individually and environmentally.

International studies have also highlighted the role that earlier life stress has as a factor in the development of substance-use disorders (Simpson & Miller, 2002). Enoch (2011) found that when compared to adolescents, pre-pubertal children were more susceptible to chronic stress, leading to the increased likelihood of developing AOD problems in early adulthood. However, genetics and environmental factors can act to moderate the development of AOD problems.

A New Zealand Dunedin-based study consisting of 981 participants, which explored the role of an individual’s family history (depression, anxiety disorder, alcohol dependence,

drug dependence) in developing a mental health disorder, found that “family history was associated with the presence of all 4 disorder types. In addition, family history was associated with a more recurrent course for all 4 disorders” (Barry, Avshalom, Honalee, Richie, Michael & Terrie, 2009, p. 1).

Enoch (2011) stated that the negative effects of alcohol and drug dependence impact on all aspects of society. Furthermore, he cites Hasin et al. (2007), and asserts that the lifetime occurrence of dependence is 30%; and when citing Goldman et al. (2005), says that genetics account for 50% of all people presenting with alcohol dependence, and up to 70% for cocaine and opiate dependence. Enoch (2011) also points out that because of this both environmental and genetic factors are equally evolved in the prevalence of AOD dependence.

Hoffman and Froemke (2007) point out that there had been new developments in perceived causes of AOD problems supporting the disease model. These came about as a result of PET scans of the brain, which allow researchers to see physical changes in brain function. In AOD dependent people, significant biochemical changes are seen in the reward centre of the brain (mesolimbic dopamine system) compared to people not dependent on alcohol and other drugs (social substance users). These changes in the brain are believed to contribute to the increasing compulsion and obsession to seek alcohol and other drugs in people with AOD related problems. This discovery has even led to proposing a new definition of addiction as a brain disease rather than a mental health disorder. Professor Doug Sellman (2011), a key New Zealand researcher on alcohol and drug issues, states that, after many years of debate, recent findings about brain activity have led him to viewing addiction as a brain disease.

### **1.8 Number of People Accessing Alcohol and Drug Services in New Zealand, and Therapeutic Modalities Used In Treatment**

“According to a 2004 New Zealand Mental Health Service Use Survey... [a] total number of 18,080 clients are seen by alcohol and drug teams per year. Of these, the majority were male (11,354 male clients compared to 6726 female clients)” (Alcohol Advisory Council of New Zealand, 2011, p. 1). These statistics do not include private treatment providers or community organisations such as 12-step groups. However, Baker, Sellman and Horn (2006) state that 12-step fellowships in New Zealand are estimated to have 5000 attendees with 430 registered groups operating.

Adamson, Sellman, Deering, Robertson and De Zwart's (2006) research also gathered data on 383 people accessing treatment from a number of treatment providers in New Zealand and found 65% were male, 32% Maori, with the mean age of consumers being 34. Consumers with alcohol problems made up 47% of the people accessing services, cannabis problems 24%, opiate problems 15%, and amphetamines 10%. Amphetamine use displayed the most significant rise with zero use recorded in 1998.

The Alcohol Drug Association New Zealand (2011), in their national addictions treatment directory, list a number of approaches used within AOD services throughout New Zealand. These approaches include: Motivational Interviewing, Cognitive Behavioural Therapy, 12-step Orientation, Client Centred Practice, Community Reinforcement, Harm Minimisation, Abstinence, Cultural Perspectives, Relapse Prevention, Family Inclusive Practice and Therapeutic Community based models.

### **1.9 Current Diagnosis Criteria of Dependence on Mood Altering Substances**

Alcohol and other drug use can be classified into four types under the Diagnostic and Statistical Manual of Mental Disorders edition 4 (American Psychiatric Association, 1994); edition 5 is due for publication May 2013 (Kupfer & Regier, 2010):

- People who are non-users
- People who use in a social manner without negative consequences
- People who abuse alcohol or other drugs and have negative consequences, however are able to moderate their consumption and therefore reduce resulting consequences
- Those who are dependant (addicted), who are unable without support to moderate their consumption of alcohol and/or other drugs and therefore experience repetitive negative consequences

The criteria for substance dependence (addiction) classified in the Diagnostic and Statistical Manual for Mental Disorders IV (DSM-4) includes: increased tolerance, withdrawal, loss of control over use of the substance, recurring desire to cut down or stop, preoccupation with drinking or using, the abandoning of important social obligations and continued use despite adverse consequences (American Psychiatric Association, 1994).

This study design included only participants with dependence to alcohol, other drugs, or both as defined in on page 53; AOD dependence is explored in more detail in Chapter Two.

### **1.10 Researcher's Personal Bias**

After working in the rehabilitation field for nine years as a rehabilitation counsellor and then a hospital director (with six of those years working with consumers with AOD dependence), this question has arisen: What elements are needed to develop a recovery lifestyle, not merely abstinence from substance use? Some say a recovery lifestyle means staying away from risky situations and attending some form of support meeting regularly. However, supported by the literature reviewed (see Chapter Two), the researcher's professional experience is that for many people in recovery, much more is involved.

It is also the researcher's belief that having experience as a treatment provider in the AOD sector in New Zealand provides a unique research opportunity. The researcher will be able to review the study findings in light of applications to the treatment setting with a level of objectivity not influenced by any personal recovery experience. The term 'level of objectivity' is used because the researcher also acknowledges the presence of pre-existing biases based on the differing approaches he has utilised.

It is important to note that the researcher's Social Science (Social Work) undergraduate training has shaped his perspectives on the importance of social systems to people's overall well-being.

### **1.11 Terms Used**

There are a number of terms used throughout this thesis that may have different meanings to different people. Because of this Appendix A has been added, entitled 'working definitions', to ensure the intended meaning of these terms is understood.

### **1.12 Summary and Review of Introduction**

After a review of background information and literature on AOD recovery (explored in Chapter Two), it was discovered there is a lack of information on this topic. Literature does provide data on individuals during the assessment and intervention phases of treatment, and the effectiveness of that treatment, but not about specific lifestyle changes recovering people themselves make to enhance their on-going recovery. In addition, specific literature about what recovery from AOD dependence involves from a consumers' perspective in the New Zealand context appears absent. International studies do provide some insight into the recovery experience but, due to their geographical location, the validity of their findings is unknown in New Zealand. Currently, people wanting to know what is involved in an

abstinence-based recovery lifestyle from AOD dependence have to rely on information given by recovering people they may meet, support groups such as Alcoholics or Narcotics Anonymous, information on the internet, and the health professionals that work with them. Because of this, there is merit in completing a study that focuses on what recovery and well-being involves in the first two years of pursuing an abstinence-based recovery lifestyle from a consumer perspective in the New Zealand context.

### **1.13 Structure of this Thesis**

The structure of this thesis is as follows: Chapter 2 outlines the literature reviewed; Chapter 3 explains the research design, methodology, methods, and ethical processes undertaken to complete this study; Chapter 4 details the research findings from the study; Chapter 5 discusses the research findings in light of relevant literature; and Chapter 6 explores the conclusions, implications, limitations and recommendations from this thesis for treatment professionals and people recovering from AOD dependence.

## **Chapter Two: Literature Review on Alcohol and Other Drug Recovery**

### **2.1 Introduction**

This chapter explores current literature about a number of aspects that influence AOD recovery in the New Zealand context. This includes but is not limited to: the current definition of alcohol and other drug dependence (addiction), definitions and varying perspectives of recovery, and why people choose to get help for their AOD problems. Further consideration is given to how societal views can impact on people who want to address their AOD problems, and the current treatment options available for people with AOD problems in New Zealand. In addition, a number of studies that investigated the active ingredients involved in successful AOD recovery are reviewed. Some of these aspects include recovery-supportive groups, spirituality and identity. The phenomena called Natural Recovery, which is where people recover from AOD problems without professional help, is also explained. And the roles of fitness, skill development and relapse in early recovery are examined. Maori cultural perspectives and change theories and models that describe the recovery process are reviewed. Finally, conclusions from the literature review are made and a literature comparison chart has been added to show the aspects relevant to AOD recovery found in the literature review.

### **2.2 Alcohol or Other Drug Dependence (Addiction)**

The World Health Organization in 1981 stated, “dependence is the use of a substance or excessive thoughts about a substance assuming great importance to the detriment of other activities that had previously had greater importance” (Miller, 2009, p. 78). As stated previously, the criteria for a diagnosis of substance dependence, as classified in 1994 in the DSM-IV include: increased tolerance, withdrawal, loss of control over use of the substance, recurring desire to cut down or stop, preoccupation with drinking or using, the abandoning of important social obligations and continued use despite adverse consequences. In 1987 the word ‘addiction’ was replaced with the word ‘dependence’ as it was seen as a more neutral term (American Psychiatric Association, 1994).

The American Society of Addiction Medicine has recently (2011) released a new definition of alcohol and other drug dependence as a primary chronic brain disease with a genetic component affecting the reward, motivation, and memory circuits of the brain. The characteristics of the disease are an “inability to consistently abstain, impairment in behavioural control, craving, diminished recognition of significant problems, [and] a

dysfunctional emotional response” (American Society of Addiction Medicine, 2011, p. 2). Further aspects including triggers, relapse, behaviour, cognition, and emotional changes are explained in detail. These additions and other amendments to the DSM-IV criteria are due to be released in the new DSM-5 expected to be published in May 2013 (Kupfer & Regier, 2010).

### **2.3 Why do people choose to get help or address their AOD problems?**

Why do people choose to address their AOD problems? Kingemann et al. (2001) reported that most people with AOD problems pursued recovery after honest self-appraisal. Sobell, Ellingstad and Sobell (2000) reviewed 38 articles from 1960 to 1997; half of the articles on natural recovery from AOD problems (without formal treatment) were published in the eight years prior to 1997. The sample sizes ranged from 5 to 2456 participants (mean 140.9 median 43). They found that 42.5% of participants reported health concerns as the dominant reason for addressing their AOD use. The second highest reason, reported by 27.5% of participants, was family or significant others’ involvement or coercion. The mean age of participants when they pursued recovery for their AOD problems was 34.4 (SD 6.2). The authors noted that most of the studies lacked data on participants’ demographics and substance use history.

### **2.4 Societal Views**

To reduce the stigma that recovering people experience, societal views will need to change, however changing views of those who already have negative views of people with addiction problems may not be easy. Change should not lie with alcohol and other drug dependent people alone. Room (2005) states that stigma and marginalisation is a real issue for recovering people. Hoffman and Froemke (2007) point out that people with AOD dependence are often still seen as ‘social outcasts’ despite the significant gains made in neuroscience with PET scans which show a disease process with organic brain changes in people with AOD dependence.

In spite of the conclusions of the American Medical Association, The World Health Organization, and doctors and researchers worldwide – there remains a notion, whether it is expressed overtly or hidden, that addicts are blamed for their own suffering and they are viewed by some as weak and immoral (Hoffman & Froemke, 2007, p. 188).

A US study which enlisted 815 participants from a national online research panel found that addiction was more highly stigmatised than all other mental health disorders (Room, 2005). Schomerus, Lucht, Holzinger, Matschinger, Carta and Angermeyer's (2011) meta-analysis review further demonstrates the stigmatisation of people with addiction problems. A review of 17 representative population studies exploring the prevalence of the stigmatisation of alcoholism in relation to other mental, medical or social conditions in Europe, North America, and New Zealand concluded that all 17 studies showed that "Alcoholism is a particularly severely stigmatised mental disorder" (Schomerus et al. 2011, p. 105).

Stigmatisation is not only limited to those who misuse alcohol or other drugs. International studies have shown that the children of those who misuse alcohol or other drugs often experience stigma and feelings of shame about their parents' AOD misuse. This has also been correlated to learning and social problems (Schomerus et al. 2011).

Boysen and Vogel's (2008) study found that giving positive AOD education to people with pre-existing negative perceptions about people with addiction or other mental health disorders only increased their existing negative perceptions, whereas education increased the existing positive perceptions of other people.

In the National Committee for Addiction Treatment (2011) position paper it is stated that New Zealand's views on AOD problems need to shift to view AOD misuse as a health issue not just a social or welfare concern.

Though societal change is important, directly researching these issues is beyond the scope of the ADWRNZ study. However it can be concluded that the likelihood of study participants facing stigmatisation during their recovery experience is high. Because literature shows that others in society do not always support recovery, focus will be given to how study participants dealt and coped with stigmatisation when or if this occurred.

## **2.5 Alcohol and Drug Treatment**

Project Match (Gordis, 1997), a seminal study and the largest study of its type, highlighted three dominant treatment modalities used in the treatment of AOD problems. The study enlisted 1,726 participants with either substance abuse or dependence from 10 treatment settings throughout the USA. Participants were assigned to one of three styles of treatment modality groups: Motivational Enhancement Therapy (MET), Cognitive Behavioural Therapy (CBT), and Twelve Step Facilitation (TSF). The TSF and CBT

groups received 12 weeks of one-on-one therapy, and the MET groups received four sessions of one-on-one therapy in keeping with the MET brief intervention approach. The purpose of Project Match was to explore whether participants' characteristics were better suited to different treatment approaches/styles. All participants received an initial assessment and were then randomly assigned to either MET, CBT or TSF treatment.

Gordis (1997) states that Project Match findings showed that although participant characteristics were not matched to specific treatment approaches, MET, CBT and TSF all produced similar outcomes, and overall, 50% of participants who reported problem drinking at the start of the study no longer reported this at the 12 month follow-up. The mean average drinking days per month in all three modalities reduced from 25 to fewer than six. Furthermore, a significant reduction in the amount of alcohol drunk on a drinking day was also reported. The only significant variable was that 25% of participants assigned to the TSF outpatient groups achieved higher rates of continuous abstinence compared with 15% of participants in the CBT and 14% of participants in the MET treatment groups.

Adamson, Sellman and Frampton's (2009) study explored what the predictive factors affecting treatment outcomes were by undertaking a meta-analysis of 51 studies that looked at different treatment outcomes. Overall the findings showed that "dependence severity, consumption level, and treatment history are perhaps the most intuitive predictors of treatment outcome, and coexisting psychiatric conditions and motivation might perhaps be added to these..." (2009, p. 82).

Overall alcohol is still the dominant problem drug of choice for people accessing AOD services in New Zealand. The 12-step, Motivational Interviewing, and Cognitive Behavioural approaches are the dominant approaches in treatment of AOD problems.

The more severe a person's AOD problem is at the time of accessing help, the higher the volume of alcohol consumption, and the more times a consumer has received treatment all negatively shift the outcomes of successful treatment. These findings indicate that the earlier a person accesses help for alcohol and drug problems the better; the old adage 'letting a person reach rock bottom' is not supported by the research discussed.

The treatment of AOD problems is not the specific focus of the ADWRNZ study; this study focuses on participants' recovery lifestyle rather than the treatment they received. However treatment may have been the catalyst to assist a person into pursuing a recovery lifestyle. It is important to note that ongoing treatment can be part of a person's recovery

lifestyle and this may take different forms including individual counselling and/or professionally led groups. The study findings will record where this occurs, or where skills learnt during treatment are used to assist in maintaining one's recovery and well-being. Not including the effect of treatment in the long-term maintenance of recovery and well-being is a limitation of this study and will be discussed in the limitation section of this thesis. As stated earlier, study participants' drug(s) of choice will also be recorded.

Moos' (2007) study reviewed and identified the successful ingredients of different treatment approaches for people with substance use disorders. Four dominant theories were found to underpin a number of approaches identified. These were: social control theory, behavioural approaches, social learning theory, and stress and coping therapies. Moos (2007) suggested the active ingredients identified in Social Control Theory were "bonding or support, structure or monitoring, and goal direction" (p. 111). He suggested the active ingredient in Motivational Interviewing was a "collaborative relationship between the client and the counsellor" (Moos, 2007, p. 111). In Cognitive Behavioural approaches he proposed the active ingredients were "the focus on increasing resistance to self-efficacy and general self-confidence, acquiring and using substance-specific and general coping strategies and reducing positive expectancies for substance use" (Moos, 2007, p. 115). Within Contingency Management and Community Reinforcement approaches he suggested that the active ingredient was "specific kinds of rewards ... related to better substance use outcomes" (Moos, 2007, p. 117). These rewards may include regular drug testing or special privileges for certain behaviour demonstrated. Moos (2007) also listed a number of possible active ingredients in 12-step facilitation approaches. These included group involvement, mixing with 12-step friends, having a sponsor, reading 12-step materials, and focusing on abstinence. He also noted that attendees of 12-step programmes tended to endorse 12-step beliefs, and that their self-efficacy and coping skills also improve during TSF treatment.

A New Zealand study conducted by Todd, Sellman and Robertson (2002) explored barriers for consumers accessing help with coexisting substance use problems which utilised 12 focus groups consisting of practitioners, consumers, and significant others involved in AOD services throughout New Zealand. A total of 261 participants were included in the study. The three main barriers highlighted for consumers fell into system, clinical and attitudinal issues. System areas included planning and resource availability failures. Clinical issues included lack of skills and knowledgeable people working with

consumers with AOD problems. Further clinical issues included a lack of family involvement and follow up services for consumers. Attitudinal areas included service providers being judgmental, rejecting the disease model, territorial attitudes between service providers, lack of a harm minimisation approach being offered, and Mental Health Services rejecting consumers with AOD problems as they were not seen to be the responsibility of Mental Health Services.

In relation to this proposed study it will be worth noting which of these, or other barriers were experienced by the study participants, and how they overcame these barriers throughout their recovery journey.

## **2.6 Recovery**

The term 'recovery' in the context of AOD dependence is often used in both treatment and support group settings such as the 12-step movement. Recovery often incorporates concepts such as rehabilitation and habilitation. Rehabilitation encompasses the idea of returning to a former state following injury or illness. La Grow (2008) states "rehabilitation may be defined as a process which seeks to limit the disability (i.e. functional limitation) and eliminate the handicap (i.e. disadvantage) resulting from an impairment or interaction between the impairment, disability and the environment" (p. 1). Whereas habilitation focuses on developing new skills and abilities that the person has not previously displayed for the purpose of better functioning in society (La Grow, 1996). Pledger (2003) points out that there has been a paradigm shift in the rehabilitation field regarding the concept of rehabilitation from a medical model, which focuses on the physical condition, to a social understanding of rehabilitation that acknowledges the environmental influences that either assist or hinder the rehabilitation process.

Though used frequently, the term recovery may be misleading. In the AOD treatment sector, recovery may be better defined as self-management of a chronic condition (Galanter & Kleber, 2008) because many people do not ever fully recover from their addiction to alcohol or other drugs, however they learn to apply on-going strategies that result in the addictive symptoms of obsession and compulsion being well managed. In other words, they have to maintain certain practices to stay free from the compulsion to use alcohol or other drugs. Substance Abuse and Mental Health Services Association (SAMHSA, 2011) formulated a working definition of recovery with behavioral health leaders and people in mental health and addiction recovery. Their conclusion was:

Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential.

SAMHSA listed the principles of recovery [as being]

- Person-driven
- Occurs via many pathways
- Holistic
- Supported by peers
- Supported through relationships
- Culturally-based and influenced
- Supported by addressing trauma
- Involves individual, family, and community strengths and responsibility
- Based on respect; and
- Emerges from hope.

(SAMHSA, 2011, p. 1)

## **2.7 The Ambiguity of the Meaning of Recovery**

Te Pou, the National Centre of Mental Health Research, Information and Workforce Development in New Zealand, arguably a key stakeholder in addiction treatment development in New Zealand, highlights the ambiguity of the meaning of recovery when citing the Pennsylvania Department of Public Welfare Office of Mental Health and Substance Abuse Services which states that:

Recovery is variously described as something that individuals experience, that services promote, and that systems facilitate, yet the specifics of exactly what is to be experienced, promoted, or facilitated, and how, are not often well understood by either the consumers who are expected to recover or by the professionals and policy makers who are expected to help them (Erney, 2005, p. 25).

Whereas McLennan (2011), reporting on a working group instigated by Betty Ford Center inviting clinicians, policy makers, family members, and recovery advocates to share, found that recovery was a “a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship” (p. 6). Regarding the strength of a person’s sobriety this was

defined as: early sobriety - one to eleven months, sustained sobriety - one to five years, and stable sobriety - five years or more.

## **2.8 Individual Perspectives of Addiction Vary**

Individual definitions of recovery also vary, with Hoffman and Froemke (2007) recording a number of recovering people's perspectives. In one case a person personifies their addiction in these terms: "This thing is so deceitful; it's so cunning, and it's so baffling. It's my security blanket, for now. And that's why I need to go out and get the help. Because alcohol should not be a security blanket" (2007, p. 2). Another recovering person writes about the total loss of emotion resulting from their substance use "...I never had feelings. I numbed them . . . from a very early age, and I didn't realise what I was doing. 'Cause when you start drinking at 13 or 14 years of age you've numbed a certain amount of your brain and everything else [,] and feelings were things ... [that] ... [felt] good when I drank" (2007, p. 167). Paris and Bradley (2001) write about one of their study participants using mood-altering substances to medicate the consequences of a passive existence: "A central theme throughout Alison's story is her intense desire to belong. In her quest for love and approval, Alison sacrificed her own wishes to please others: her parents, by marrying the man they wanted; her husband, by deferring her own career to put him through law school; and his family, by joining their social drinking culture" (Paris & Bradley, 2001, p. 653).

Participants' personal perspectives are a focus of the ADWRNZ study. The personifying of a person's addiction is of particular interest as relationship is predicted to be critical to recovery and well-being of study participants. It is worth noting that 'relationships' is used in the wider sense of the word to include not only drug of choice, but also people, nature, and higher powers; relationship will be a focus of this study.

## **2.9 The Ministry of Health Perspective of Recovery**

The Ministry of Health (MOH) provides some insight by stating recovery:

is a process rather than an end point, but control of substance use ... is an important aspect of recovery from addiction. The National Committee for Addiction Treatment (2008) notes that in the addiction sector recovery has meant aiming for a lifestyle of abstinence when used within the framework of a 12-step programme (Ministry of Health, 2010, p. 7).

In broad terms the MOH stated that recovery occurs when a person regains personal

power and dignity in society, pursues abstinence or reduced harm from their AOD use, is 'living well' as defined by the individual, and develops positive expectations and hope for the future (Standards New Zealand Paerewa Aotearoa, 2008) (Ministry of Health, 2010). The MOH adds further scope by stating that, "recovery does not necessarily mean a person:

- Will no longer have a mental illness (including addiction)
- Will no longer have struggles
- Will no longer use mental health and addiction services
- Won't use medications
- Will necessarily be working, off a benefit, or completely independent in meeting all of their needs" (Standards New Zealand Paerewa Aotearoa, 2008, p. 6)

The limitations of these definitions are in the terms used. What does 'personal power' mean, and how does a person gain it? Furthermore, 'living well' is also ambiguous as it could be argued that a person actively using mood-altering substances might say they are already 'living well' due to the denial process which Hoffman and Froemke (2007) explain is often present in substance use dependency. For example, could a person actively using alcohol and other drugs perceive they are living well and have personal power?

This study hopes to define in more detail the empowerment and well-being aspects of the recovery experience of participants. As the study design only requires a maximum of 12 people, the transferability of these findings to other populations will be limited but not insignificant in adding to the literature on this topic.

## **2.10 USA Study Defining Recovery**

The study by Laudet (2007) begins to add understanding to the recovery lifestyle. This study explored consumer perspectives by conducting a telephone survey in the USA, which screened a significant sample of 289 recovering people. Screening included meeting the DSM-IV criteria for substance abuse or dependence, being abstinent one month or more, and not attending formal treatment at the time. The study found that 85.5% of participants had been to treatment, and 88.9% of participants attended AA, of which 78.9% considered themselves having been in recovery between one month and 27 years. The mean term of abstinence amongst participants was 45.7 months. The survey included both multi-choice and open-ended questions asking participants about recovery. The multi-choice questions asked participants about the volumes of their AOD use in

relation to a definition of recovery. Of the participants surveyed, 86.5% chose abstinence as the defining meaning of recovery. This is not surprising considering AA is abstinence-based in its philosophy and that the multi-choice questions only asked about volume.

However, Laudet's (2007) findings showed that recovery had more definitions than just abstinence, including: a new life, reclaiming one's self, personal growth, and an ongoing process. When asked about the benefits of recovery 57% of study participants provided two or more answers. The most frequently cited benefit of recovery mentioned by one third of participants was a new life or a second chance; 23% cited being drug free. Other benefits cited were as follows: "self-improvement (22.7%); having direction, achieving goals (17.5%); improved/more positive attitude (17.2%); improved finances/living conditions (16.2%); improved physical and/or mental health (16.1%); improved family life (13%); and having friends/a support network (11%)" (Laudet, 2007, p. 256).

The limitations of these findings are that both AOD abuse and dependence were measured therefore the severity of the substance use and related problems is unclear; also the geographical locality limits the validity of the findings in the New Zealand context. For example Baker, Sellman, and Horn's (2006) New Zealand study showed only 35% of participants in their study attended 12-step meetings compared to 88.9% reported in the Laudet (2007) study. Furthermore, terms like 'new life and 'well-being' are unclear and need further explanation.

The ADWRNZ study hopes to clarify these definitions, explore whether these definitions are applicable to the study participants, as well as add further depth of understanding to the recovery experience.

### **2.11 Longitudinal Recovery Study**

Hser (2007) adds further detail with his research, which showed that recovery is not merely starting a new lifestyle, but choosing to leave an old lifestyle. In his 33-year follow-up study of 242 recovering heroin addicts in California, Hser reports that recovery includes dimensions of discovery, developing self-efficacy, and building new social networks or relationships.

These addicts started new social networks of new relationships, were able to support themselves and their families, and were supported by their spouses and family members, and over this process built self-confidence and self-efficacy in maintaining abstinence. Conversely, continued drug use ensured involvement with

drug-using networks and led to criminal involvement resulting in arrest and incarceration, which impeded keeping a job and maintaining relationships or family ties, in turn pushing addicts to isolation and more immersion in the drug culture (Hser, 2007, p. 58).

The strength of this study is that it clearly defines the importance of healthy social networks and family relationships. The limitations of this study are that, though the population size was significant, participants' drug use was limited to heroin.

As stated earlier the ADWRNZ study predicts that relationship will indeed be significant to the recovery experience of study participants with the addiction.

### **2.12 Maintenance Factors in Recovery**

The concept of recovery occurring in a social context rather than only in the individual is further supported by Sobell, Ellingstad and Sobell's (2000) review of studies on people who recover without formal treatment. Sobell et al. (2000) found a number of apparent maintenance factors. These areas included "social support/change in social groups... significant others/family... developing of non-substance interests... lifestyle change, avoidance of substance use situations... work-related [endeavours]... religion... self-control or willpower... changes in living arrangements... positive personal attributes... finances, [and] health..." (p.757).

This study further highlights that recovery for some people may involve many practical pursuits such as gaining employment, developing interests, and changing their living situation. Though this study identified a number of different lifestyle areas important in recovery, the role of mutual support groups, professional support, challenges of early recovery, or identity reconfiguration were not mentioned.

The ADWRNZ study hopes to clearly identify the participants' support networks as well as the more practical aspects of their recovery experiences that are not specifically focused on abstaining from alcohol or other drugs. It may be found that stopping alcohol or other drug consumption is as important as what non-alcohol or drug related activities replace the alcohol and other drug using lifestyle.

### **2.13 Recovery-Supportive Groups**

Mutual support groups (MSG) are integral for many recovering people. "Mutual support groups are non-professional groups comprising members who share the same problem

and voluntarily support one another in the recovery from that problem” (SAMHSA, 2008, p.1).

Narcotics Anonymous Aotearoa New Zealand (NA) (2004) conducted a survey throughout New Zealand NA groups in 2004. A total of 475 people participated in the survey, which was estimated to be two thirds of all their members. The demographics of surveyed participants showed 58% were male; members ranged in age from under 20 to over 60 years of age with the mean age of members being 35 years of age (no SD reported). Of survey participants, 74% identified themselves as European, 13% as Maori, and 13% were other ethnicities. Having attended a treatment centre was identified by 37% of survey participants as the primary reason they initially attended NA, with 34% survey participants reporting that meeting another NA member was the reason they initially attended NA meetings. Regarding the length of time participants actively used drugs before pursuing an abstinence-based lifestyle, 55% reported using drugs for 15 years or more, with 24% of participants stating they actively used drug for 10 to 14 years before pursuing an abstinence-based lifestyle.

In 2011 the Alcoholics Anonymous (AA) General Service Office in New York estimated there were 2,057,672 AA members worldwide, with 107,976 AA groups being run on a regular basis. In 2004 Alcoholics Anonymous (2004) published a survey of its New Zealand members. The findings were that 3800 to 4000 people attended AA meetings throughout New Zealand on a weekly basis, with the average meeting size being between 13 to 14.6 people, and members attending on average 2.5 meetings per week. Of all members, 40% were female, the average age of members was 46 years of age, with 60% of members aged between 35 and 54 years of age. The ethnicity of members was 82% New Zealand/Pakeha with the remaining members consisting of other ethnicities. On average members had attended AA for 4 years before entering stable sobriety.

Many peer support groups are tailored to meet specific needs. As previously stated, some of these include Alcoholics and Narcotics Anonymous, which use the 12 suggested steps for recovery formulated by Bill Wilson, one of the founders of the movement. Not all MSGs are 12-step based. Women for Sobriety groups only have women members. The programme includes 13 statements focusing on emotional and spiritual growth with abstinence as a prerequisite. “SMART Recovery” groups use cognitive-behavioural approaches (CBT). “Its four principles are to (1) enhance and maintain motivation to abstain, (2) cope with urges, (3) manage thoughts, feelings, and behaviours, and (4)

balance momentary and enduring satisfactions” (SAMHSA, 2008, p. 3).

Literature is clear that professional or community support groups of different types are a significant part of many recovering people’s journey. Morgenstern, Kahler, Frey and Labouvie’s (1996) study highlighted nine core AA behaviours associated with recovery “... (a) AA meeting attendance, (b) talking with sponsor, (c) attending Step meetings, (d) engaging in 12-step service activities (e.g. setting up for meeting), (e) reading AA or other recovery literature such as the Big Book or Hazelden Press publications, (f) reaching out to other AA members, (g) prayer or meditation, (h) the extent to which one’s life revolved around AA activities (drawn from Snow, Prochaska & Rossi, 1994), and (i) seeking advice from AA sources such as sponsors, the Big Book, or sharing in a meeting when making significant personal decisions” (p. 49).

Another important dimension to MSG involvement is helping others, which research has shown also correlates with positive outcomes where “helping helps the helper” (SAMHSA, 2008). This community involvement appears to be a dominant aspect for many recovering people and has positive benefits. Kelly, Stout, Magill, Tonigan and Pagano’s (2010; 2011) controlled study of 1706 recovering alcoholics over a 15-month period found AA involvement also reduced the prevalence of depression and increased participants’ overall well-being compared to the control groups who were not using MSG as part of their recovery process. Though these findings do provide details regarding involvement in support groups, the interplay and impact of spirituality and a recovering person’s identity, and other interconnections outside of the support group settings were not shown. What is clear from this study is that, for many people, pursuing a recovery lifestyle is multifaceted and involved.

Rushing’s (2008) study looked at the role of serenity for nine recovering people. Five of these study participants were women, with the ages of all participants in the study ranging from 34 to 69 years. The average length of sobriety for participants was 9.5 years with participants experiencing an average of five relapses over the term of their sobriety. Characteristics of Rushing’s study participants included:

- Participants related a litany of negative consequences, both episodic and emotional, from their addiction.
- All participants identified themselves as members of a 12-step organisation and valued the support they both received and were able to give others.

- All participants shared that a 12-step programme was vital to their success in recovery from addiction.
- With only a single exception, all of the participants had experienced one or more relapses and all related that they were ever mindful of the potential for relapses.
- Each participant shared that a spiritual experience/awakening was pivotal in the recovery process.
- All participants related that regular involvement in 12-step activities and frequent, consistent attendance was necessary for their long-term sobriety.
- All self-identified as experiencing serenity in their journey toward sobriety, healing, and wholeness (Rushing, 2008, p. 205).

Majer, Jason, Ferrari and Miller (2002) explored the relationship between social support, self-efficacy for abstinence and identification with peers. Study participants consisted of 57 men and 43 women living in Oxford Houses in the USA, which are 12-step supportive living environments for newly recovering people. The findings showed that the longer length of stay in Oxford House and 12-step involvement correlated to higher self-efficacy for pursuing abstinence and higher levels of abstinent social support networks. What was of particular interest in this study was that some individuals had lower self-efficacy for abstinence and struggled to identify with abstinent peers due to having a previous history such as incarceration.

Majer, Jason and Olson (2004) also explored the relationship between optimism, self-efficacy for abstinence, and self-mastery (belief that self change is under one's control). This study enlisted 84 participants from Oxford Houses, who were open 12-step members. Of the 84 study participants 60 were male. The study showed that optimism, self-efficacy for abstinence and self-mastery were all highly correlated. Furthermore, participants who had 180 days abstinent or more had higher self-efficacy than those who have less than 180 days abstinence from alcohol or other drugs.

Majer, Jason, Ferrari and Miller's (2011) US study explored 12-step activities and the correlation with self-efficacy to pursue abstinence as well as outcomes for long-term abstinence. The study recruited 897 adults of which 604 were male from within Oxford Houses and self-run recovery-supportive residential settings. The mean age of participants was 38.4 years with 69 % being employed. The 12-step activities included

working with a sponsor, reading 12-step material, being involved in service work, and calling other recovering people when needing help. A number of commonly-used questionnaires were used to determine the level of participation in the 12-step activities including the Alcoholics Anonymous Affiliation Scale also discussed in this literature review and the Alcohol Abstinence Self Efficacy Scale.

These findings showed the level of study participant's involvement in 12-step activities had a higher correlation with the rate of abstinence achieved at 12 months than meeting attendance. The limits of this study are: participants were recruited from Oxford Houses within the US, which may misrepresent the findings for other population groups. Because Oxford Houses are 12-step supportive environments, it is unclear how much the Oxford House environment itself is responsible for positive outcomes. For example, Jason Olson, Ferrari, Majer, Alvarez and Stout's (2007) study showed that Oxford House's stable environment increases outcomes for recovering people. What this study does highlight however is that working a 12-step programme and the correlation with abstinence involves more than merely attending 12-step type meetings.

Not all studies have found all populations are open to 12-step support groups. Best, Harris, Gossop, Manning, Man and Marshall's (2001) study of 200 people accessing detoxification services in the UK found people with alcohol misuse problems were more resistant to 12-step fellowships than people with drug misuse problems.

Humphreys et al. (2004) summarise the findings of an expert work group on self-help organisations. Based on a wide range of research, the work group found that AA attendance improves alcohol-related outcomes, and longitudinal studies show increases in abstinence, social functioning, and self-efficacy. Self-help groups reduce the cost to the health care system and should be seen as a continuing care option. The combination of professional treatment and self-help group involvement produces better outcomes.

The working group also suggested a number of potential strategies to better utilise self-help groups in the local community. Firstly, that clinicians should use clinically proven methods when encouraging involvement in self-help groups; secondly, because there are a number of pathways to recovery a variety of treatment and support groups options should be made available to clients; thirdly, clinicians need further training and incentives to encourage clients to utilise self-help support groups. Effective referral to self-help groups is also needed, and clinicians need to communicate to clients that many people

recover through self-help groups as well as other methods. In addition, all treatment programmes need to evaluate their practices as to whether they support self-help group involvement. Their final conclusion was that because addictions are difficult to resolve, financial resources are limited, and self-help groups have been shown to be effective, therefore, self-help groups should be supported at a policy level.

## **2.14 Spirituality and Identity**

“According to [Lewis and] Brown [1999], identity renewal is [also] a central task of the alcoholic in early recovery, followed by an increased ability to relate authentically, intimately, and reciprocally to others” (Paris & Bradley, 2001, p. 663). Robinson, Cranford, Webb and Brower’s (2007) study also found that spirituality and religiousness increased for 123 outpatients with alcohol use disorders over the first six months even after controlling for AA involvement. They further note, “behavioural and experiential dimensions appeared to be most sensitive to change” (Robinson et al. 2007, p. 288). In addition, a sense of purpose or meaning increased and alcohol use decreased over this six-month period. Weegmann and English (2010) also support the role of identity formation in recovery, stating that liberation from drugs involves the formation of a new identity that needs to be continually pursued.

Spirituality is an important dimension for some recovering people. Galanter, Dermatis, Bunt, Williams, Trujillo and Steinke (2007) write “Spirituality, however difficult to define in operational terms, likely constitutes an important motivator in recovery for some (perhaps many) substance-dependent people” (p.263). Baker, Sellman and Horn’s (2006) New Zealand study found spirituality was a significant factor for many recovering people. This study interviewed 90 consumers accessing AOD treatment in New Zealand and found that 62% reported life-changing spiritual experiences of some kind as a part of their recovery experience. Of those reporting life-changing spiritual experiences, 39% reported involvement with a spiritual group, 35% 12-step based, and 12% religious based. The limitations of this study were that the impact of spiritual experience was not measured in relation to achieving recovery. This raises the question of whether one-off spiritual experiences or ongoing spiritual lifestyle changes are significant in successful recovery occurring. Galanter and Kleber (2008) point out that none of the studies they reviewed showed that spiritual experience was significant in achieving long-term recovery. However, Neff and MacMaster (2005) suggest that spirituality often has a community

context arguing “spiritual transformation at an individual level takes place in a social context involving peer influence, role modelling, and social reinforcement” (p. 669).

## **2.15 Higher Power**

Tonigan, Miller and Schermer’s (2002) study reviewing Project Match findings, the largest AOD study undertaken to date (1526 participants), showed that Alcoholics Anonymous group attendance predicted positive outcomes independent of spiritual beliefs (i.e. atheist, agnostic, or religious). This may suggest that AA involvement is more indicative of positive outcomes than spiritual belief.

What does New Zealand research say about spirituality for the substance abusing population? Baker, Sellman and Horn’s (2006) study of 90 consumers accessing substance treatment in New Zealand found that 62% reported life-changing spiritual experiences of some kind as a part of their recovery experience. Of those reporting life-changing spiritual experiences, 39% reported involvement with a spiritual group, 35% 12-step based, and 12% religious based. Spirituality in differing forms appears to be significant to many people in recovery.

Although the evidence appears mixed, from the personal perspective of a recovering person comes this: *“There was a force outside myself that said, ‘You got more here to do.’ I did a lot of silly things. I had a feeling that there was a reason that I had not been seriously hurt, I mean killed. An overall spirituality gives inner strength and meaning: It doesn’t matter how you worship, but if you have a sense that there is a God by whatever name . . . a higher power in AA . . . and I do have that. I do think there is order in the universe, as unimportant as we may be. Our bodies are really microcosms of creation . . . there are worlds within worlds in every human body . . . it’s a miraculous, fantastic thing”* (Paris & Bradley, 2001, p. 662).

James (2011), a founder in the study of religious and spiritual experiences also cited in the 12 step literature, explains many dimensions to religious and spiritual experiences including the concept of a higher being as relational, and a belief in a higher good and purpose. What will be of interest are ADWRNZ study participants’ concepts of a higher power.

## **2.16 Natural Recovery**

Natural recovery is another dimension of recovery from alcohol or other drugs. This is where people recover without any formal treatment. An older study conducted by Sobell, Cunningham and Sobell (1996) explored the natural recovery of 392 participants in both Canada (322) and New York (70) and found that 77.6% of participants resolved their excessive drinking and resulting problems without treatment, counselling, or self help involvement. A more recent study by Bischof, Rumpf, Meyer, Hapke and John (2007) further explored natural recovery and found that social support was most significantly correlated to natural recovery and increased abstinence rates. “Data show[s] that the interplay between psychosocial resources and substance-related problems may still account for differences in trajectories of naturally remitted individuals in a 2-year follow-up” (p.904). Again, social support appears to be a significant factor in the experience of many people in recovery.

As stated earlier the ADWRNZ study predicts that relationship will be significant to the recovery experience of study participants.

## **2.17 Fitness**

According to Galanter and Kleber (2008), good physical health as part of one’s recovery has been found to be important for some recovering people. Read et al.’s (2001) study of 105 participants with AOD problems attending treatment in Rhode Island in the US found that half of these people engaged in regular exercise and reported improvement in self-esteem as a result. Although this study did not find that exercise had any correlation to levels of sobriety, Brown et al. (2009) say “The preliminary outcomes of ... [his] pilot study revealed good adherence to the exercise intervention with demonstrated benefits in cardio respiratory fitness by the end of the 12-week intervention. In addition, compared to baseline, there were significant increases in the number of days abstinent as well as decreases in drinks per drinking day at follow-up time points” (Brown et al., 2009 p.14). In the US, the National Institute on Drug Abuse (NIDA) is committing US\$4 million towards scientific research on the benefits of exercise in recovery (NIDA, 2008). The completion date for this study has not yet been confirmed.

As there is support for the importance of fitness and health promoting activities for some recovering people, these will also need to be noted in ADWRNZ study findings.

## 2.18 Skill Development

Another dominant area of research on recovery is the development of new skills. As stated earlier, social involvement and developing new skills are part of recovery for many recovering people; “Alcohol dependent clients receiving social skills training consumed less alcohol and reported more sober days over the year following treatment than the control groups” (Eriksen, 1986) cited in (Miller, 2009, p. 172). Galanter and Kleber (2008) state a number of skills used in recovery are gained during treatment from Cognitive Behavioural Theory (CBT) training. These include understanding the patterns of thinking or behaving that support substance use, weighing the pros and cons of possible using, implementing strategies for coping with cravings, understanding the longitudinal effect of small decisions, and planning for unforeseen risky situations.

“Stress-reducing activities such as social support, exercise, meditation, or other stress-buffering or relieving activities,” (Miller, 2009, p. 226) are also used as tools in the management of substance dependence treatment. Mindfulness is a relapse prevention tool that teaches recovering people to become aware of what they are thinking about. The theory suggests that thinking is automatic and a person can develop the ability to observe what they are thinking in a non-judgmental way thereby being able to differentiate between what happens in reality and what is created by their own minds (Miller, 2009).

Galanter and Kleber (2008) assert that learning to process feelings has significant implications for newly recovering people and this takes time and is a core skill in early recovery. “Negative feelings are a common precursor to relapse. This would include feelings like shame, depression, loneliness, anger, or anxiety. It became like second nature to addicts to utilise a quick fix anytime any one of these feelings would pop up. That is why so many times an addict hasn't developed any coping skills at all to deal with feelings. This becomes a dangerous thing in terms of relapse” (Savage, 2007).

Managing triggers and preventing relapse is another dominant theme in recovery literature; “I think the factors that trigger addiction are loneliness and insecurities” (Anonymous, 2009). “I have been reading a lot on what triggers my addictive behaviour. I am full of the guilt with my children. I have only been clean and sober for 7 months. Working real hard on this behaviour” (Anonymous, 2009).

Litt, Kadden, Kabela-Cormier and Petry (2008) looked at the role of predictive factors for long-term abstinence with 240 adults dependent on marijuana. Of these participants 71%

were male, with an average age of 33 years. The study monitored participants every 90 days up to 12 months post treatment. Their findings showed that “long-term abstinence was predicted by use of coping skills and especially by post treatment self-efficacy for abstinence” (2008, p. 638). The coping skills measured consisted of 48 strategies used to assist in abstaining from marijuana use. The details of the strategies measured were not noted.

What can be concluded from this part of the discussion is that skill development is another important domain of recovery for many recovering people. It is also important to note people entering into a recovery lifestyle have a variety of experiences and as a result a variety of skills. Because this study is not going to investigate previous life experience or the skills participants had before entering into recovery lifestyle, attention will need to be given during the data collection stage to identify skills that study participants use whether spoken or unspoken. It is also hoped that specific skills will be identified in the study findings, both those skills learned by trial and error and those learned intentionally or unintentionally during the first two years of pursuing a recovery lifestyle.

### **2.19 Challenges of Early Recovery**

Conyers (2009) writes that recovery is not without difficulties, and lists a number of hard realities for many people in early recovery. There are the immediate effects of withdrawal or coming down from alcohol or other drugs; for many recovering people insomnia is a significant challenge, which can last months or even years. Conyers (2009) writes, “Addiction is primarily a disease of escape – escape from emotions, responsibility and everyday reality” (p. 32). Early recovery often involves learning to deal with emotions, choosing not to run away from problems, facing lost opportunities or resulting lifelong consequences from their AOD use, dealing with shame, leaving a lifestyle of isolation and alienation, beginning to belong again or finding places to belong, and developing work ethics. What is unclear from this perspective is how the duration of substance use affects basic lifestyle skills. Galanter and Kleber (2008) state that the longer a person has been dependant the greater the loss of social skills. Mitchel (2001) identified the symptoms of early dependence as insomnia, agitation, confusion, isolation, guilt, arrogance regarding one’s vulnerabilities, loss of control over one’s emotions, complacency, loss of appetite, impaired memory and anger.

Because the aim of this study is to clearly report the AOD recovery experiences in the first two years, focus will need to be given to the challenges and difficulties participants have faced. It is predicted that the ADWRNZ study will highlight that the recovery experiences of participants will be a mix of both positive and negative. How participants coped with the variety of experiences they faced will be noted.

## **2.20 Relapse**

Hoffman and Froemke, (2007) citing Volkow, the National Director of NIDA, states that relapse is a common process of this disorder. Relapse occurs when a person re-establishes use of a mood altering substance they had been abstaining from. Volkow reports that relapse rates for addiction are similar to other chronic disorders such as diabetes, hypertension, and asthma. Chan et al. (2009) say that recovery from addiction can be a long-standing process often involving repetitive treatment episodes. Hoffman and Froemke (2007) point out that this may be one of the hardest dimensions of the disorder that recovering people and their families have to contend with.

McGovern, Wisley and Drake's (2005) review identified key relapse prevention strategies "...includ[ing] reducing exposure to substances, fostering motivation for abstinence, self-monitoring, recognizing and coping with cravings and negative effect, identifying thought processes with relapse potential, and deploying, if necessary, a crisis plan" (p. 1270).

Relapse is clearly a part of many recovering people's experience. Because of this it is highly likely that for many participants in this study it may not be the first time they have had a period of abstinence and the reflections of some study participants are likely to be a combination of learning from previous attempts of pursuing an abstinence-based recovery lifestyle. These occurrences will need to be portrayed in the study findings to improve the authenticity of the study results.

Charney, Zikos and Gill's (2010) study explored relapse in early recovery. Of the 175 patients who were monitored fortnightly once leaving formal treatment, 100 relapsed in the first four weeks. Those who relapsed were more likely to report non-dependence on another mood altering substance during assessment phase of their treatment, exhibit higher levels of impulsive behaviour, and have greater social problems at the time of admission. Charney, Zikos and Gill's (2010) findings also showed using a secondary mood altering substance further correlated to relapse for this population.

## **2.21 Well-being**

The World Health Organization refers to a person's overall well-being as being interconnected with a person's mental health. "Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community" (World Health Organization, 2011, p. 1). Land, Michalos and Sirgy (2012) state that there are many terms used to define wellbeing. Some of these include "life satisfaction, trust in others, positive emotions, meaning and purpose in life, and engagement and interest" (p.137).

## **2.22 Cultural Maori Perspectives**

A Maori perspective incorporates relational, identity, and spiritual worldviews; "a holistic view including spiritual aspects and connections with natural phenomena is central to well-being" (Hulse, White & Cape, 2002). The Te Whare Tapa Wha model highlights four domains for well-being. These are: spiritual, mental, physical, and family. The Te Wheke model gives further explanation of a Maori worldview and uses an octopus-like model consisting of 'tentacles': spiritual, mind, physical, extended family, immediate family, well-being of individual and family, acknowledgement of the life force in all things, the unique identity of individuals and families, the breath of life given by forebears, and healthy expression of emotion (Pere, 1995). Galanter and Kleber (2008) state that recovery from AOD dependence for some people may include "cultural recovery ... regaining a viable ethnic identity and developing a healthy affiliation with an individual ethnic group, as well as requiring a functional social network, a religious or spiritual commitment, a rebuilt social status in the recovering as well as the cultural community" (p. 50). Cowan (2008) writes that further work needs to be done to adequately define recovery for Maori, Pacifica and Asian peoples.

The study design for the ADWRNZ study needed the capacity for capturing the cultural aspects of participants' experiences that they perceive are important to their recovery and well-being experience. Because of this, qualitative rather than quantitative methods were chosen.

## 2.23 Change Theories and Models

Listed below are a number of theories that have been developed to answer the question of why people choose to address their AOD use:

1.	Janis and Mann's Conflict Theory, which proposes that internal dissonance between attitudes results in motivation for change (Janis & Mann, 1968).
2.	Prochaska and DiClemente's Transtheoretical Model of Change proposes individuals move through different stages of awareness before making changes (Prochaska & DiClemente, 1984).
3.	Baumeister's Crystallization of Discontent theory states that people will aim to maintain the beliefs they hold by rejecting evidence that conflicts with their perceived beliefs and attracting support that reinforces their beliefs. People make changes when due to the consequences and the level of discomfort felt from holding on to a certain belief is great enough. An example could be, 'I need drugs to function' however when the pain of using drugs gets bad enough the person will reassess their belief about needing drugs (Baumeister, Heatherton & Weinberger, 1994).
4.	Ebaugh's theory of change is similar to Baumeister's theory and suggests that change occurs when chosen roles no longer produce the effects desired. (Ebaugh, 1988).

In summary, the majority of these theories and models show that discomfort is a significant motivator for pursuing a recovery lifestyle and that recovery is a complex process. It is hoped that the ADWRNZ study will provide further insight into other motivations for ongoing change (maybe positive), as well as how much discomfort-based motivations encourage recovery in the first two years (if discomfort motivations do indeed encourage recovery).

## 2.24 Theories that Describe the Recovery Process

A number of theories derived from the rehabilitation sector may also provide insight into the recovery process. Livneh and Parker (2005) classify historical models explaining the

rehabilitation process into: single stage models, linear-like models, pendulum models, and interactive models. Stage-like models have predictable stages. Linear-like models are more complex in construction and acknowledge that there are multiple issues affecting a person's adjustment process including personality, the condition itself, coping skills, and their self-concept. Pendulum models, as the name suggests, acknowledge the swinging effect that people exhibit between former self-concepts and condition inclusion self-concepts. Interactive models not only focus on the individual adjustment but also the environmental influence within the adjustment process.

Another theory, Chaos and Complexity Theory (CCT) (Kingemann et al., 2001), applied in the rehabilitation setting may be worth considering. It originates in meteorology, mathematics and other fields and helps explain some of the characteristics of natural phenomena too complicated to understand fully. In the last 20 years the application of CCT theory in behavioural and social sciences fields has been explored. CCT states that when consumers and their families are adapting to change due to chronic conditions the process is often dynamic, unpredictable, cyclical, and complex in nature. Within this chaotic process CCT proposes there are still identifiable systems that may be useful to observe (Livneh & Parker, 2005). For example, non-linear systems are often present at the beginning of the adaption process when reactions are not proportional to the activation event. This theory identifies points of attraction or focus of systems named attractors. For example, 'fixed point attractors' are points of fixation where the whole system is fixed and is closed to outside influence. Often these fixation points within non-linear systems focus on the here and now. 'Sensitive dependence' has been termed to name this reaction and is associated with the initial shock responses of individuals and their families adapting to chronic illness or disability. The theory states that the natural order of things is for systems to move to more ordered harmonious configurations. These are called dynamic systems having both random and ordered processes. Dynamic systems are open; information, energy and resources are exchanged with each other in the systems and the environment. Unlike non-linear systems, these systems do lose energy over time therefore they need to reduce their disorder and pursue equilibrium as a survival response.

## **2.25 Literature Review Summary and Conclusion**

After a review of national and international literature a number of aspects relevant to AOD recovery were found. These included a variety of current and developing understandings of dependence (addiction) including understanding dependence as a brain disease.

Further explorations looked at how discomfort creates the motivation for people with AOD problems to get help. Several wider issues were also discovered including the stigma often associated with having a AOD problems, as well as systemic clinical deficits, and professional attitudes that have been found to be barriers for people with AOD problems when accessing help in the New Zealand setting.

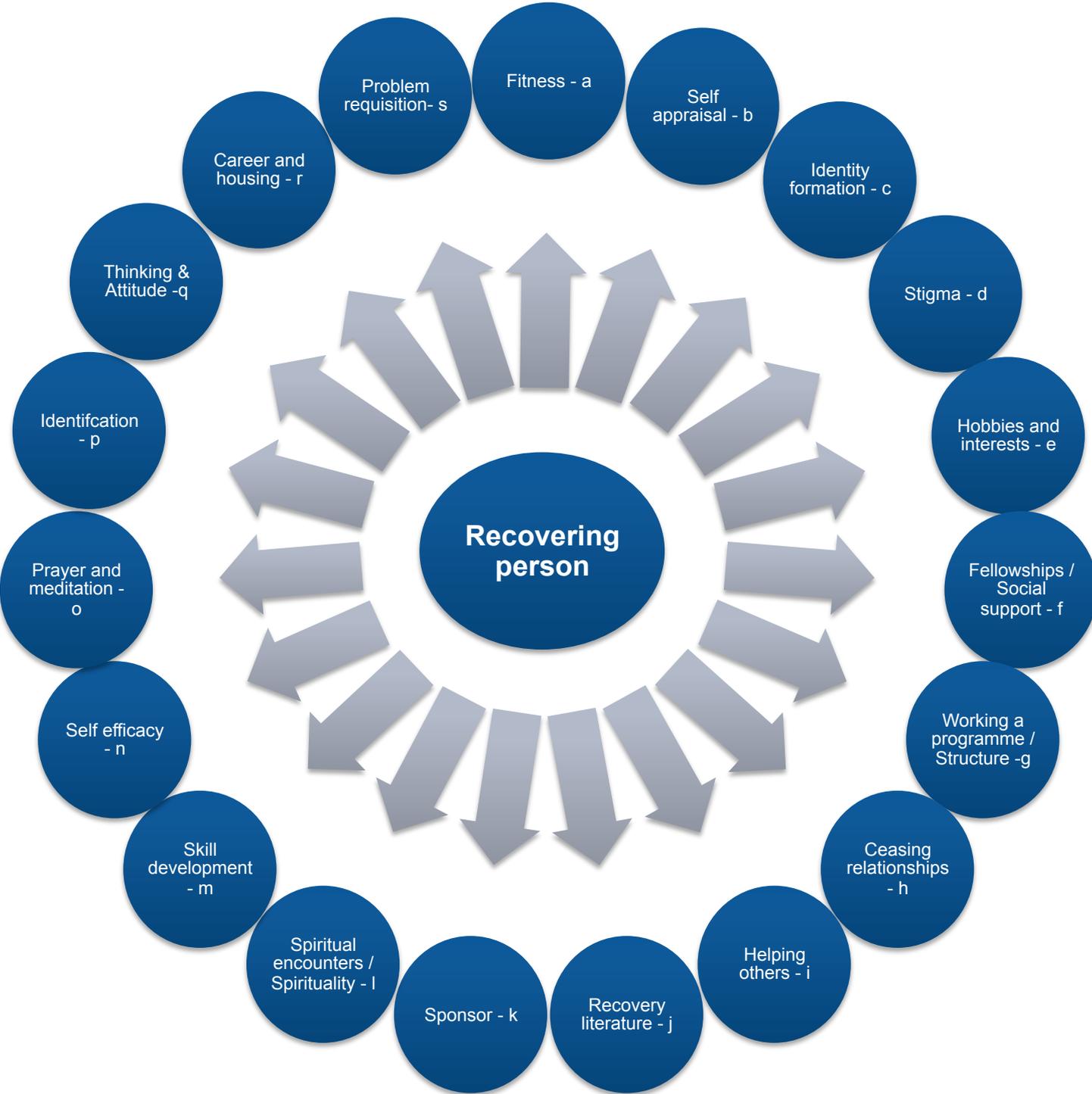
Research also showed there are a number of different treatment approaches used for people with AOD problems. The dominant treatment approaches with people with AOD problems include CBT, motivational interviewing, and 12-step facilitation approaches. One study explored what were the successful treatment ingredients. These included: bonding and support, collaborative relationships, and the use of meaningful rewards to name a few. The place of developing recovery supportive relationships and ceasing relationships that are detrimental to one's recovery was also identified. Following a recovery programme or philosophy of life and developing an identity that is not reliant on drugs or alcohol was also discussed.

Learning new practical coping skills, including structuring one's day, dealing with challenges and the emotions that result so as not to return to alcohol or other drug use were also identified as issues newly recovering people may face. Furthermore, for some people making practical changes in career, personal interests and living situation was shown to be important in achieving a positive recovery and improving their overall well-being for some recovering people. A number of theories and models describing the recovery process were reviewed that may explain the adjustment process people recovering from AOD work through.

Finally, though there is international and national literature on the AOD recovery experience, this tends to be limited to specific aspects of a person's recovery. These limits are further exacerbated in research in the New Zealand context. Therefore there is merit for the ADWRNZ study in order to broaden understanding of abstinence-based recovery for people with AOD dependence in the first two years in the New Zealand context utilising qualitative research methods.

The following chart has been formulated to assist in conceptualising the many areas that literature has shown to be part of the alcohol or drug recovery process for differing people.

**Figure 2.1**



- a (Brown et al., 2009; M. Galanter & Kleber, 2008; Read et al., 2001)
- b (Kingemann et al., 2001)
- c (Laudet, 2007; Weegmann & English, 2010)
- d (Boysen & Vogel, 2008; Hoffman & Froemke, 2007; Room, 2005; Scohomerus et al. 2011; Todd, Sellman & Robertson, 2002)
- e (Sobell et al., 2000)
- f (Baker, Sellman & Horn, 2006; Bischof et. al, 2007; Hser, 2007; Laudet, 2007; Majer et al. 2002; Miller, 2009; Morgenstern et al.1996; Moos, 2007; Paris & Bradley, 2001; Rushing, 2008; SAMHSA, 2008; Scobell et al. 2000; Sobell & Cunningham, 1996; Tonigan, Conner & Miller, 1996; Tonigan, Miller & Schermer, 2002)
- g (Jason et al., 2007; Laudet, 2007; Morgenstern et al. 1996; Rushing, 2008)
- h (Hser, 2007; Sobell et al. 2000)
- i (SAMHSA, 2008)
- j (Morgenstern, Kahler, Frey & Labouvie, 1996)
- k (Morgenstern et al., 1996)
- l (Baker et al., 2006; M. Galanter et al., 2007; M. Galanter & Kleber, 2008; Neff & MacMaster, 2005; Tonigan, Miller & Schermer, 2002; Paris & Bradley, 2002; Robinson, Cranford, Webb & Brower, 2007; Rushing, 2008)
- m (Conyer, 2009; Galanter & Kleber, 2008; Litt, Kadden, Kabela-Cormier & Petry, 2008; McGovern et al. 2005; Miller, 2009; Savage, 2007)
- n (Kingree, Thompson & McCray, 2007; Majer et al. 2002; Majer et al. 2004, Majer et al. 2011)
- p (Morgenstern et al.1996)
- p (Majer et al. 2002)
- q (Galanter & Kleber, 2008; SAMHSA, 2008)
- r (Sobell et al. 2000)
- s (Kingemann et al. 2001; Rushing, 2008; Sobell et al. 2000).

## **Chapter Three: Research, Design and Methods**

### **3.1 Introduction**

This chapter includes a discussion on the research ethics approval processes, methodology, methods chosen to complete the ADWRNZ study, including sample selection, retention rates of study participants, demographic information, and results of the DSM-IV self-screening tool.

### **3.2 Research Methodology**

Davidson and Tolich (1999) state that understanding research methodology means understanding the assumptions that underpin the particular research approaches used in a given study. For example qualitative/interpretive based research aims to gain new understanding of social interactions. Furthermore, a qualitative approach assumes social interactions are not constant but changeable whereas positivist research assumes there are known natural laws that can be identified that are predictable and control certain events.

This study design utilised a qualitative/interpretive methodology because the aim of the study was to gain theoretical insights from the study findings, rather than to propose a theory prior to undertaking the research, seeking evidence to support a hypothesis. Miller, Strang and Miller (2010) state that the strength of the qualitative approach is that it can redefine or develop concepts about given phenomena.

Bryman (2008) states there are three traditions that dominate qualitative based research. These are phenomenology, ethnomethodology and interactionism. In their most simple form, phenomenology is the study of individuals' experiences independent of external agents; ethnomethodology is the study of how individuals use conversations, gestures and symbols to make sense of the world; and interactionism is the study of how individuals interact in society based on the meaning they attribute to certain aspects of social phenomena.

At some level all of these methodological traditions underpin this study design because this study focuses on the subjective experience of individuals' recovery experience, the language and symbols they use, and the meaning that individuals place on certain aspects of their recovery community.

Bryman (2008) describes general steps that qualitative researchers follow. These are: formulate a general research question, select the appropriate research participants, collect relevant data, interpret the data, conceptualise a framework from data to clarify the research question, collect further data based on the clarified research question, and write up findings and conclusions.

### **3.3 Limitation of Existing Research**

Orford (2008) raises a number of concerns about existing research about addictive behaviour change. Some concerns are that in general research often does not take into account the views of those with addictions, it fails to explore the wider systemic influences on addiction, and tends to focus on techniques over relationships. Overall, Orford (2008) concludes the major limitation of existing research is its focus on technique over the addiction and recovery process. Therefore, this study was designed to focus on the views of people experiencing the recovery process.

Though understanding the recovery process is important, this is beyond the scope of this study as this would require gathering either a longitudinal study cohort or exploring what participants perceived was important to their recovery at selected time periods, for example, at three, six, 12, 18 months and at two years. What the ADWRNZ study was able to capture in significant detail were the views and experiences of people with AOD dependence.

### **3.4 Brief Research Methods Chosen**

A number of qualitative methods were reviewed as to their appropriateness in achieving the study aims. These included discourse analysis, semi-structured interviewing, self-completed questionnaires, focus groups, focused conversations, photo voice, study participant journals and structured observation.

The methods chosen as most appropriate to answer the research question were self-completed questionnaires, open-ended questionnaires, focus groups utilising principles from focused conversations, photo voice, and participant journals. As identifying recovery areas/themes is desired, the data was analysed using a thematic analysis approach.

### **3.5 DSM-IV Dependence Self-Screening Tool for Participants in the Study**

To ensure that study participants met the condition of dependence on alcohol and/or drugs, the Diagnostic and Statistical Manual for Mental Disorders IV criteria for alcohol and other drug dependence was used to develop a screening tool.

For a person to meet the criteria of dependence on alcohol and/or other drugs they must manifest 3 (or more) of the 7 criteria listed within any 12-month period. The more criteria a person meets the greater the severity of the dependence on alcohol and/or other drugs. Two of the criteria relate to the physical symptoms of withdrawal and tolerance, while five criteria relate to the psychological and psychosocial symptoms of dependence (see page 52).

### **3.6 Participant Questionnaire**

A participant questionnaire was included to gather general demographic information for each participant as well as confirming their suitability for the study. This includes gender, date of birth, contact details, ethnicity, level of education, term of abstinence-based recovery, mood-altering substances participants were recovering from having used, employment status, current occupation, number of months worked in the past two years, involvement in community service activities, and an assessment of their well-being after two years of abstinence-based recovery using a 10-point scale.

### **3.7 Focus Groups & Principles of Focused Conversations**

Two focus groups were planned for this study, scheduled for Thursday evenings at a local conference centre in Auckland. These groups occurred over consecutive fortnights and were each of two hours duration. A 15-minute break was taken after the first hour; refreshments were provided.

These focus groups were designed to utilise the principles of focused conversations. Focused conversations are a collaborative process where participants are able to put forward their thoughts, feelings and motivations without fear of their words or terms they choose being final. This is made possible by using a cyclical process of reassessing their contributions until participants are happy with the explanations they have used. This open discussion provided a forum where contributions from one participant could assist in triggering the thoughts of other participants in the group (Clough & Nutbrown, 2002) (Cohen, Manion & Morrison, 2007). Clough and Nutbrown (2002) write about their experience of using focused conversation, "Our sessions had all the features of a long,

animated, passionate conversation; Short pauses, long silences, discomforts, agreements, disclaimers, retractions, clarifications, humour, interruptions, repetitions, emphasis, misunderstanding, excitement, conflicts, and discoveries” (Clough & Nutbrown, 2002, p. 75).

Participants were given a number of possible conversation starters to consider before the focus groups sessions were held (see Appendix B). It was also stated clearly that the conversation starters were optional for participants, and for the purpose of providing opportunities for those participants who preferred having some time prior to entering a group setting to consider their contribution.

### **3.8 Journals**

Journals allowed participants to record their thoughts and feelings about the research process at other times, capturing data not normally accessible through the other research methods chosen. Another benefit of a journal is that participants were not limited to writing, and so mind maps, drawings, magazine cut-outs, and special quotes could all be included (Alaszewski, 2006). Nine participants made entries in their journals.

### **3.9 Photo Voice**

Cameras were also given to study participants to collect pictures that in some way captured participants' recovery and well-being experience. The participants were asked to record in their journals an explanation of the photos taken. The choice to use or not use the cameras and journals was at the discretion of the study participants. Six participants used the cameras provided. As part of participants' confidentiality agreement, stipulations were made to protect other people's personal images as well as other community or organisational groups.

Wang (2006) explains a number of considerations when using photo voice as a method of collecting research data. This includes training participants in how to use the cameras, gaining formal consent, educating participants about the type of photos they could take, specifying a time frame for taking photos (two weeks), and providing an opportunity to discuss and record an explanation of the photos taken.

### **3.10 Audio Recording of the Focus Groups**

The two focus groups were tape-recorded. These recordings were for the researcher to review and listen to the information discussed in the focus groups and to capture direct

quotes where appropriate. Permission was given by all participants to record the audio from the focus groups.

### **3.11 Sample Selection**

This study utilised a research assistant within the recovery community to approach possible study participants that he perceived met the criteria for the study. The principle researcher then made contact with the possible study participants. Study information and the appropriate consent forms about the study were then sent to participants. Of the 15 study packs that were sent to possible participants, 4 were returned, and 11 people completed the consents to be included in the study.

### **3.12 Inclusion and Exclusion Criteria**

The criteria for study participants were as follows:

- Study participants had to believe they were pursuing a recovery-type lifestyle that is beneficial to their well-being.
- Study participants had to have two or more years of abstinence-based recovery. This time frame has been chosen because the focus of the study is on recovering people's perspectives of recovery in the first two years.
- Study participants had to be over the age of 21 years.
- Study participants had to be fluent English speakers; however good writing skills were not necessary, as a scribe was used to record discussions during the focus groups. The scribe was another person and not the research assistant.
- Study participants did not include any person that I have been a primary case manager of when I was working as an AOD counsellor.

### **3.13 MUHEC Approval**

Approval from MUHEC to proceed with the study was received on 21 April 2011 (see Appendix G). A number of stipulations were made to protect the confidentiality of individuals, organisations and community groups.

### **3.14 Protection of 12-step Group Anonymity**

Because protecting the anonymity of 12-step fellowships is important, where participants referred to involvement in Alcoholics or Narcotics Anonymous, this was referred to in findings as involvement in 12-step groups. This term was discussed and agreed upon with

a number of Alcoholics and Narcotics Anonymous members involved in the conscience groups for the protection of the Alcoholics and Narcotics Anonymous anonymity mandate. Conscience groups are individual groups, which are each run autonomously to discuss and find solutions where consensus can be arrived at for the betterment of the 12-step movement. It was requested that the terms AA, NA, Alcoholics Anonymous or Narcotics Anonymous or any identifiable information of individual members or specific community groups not be used in the publication of study findings (see Appendix D).

### **3.15 Commitment to the Treaty of Waitangi**

Participants could have been Maori, however Maori were not the primary focus of the project. There was no planned subgroup analysis based on ethnicity. Participants were treated with dignity and respect regardless of their culture and beliefs.

It is also important to note that the researcher attempted to capture not only cultural perspectives but also a wide range of beliefs that maybe present within a community setting. Te Whare Tapa Wha is a well-known Maori model that highlights the four cornerstones of health for Maori. These include ensuring attention is given to the (1) spiritual, (2) thoughts, emotions, and behaviours, (3) physical, and (4) whanau/family dimensions in health and well-being. The study findings will be reviewed in light of these Maori health cornerstones in the discussion section of this thesis.

### **3.16 Thematic Analysis**

Miller (2009) states that the thematic analysis process normally follows these five stages:

- Familiarisation of the data (through written field work, notes, listening to audio-recordings, re-reading and annotating transcripts, and generating analytical memos)
- Identification of a thematic framework
- Coding (while refining the coding frame)
- Charting (listing the transcription details of codes by theme or case)
- Interpretation (generating typologies or associations)

Furthermore, data is generally coded in two steps, first level and second level coding. First level coding identifies overall categories, which tend to be descriptive; second level coding may be either thematic or analytic in nature for the purpose of dividing first level codes into richer components.

Bryman (2008) adds that when following a thematic analysis approach researchers need to remain mindful of a number of considerations. These are: remembering where the data came from; keeping to the language that study participants have used as much as possible; being aware of repetitions in the data; noting expressions specific to the participant group; noting when transitions from one topic to another occur; being mindful of similarities, differences and content not present in the data; and looking for linguistic connections in the data.

### **3.17 Data Analysis**

Of the 11 people who participated in the study, 11 completed the first focus group and nine completed the second. The two participants who were unable to attend the second focus group both were called away due to work commitments, however they made a special effort to record in detail their contributions to the study in their journals.

The researcher's assistant chosen to approach potential participants had three years of personal recovery from alcohol and other drugs. He was involved voluntarily in the 12-step recovery movement. This involvement includes attending/facilitating regular 12-step meetings and participating as a General Service Representative for local 12-step groups. He agreed to provide the initial study information sheets to recovering people whom he perceived met the criteria for the study based on the study inclusion and exclusion criteria and give them a study information sheet detailing the study (see Appendix B).

Those people who contacted the researcher to show interest in being involved in the study were then sent out further information about the study including:

- A letter of appreciation for showing interest in the study
- Another study information sheet
- The DSM-IV AOD dependence self-screening tool
- Consent forms

This information was then returned to the research assistant in a sealed envelope who forwarded it to the researcher.

Participants were then sent identifying information about the nature of the focus groups as well as the suggested conversation starters to think about before the first focus group.

The first focus group session was held on 19 May 2011 at Mount Richmond Conference Centre, Otahuhu, Auckland. This venue was chosen because of the size of the rooms

available and the resources offered, and because it met the requirements for ensuring participants confidentiality. The focus group was opened with the researcher's introduction and appreciation voiced to participants for their participation in the study. A round of brief introductions by the research participants followed this. The researcher then reviewed the details in the information sheets including the purpose of the study and availability of counselling; participants could make direct contact with the counsellor provided if they needed to. The participants were given the study questionnaire, journals and cameras and had their purpose explained. Study participants were then given the opportunity to ask any questions. The dictaphone recorder was explained and turned on. The researcher then discussed in a collaborative manner the group rules for the focus groups.

These were as follows:

- Stick to the time frame
- All contributions are valid
- Everybody gets the chance to share
- Maintain confidentiality about what is discussed
- Respect each other

The participants were given the option of starting the discussion by either working from the conversation starter questions or brain storming key areas on A1 sheets of paper. The unanimous decision was to brainstorm key ideas. When this was completed the participants unanimously agreed on the first area to discuss in detail. The scribe enlisted in the study recorded all information gathered on large A1 sheets of paper so participants were able to continue to review their contributions and make amendments as they saw necessary. New aspects of recovery flowed out of the existing areas discussed. In the first focus group 12 areas of recovery were explored in detail. Throughout the group the principle process of focused conversations, clarifying and re-clarifying individual's contributions occurred in a cyclical process. A refreshment break was taken half way through the focus group. In part two of the first group, discussion continued on from where part one discussion finished. At the end part two of the first focus group the researcher thanked the study participants and finished on time.

The second focus group was conducted on 2 June 2011 and followed the same format as the first. The A1 sheets of paper from the first focus group were placed around the room for study participants to re-familiarise themselves with the data collected in the first group.

The researcher reviewed any questions that study participants had about the study process to date. The ground rules were revisited. The journals, cameras and questionnaires were collected. Of the 11 journals given, 10 were used to varying degrees, one was returned unused. Six study participants chose to take photos, five participants returned the cameras unused, and all 11 questionnaires had been completed. The dictaphone recorder was explained again and turned on.

The researcher then reviewed the 12 areas of recovery and details pertaining to each from the first focus group. The scribe again recorded all information shared on large A1 sheets of paper so participants were able to continue to view their contributions. Further details were added to a number of the recovery areas already discussed and new recovery areas emerged following the cyclical process principles of focused conversations of reviewing study participants' contributions and making amendments where participants felt necessary; a further 5 recovery themes were identified. At the end of this second focus group all study participants were again thanked for their contributions. The second focus group finished 15 minutes over the scheduled timeframe as the study participants wanted to finish the final recovery area being discussed at the time.

The participant questionnaires were then analysed in a statistical manner identifying the average age, terms of abstinent recovery, and well-being scores. The audiotapes from the focus groups were then transcribed to enable the researcher to re-familiarise himself with the data collected.

A thematic process was utilised which followed a number of Miller's (2010) and Bryman's (2008) suggestions including:

- Becoming familiar with the data by reviewing and re-reviewing written data (A1 sheets recording/transcripts) and listening to audio-recordings gathered from the focus groups. Initial themes were noted.
- Data from the transcripts was then analysed and coded into overriding themes that emerged.
- Theme summaries were then written ensuring that all of the study participants' contributions were represented. Supporting quotes were left to support theme summaries.
- The A1 sheet recordings and transcripts from the focus groups were then reviewed to ensure all data and emerging themes were captured.

- When interpreting data, effort was made to use the language that study participants had used. Attention was given where repetitions in the data occurred as well as where study participants used expressions specific to the study participant group. Attention was further given to where transitions from one topic to another occurred, or where similarities/differences in study findings became evident. Furthermore, attention was also given to content not present in the data.
- All this data was then compared, contrasted and discussed in light of current literature on abstinence-based recovery.

### 3.18 DSM-IV AOD Dependence Self-screening Tool Results

All 11 participants approached by the research assistant met AOD dependence criteria, identifying with three or more of the criteria outlined in the screen tool. The results are as follows:

**Table 3.1**

<b>AOD DSM-IV Criteria</b>	<b>Criteria met by participants</b>
1. Tolerance	<i>n</i> = 9
2. Withdrawal	11
3. Loss of control	11
4. Desire to cut down or stop	11
5. Preoccupation	11
6. Missed activities	11
7. Continued use despite adverse consequences	11

## Definitions

1. Tolerance occurs when a person requires a greater volume of the same mood altering substance to get the same effect.
2. Withdrawal occurs when a person has physical symptoms as a result of suddenly ceasing use of a mood altering substance e.g. (shakes)
3. Loss of control occurs when a person intends to use a certain volume of a mood altering substance but uses much more.
4. Desire to cut down or stop means an ongoing desire to reduce or stop using a mood altering substance however a person does not moderate or stop their substance use.
5. Preoccupation occurs when much of a person's cognitive process is taken up thinking about the substance in question.
6. Missed activities means that activities such as employment, family, or social commitments are missed due to substance use.
7. Continued use despite adverse consequences means that a person continues to use a substance despite the problems it is causing e.g. legal or health complications.

The DSM-IV substance dependence self-screening tool showed that the majority of study participants (9) met the criteria for severe dependence on alcohol or other drugs. Two participants met the criteria for moderate/severe dependence on alcohol or other drugs. Of those who were moderate/severe, both the absent criteria were physical criteria of withdrawal and tolerance.

### 3.19 Characteristics of the Study Participants

There was a good balance between male and female participants with six participants being male. The age range of study participants was 25 – 65 years ( $M=41.36$ ,  $SD=10.71$ ). At the time of the study the majority of study participants were working with one participant not working and one participant a stay at home mother. The occupations of participants

varied: Vet Nurse, Company Director, Customer Services, Lawyer, Accounts Manager, IT Manager, University Lecturer, and Sales Support. The majority of participants (7) had a history of both alcohol and other drug dependence, with 4 participants being dependent on alcohol only. The length of abstinence-based recovery time achieved by participants at the onset of the study ranged from 2.1 years to 20 years ( $M=6.29$ ,  $SD=6.5$ ). All study participants were engaged in 12-step or other community-based service at the time of the study, 10 within the 12-step community, 1 in the church setting, and four participants in other community service roles as well. The majority (8) of study participants worked 20 months or more during the first two years of their recovery. Three study participants worked less than seven months during this time. The study participants mean score of well-being after two years of abstinence-based recovery was 7.45 ( $SD=1.92$ ) out of 10, ten being excellent and one being poor.

The next chapter details the ADWRNZ study findings.

## Chapter Four: Research Findings

### 4.1 Introduction

This section covers explanations of a number of recovery areas identified during the focus groups, and individual contributions from study participants' journals and cameras. These recovery areas will be explored in the same order they were discussed in the focus groups.

### 4.2 Focus Group Recovery Areas Identified

#### Acceptance of AOD problems & first steps to getting help

*'Denial couldn't carry on if you accepted ... and there's no more trying to think up excuses or rationalise my way out of it. To hell with it, I'm one of them'*<sup>1</sup>

Study participants explained a number of factors in the process of coming to a place of getting help for their alcohol or drug addiction. All the study participants related years of being *'in denial'* about their drinking or using. Two study participants described how surprised they were when told by others in society that they needed help for their alcohol use. Three study participants explained the initial reservations they had about 12-step fellowships. Other study participants explained how intrigued they were by peers who did not drink or use drugs and how this had led to conversations that, for them, resulted in attending a 12-step meeting. Another study participant described failed half-hearted attempts at getting professional help. Another study participant described having to overcome the mental barrier of not being able to socialise or deal with life struggles without alcohol or drugs and the resulting feelings. *'Hitting rock bottom'* was a term used by other study participants as the turning point in addressing their drinking or drug misuse. One study participant described the disintegration of his values and beliefs as a result of drinking or using drugs. One study participant explained how television advertising, which focussed on "it's how we are drinking that is the problem," had motivated her to do something about her drinking. Another study participant described how his preconceived idea of what an alcoholic was, was an initial barrier to getting help for his addiction problems. He said that, for him, an alcoholic was someone who lived on the streets, smelt bad and drank out of a brown paper bag. The obsession with drinking socially was noted by another study participant as a barrier to getting help. Another study participant stated

<sup>1</sup> All italicised quotes are from participants in this study

that for him the biggest barrier to addressing his drinking problems initially was walking past bottle stores without going inside and purchasing alcohol.

The process of accepting one's drinking or drug problems differed between study participants, however for the majority there was a strong association between acceptance, acknowledgment, and identification. For some study participants, acknowledgment was the first stage of a deeper acceptance of their addiction. Identification was noted as a significant part of the acceptance process that predominantly occurred when hearing 12-step members share about their drinking or drug-related behaviours at 12-step meetings.

For some participants, acceptance came immediately after reading recovery material following their first 12-step meeting, for others realising their dependence on alcohol or other drugs and the level of recovery activity required to stay in sobriety took months, years, or was still an ongoing process. It is important to note that study participants aligned acceptance of the severity of their AOD problems with the level of recovery solutions they applied. This was demonstrated by previous '*half hearted attempts*' to address their AOD problem due to the 'level of denial they were in at the time'.

Gaining knowledge about the disease of alcoholism or addiction was another significant factor for many study participants in accepting that they were either an alcoholic or addict. For some study participants, learning about the disease concept of addiction occurred during formal treatment settings, others learned this from their sponsor or other 12-step material they read. All the members of the focus groups noted that accepting that they were an alcoholic or addict brought a significant sense of relief. For some, the label of alcoholism meant they could do something about their life; prior to recovery they had felt they had some undiagnosed mental instability. Acceptance was also associated with trusting wider support systems for help to stay clean and sober. One study participant spoke of how the process of acceptance occurred after accepting Christ, and following this, her compulsion to use drugs ceased. Prior to this experience she talked about being on a long journey of coming to the end of her own efforts after pursuing a life of self-healing and self-help. One study participant shared that acceptance put an end to his internal intellectual debate as to whether or not he was an alcoholic. The result of acceptance was a great sense of relief as he said denial was a tiresome and full time job. For others, acceptance meant accepting there was another way to live, a solution to compulsive drinking or drug use problems. It was agreed that there was no real pattern to when someone accepted they were an alcoholic or addict. Overall, study participants

displayed a universal acceptance of life situations and personal limits. This was demonstrated by trusting in the non-demanding process for 'new comers' to 12-step meetings to come to a point of acceptance regarding their drinking or drug problems.

### **Higher Power and Spirituality**

*'I had a very amazing spiritual, incredible, blinding light, I suppose you would say, experience and that certainly transformed me and changed me and I've never looked back'*

Higher power experiences were described in much detail by a number of study participants who were surprised and appreciative of being able to talk about this topic in so much detail. A number of study participants stated that in all the years of attending 12-step meetings they had never heard people talking so openly about these types of experiences, acknowledging that their reluctance to share in the past was due to being unsure of how they may have been perceived. One study participant talked about a 'blinding light' experience which for him solidified the existence of a higher power, and that the 12-step programme would work for him. He explained that his experience occurred after completing step three with his sponsor two months into his sobriety. Another middle-aged woman described a total weightlessness that was more overwhelming than the birth of her first child. Another female study participant described a significant spiritual experience that occurred at a 12-step camp with a recovering girlfriend, which made her feel like she was not on this planet. Another study participant shared passionately about going to a Christian movie where she felt a love from outside of her flowing into her that she had never known.

Others in the group described their higher power experiences as more of the educational variety, of slow incremental steps of trust. One male study participant said, for him, this was remaining open minded to whatever possibilities there were regarding a higher power. Overall, study participants' higher power perspectives were not something they had totally figured out but rather they were a process of trust and openness to ongoing learning. A woman described lightweight spiritual experiences, little gems along the way, and times of relief, peace, lightness, or strong spiritual connections. Another study participant stated it took a few months to develop spiritual connection. He described his spirituality as a deep knowing that he was on the right path. One study participant shared how he struggled initially with the higher power component of a 12-step programme, however a

breakthrough came with realising that he didn't have to be self-sufficient anymore and that there was something out there to help him. Another study participant explained that, to him, higher power meant two things, *'there is one [God], and I am not it!'* A number of study participants explained that being able to choose a higher power of their understanding was important as some had negative experiences of religion.

Over all, two thirds of the group animatedly described having spiritual encounters which sealed the existence of a higher being and they attributed this significantly to their recovery success. Study participants wanted to make very clear that these encounters had not originated from them and they were not 'out of it' on alcohol or other drugs at the time.

### **Recovery Fellowships**

*'Yeah, it was great, just a bunch of crazies where I was finally part of a gang that accepted me and that I accepted. It was magic really'*

Of the 11 study participants, 10 still attended 12-step fellowships as part of their active recovery lifestyle. In the early days of their recovery, some study participants attended 90 12-step meetings in 90 days; others attended four times a week. Study participants stated that 12-step fellowships were where they received motivation by seeing so many people on a similar journey addressing their addictions, where they heard other peers with similar stories, had the opportunity to observe role models on how to stay sober, and gained a sense of belonging, unconditional love, and acceptance. One young man shared how in the first few 12-step meetings he received motivation from a couple of guys who were *'walking the talk'* and really enjoying their recovery. Another study participant added that 12-step fellowships were where he found people who genuinely seemed to be trying to help each other and materialism or acquiring things was not the focus, which was fascinating and attractive. He went on to explain that he did not feel good about himself when first attending a 12-step fellowship, and that the non-judgmental acceptance he received from other people in recovery was essential for him or he would not have stayed.

Other participants shared how surprised they were at the level of honesty displayed by 12-step members about their life. It was agreed that the more honest in meetings and with peers a person was about their life the more they were esteemed. A number of study participants highlighted the profound contrast of the authentic relationships in the 12-step environment to their drinking or drug using environments. One study participant said he

felt more love within the 12-step fellowship than he did from his own family. Another young woman expressed her appreciation that she did not feel she had to be bad enough to join the fellowship. This was due to her youth and the limited consequences resulting from her using. There was strong agreement that newly recovering people helped each other as much as their sponsors in the early days of their sobriety. Meeting with other 12-step members not only occurred within meetings, but members also met socially and in their own time to support each other. One male study participant gained a lot of support from a fellow employee who was also in recovery. One study participant utilised a church support setting rather than the 12-step community for her recovery. She related strongly to the experience of those who utilised a 12-step support setting, specifically how important it was in the first three years to have the unconditional love of her parents, who were Christians, when returning home pregnant after a long-term estrangement due to a lifestyle of heavy drug use.

### **Sponsorship**

*'When I started on step 4 with my sponsor, he encouraged me to bring up the worst stuff... things ...[I was most] ashamed of and he gave a few examples of his own stuff and so we did, ... stuff that I really thought I would never tell anybody, it was too shameful really... that was, ...[a] huge sense of relief'*

Sponsorship was another area that all the study participants stated was very important to their recovery in the first two years. They used terms such as 'leadership, mentorship and accountability' to describe their sponsorship experiences. Sponsorship was explained as a common practice within 12-step fellowships where newly recovering people received one-on-one support. Sponsors helped study participants to develop structure in their days; were someone they could talk to about the early challenges of their recovery, and who could assist them to work through the 12-steps. Study participants valued being able to share openly and honestly with their sponsor about their previous life experiences, things they had done or not done in the midst of their drinking and using, and things they had strong feelings of guilt and shame about when first entering recovery. It was also important to a number of study participants that their sponsor was a recovering alcoholic or addict because that helped them to share more openly about failings. There was strong agreement that sharing these types of experiences with their sponsor resulted in significant emotional relief and peace. One study participant said it was a form of what he

perceived confession to be. One male study participant explained that his relationship with his sponsor included being completely honest about the darkest, worst things he had ever done. Sponsors were people who newly recovering people often admired. The study participant who did not utilise 12-step support groups, but attended a church, also identified key sponsor-type people in her recovery journey. She described these relationships in terms of connection and bonds and related strongly to the experiences of other study participants.

### **Relationships with Others including those still using AOD**

*'...There were about 10 of us women, and there was a couple of guys dancing ..., how awesome is this? We're all doing the same buzz, we're in a pub, having the time of our life and we're all sober...'*

Relationships with others created a lot of discussion in the focus groups. This included how important supportive relationships were in early recovery and how some old relationships had changed now that study participants were sober. For one study participant this meant leaving his partner who was still drinking. Further discussion included how study participants had learnt to set boundaries around how much exposure they had with people still drinking or using drugs, being honest with themselves about their motives for attending certain events, and how being with people who were drinking or using drugs while sober themselves often changed study participants' perspective on the value of the drinking and using culture.

Some study participants found themselves uncomfortable around alcohol and drugs in general, whereas others explained how they liked being around people who treated alcohol in a non-dependent manner. Younger study participants still tended to socialise at times in drinking situations, however they practiced vigorous self-honesty about their vulnerability to drink in alcohol-saturated environments. Two younger study participants explained how they still went clubbing and how exhilarating it was to be with other recovering people sober in these types of environments. Furthermore, one explained that if her '*head was not in the right space*' she would not go out where alcohol was present.

Female friendships were important for one male participant who explained how much the regular company of two female friends meant to him in early recovery after leaving his partner who was still drinking. He met with them weekly for a meal out. A number of study participants explained how they had planned strategies when socialising with friends,

family, or associates who were heavy drinkers or drug users. These included having reasons to leave and taking their own car. Some study participants explained how old friends sometimes did not understand the abstinence stance they had taken in the management of their addiction. Some stated they could not associate with non-supportive people in the first two years of their sobriety. Having fun while sober was also important to all study participants who explained that they had more fun sober than they ever had while drinking or using drugs. One male study participant explained how he had to learn to have fun sober. One explained how he was initially fearful to the point of having panic attacks about associating in places where alcohol was present. He explained how through graduated exposure and setting boundaries he gained confidence to ensure his sobriety. Another study participant shared how being away at work conferences now meant she would have an *'early night'*.

A couple of study participants explained that lollies/sugar were helpful to replace the alcohol they used to drink. Others shared that having special non-alcoholic drinks was a useful strategy in early recovery. Another study participant explained that it was important for her to have a non-alcoholic drink in her hand when she was out socialising.

### **Working a Programme, Addressing One's Egocentricity**

*'I've always been self-sufficient, my way or the highway, I know the best, nobody can tell me how to do it'*

Working a programme was another theme discussed during the focus groups, which all participants considered important to the success of their recovery. This was an active commitment to complete certain tasks within one's day or week. Study participants explained that recovery was not just about abstinence but pursuing a whole lifestyle change. Other study participants explained that working a programme meant achieving specific tasks toward bigger goals; for example, if the task was completing a list of resentments as part of step 4, then they would work through one or two resentments a day until completed. Step four of the 12-steps (see Appendix C) directs a person to take a fearless moral inventory of their behaviour. One study participant explained that he maintained a gratitude list as part of his recovery programme. This included things such as good health, being sober and supportive friends. A number of study participants related to abstinence not being the focus of their recovery but rather living life. Another study participant explained that recovery meant learning to see himself the way he really was

and taking responsibility for his actions. Another study participant explained that living one day at a time worked well for him and stopped him worrying about future events that have not happened yet.

Ten study participants said that *'working the 12-steps'* with their sponsor was a primary focus of their recovery. Of these steps, they made specific mention of steps 4, 5, 8 and 9, (see Appendix C) which related to taking a fearless moral inventory, making amends and continuing to take a moral inventory. One study participant explained that after completing step 5, for the first time in his life his thinking stopped racing, resulting in a profound quiet and peacefulness. Other study participants also explained that addressing resentments and moral shortcomings was essential to on-going sobriety. They made reference to key 12-step literature where resentments are referred to as the number one offender in relapse. Another male study participant shared about his struggle with needing and asking for help in the first two years of his recovery and how, on reflection, this was due to being overly self-sufficient. He explained that in the end taking small steps and focusing on completing the next recovery task worked for him.

Study participants shared how working the steps had become a part of their day-to-day lifestyle, but for some the benefits took time. Other study participants described how the steps were not just completed once but were lived on a daily basis. One study participant explained how he uses step 10 (continue to take a moral inventory) in his daily life; if he is at all disturbed he needs to *'do a step 10'* with his sponsor. Another study participant said this meant recognising hurtful behaviour and then apologising immediately. A number of study participants also endorsed the value of the many recovery sayings in working a recovery programme though initially some found these irritating. Sayings included *'living one day at a time'*, *'let go and let God'*, *'easy does it'*, *'acceptance is the answer to all of my problems'*, *'nothing happens by mistake'*, and *'it's not the drinking it's the thinking'*.

One study participant shared more specifically about needing to address her thinking, especially critical thoughts towards others. Another study participant said that part of working a programme meant addressing their unrealistic thinking patterns. One study participant explained that he still had expectations but balanced those with knowing he could not control the outcome. The female study participant who utilised the church setting agreed with those in the 12-step setting that there was a significant difference between not drinking and living a faith-based recovery programme. She watched a Christian teacher on

television on a regular basis who helped her address her selfish thinking, which she saw was important to her recovery.

Ego deflation was another main theme supported by all the study participants. This was explained as relevant in both 12-step and Christian teachings where a person is directed to address their sense of over self-importance and self-sufficiency. One study participant summed it up with '*I needed to learn to stop directing the show*'. One female study participant explained her egocentricity prior to working a recovery programme as a '*my way or the highway*' philosophy. Another study participant explained that she had learnt for the first time in her life, to listen and take advice from others. A number of study participants explained that accepting their limits over others and other life situations was an important lesson in early recovery. There was further reference to the serenity prayer spoken at every 12-step meeting, which is a prayer of acceptance. One study participant noted that he had to learn that he didn't have the right to special entitlements because he had stopped drinking. One male study participant explained the triangle teaching of 12-step fellowships: unity, service, and recovery. He explained that healthy recovery requires all three aspects of the triangle, which collapses if one side of the triangle is missing. Another study participant explained that the more she stopped trying to control her life and trusted her higher power the more balance and peace she experienced. The study participant who utilised the support of a church setting shared that addressing her ego meant giving herself permission to grow up.

## **Helping Others**

*' I had the coffee commitment on Sunday morning ...they had this huckery old coffee machine, it took like at least an hour to make coffee, and people got there early..., what I didn't realise is it was the most important job I'd ever had because I was there when everybody walked into that room..., all of a sudden I was part of the group and every person came up and got a cup of coffee ...'.*

Helping others or service work was an important ingredient towards their ongoing sobriety for all the members in the study. This was termed by some study participants as '*getting involved*' in the twelve-step fellowship. Study participants agreed that what seemed to be menial tasks initially turned out to be quite significant to their recovery and integration into the 12-step movement. For example, setting up the coffee and greeting newcomers at

meetings. Some study participants explained that they were helpful by nature and when they entered the 12-step movement became fully involved in the fellowship, boots and all. Service was also seen by all study participants as a guard against complacency and ultimately relapses. Furthermore, helping others assists the helper to moderate their 'ego' (self-importance) as well as ground them in the realities of their own addiction. One study participant explained that for him the best thing he could do when he was having a 'crap' day was to help another recovering person. Another study participant described how he had learnt he would not keep his recovery if he did not pass this on to others. Another study participant added that for him recovery was helping others. One study participant explained that for him helping others meant sharing his recovery experience with those who would benefit. It was explained that within 12-step fellowships sharing was delivered from personal experience only rather than lecturing others on what to do or not do. A participant who made use of a church setting for support in her recovery identified with those utilising the 12-step fellowship for support regarding the value of service in her recovery lifestyle and explained how significant her service was in the church setting to her recovery. Another participant shared a metaphor that motivated her in her service work. She said *'In African plains where there are herds of antelope, staying with the healthy antelope in the middle of the pack is the safest way to not be attacked by a lion'*. Another study participant explained that spirituality and service were closely related because service meant focusing on something other than himself as self had failed him.

### **Managing Feelings**

*'I think the feelings thing is really hard in early recovery because you stop drinking and then you have all those feelings come up that you don't know what they are or where they're from or why you're feeling them or anything'*

Managing feelings was another agreed area of importance for all study participants in the first two-years of recovery. Prior to pursuing an abstinence-based recovery lifestyle study participants stated that feelings were often things that were moderated by AOD use or avoided. Once sober study participants described the challenges of having to work through feelings sometimes resulting from regret or guilt about past actions while drinking or using, or alternatively, present situations that produced a range of foreign and often new feelings. One participant said prior to getting into a recovery lifestyle, he lived in his head and did not have feelings. Some described how after stopping alcohol and drug use

their emotions returned like a flood. One participant explained this was like having the carpet pulled out from under him. Some participants explained that in their earlier recovery it took time to learn to name or identify certain emotions. One participant said he saw alcoholism as a cancer of the emotions. Participants added that they learnt that things rarely stay the same forever and therefore feelings would also pass. Another participant explained that the purpose of the 12-step programme was learning to accept life on life's terms and feel good about it. Participants explained that they had learnt to manage emotions through 12-step meetings or their sponsor. Of particular focus was how angry a number of study participants felt in the first months of their recovery as they faced the reality that things did not always go the way they wished. One study participant explained this as a rage. One participant stated that he always thought he was laid back until he stopped drinking. Accepting life as it is was a central task of earlier recovery for many participants. An example was the ongoing fatigue and poor sleeping patterns that most members in the group related to. One participant shared how when talking to his sponsor about his sleeping and fatigue only weeks into earlier recovery he was told, '*oh that's normal*', then when he asked how long it would last their sponsor answered '*oh about two years*'. One participant explained that life did get better for him straight away. Furthermore, dealing with his sense of entitlement was a barrier in the first two years of recovery. One participant explained that she was not sure who she was when she first got sober. There was agreement from a number of participants that they had grown the most in times of emotional crisis as uncomfortable as this was and that it took time to develop a sober identity. There was also agreement that drinking stunted emotional growth. One participant went so far as to say that he felt his emotional age was the same as the years of sobriety he had achieved, which was 4 years. Finally, a number of participants discussed managing emotions, which is about being fully present in reality and how truly enriching learning this skill was.

## **Routine, Including Hobbies and Interests.**

*'You got 24 hours a day. I'm sleeping for 8 hours of it, recovery for a couple of hours of it, work, but what was I doing for me?'*

Routine was another area of discussion, which incorporated hobbies and interests. There was agreement that boredom was a significant risk factor for relapsing in early sobriety. One study participant explained how changing her routine had the benefit of not activating dangerous thinking patterns. This was as simple as choosing a different way home so as not to pass by a local bottle store. One man explained how important building routine including hobbies and interests into his recovery programme was important so he didn't relapse.

Certain times of the week or year were noted as difficult or risky times for relapse. These included weekends, with Sundays being the most dangerous time for a couple of participants. One participant explained that he associated relapsing with watching TV on weekends and that he had learnt to pigeonhole the different responsibilities of family, friends and work. Another study participant explained that Christmas was a tough time for him.

Revisiting hobbies or interests from formative years was part of identifying which hobbies and interests study participants should try. Some found regular exercise an important part of their weekly schedule. One study participant stated that he did not find boredom an issue in early recovery. He put this down to attending 12-step meetings on a daily basis, which he chose to do following a suggestion from his sponsor to attend 90 meetings in 90 days.

All study participants stated that their recovery lifestyle was better than their drinking or using drugs lifestyle despite the effort they had to put into their recovery. Some study participants had to learn how to use old skills again while sober, like skiing. Furthermore, they wanted people to know that they had lots of fun now they were sober.

## **Impressions from Focus Groups**

The researcher's overall impression from the focus groups was that all study participants contributed in the discussions; there were times of strong expression, reflection, insight, and identification with other study participants. Discussion topics flowed naturally out of previous discussion topics, and some discussion topics were revisited. Study participants were able to explain how their recovery experience was similar and how it varied from that

of others. Overall the researcher's first impression on completing the focus groups was that study participants had found not only a way to stop drinking or using drugs, but also a way of living that met their core human needs of authentic relationships, purpose, fulfilment, and belonging which in turn improved their overall well-being. All study participants perceived that their lives now were more meaningful, had more purpose, and were more fulfilling than before they began drinking or using drugs and this stood out. Finally, being an AOD counsellor, the researcher was also struck by the realisation that years of counselling or therapy would not achieve the degree of change in the lives of these study participants that had occurred within these dynamic recovery communities. In particular, the shift they had each made in their outlook on life.

### **4.3 Findings From Photos**

The option to take photos was encouraged as another medium to record study participants' perspectives of what was important to their recovery in the first two years of pursuing sobriety. It was requested that an explanation of photos taken be recorded in the study participant's journal. Of the 11 study participants, six used their camera. Disappointingly, due to the quality of the cameras purchased for the study, a number of photos were not clear enough to publish. Fortunately the context of all the photos taken could be identified. The instructions regarding the use of the cameras was that study participants only take photos of what they perceived was meaningful to their recovery in the first two years. The only restriction was that study participants were not able to take photos that would identify people or organisations, as this would require ethics approval that the study had not been given.

The photos taken included:

- Scenes of bush and beaches
- Sunsets
- A study participant's feet
- Recovery books and other study material
- Fitness equipment
- Sewing equipment
- Cooking equipment

- Walking paths
- Homes
- Swimming pool
- TV



*“ I use the Big Book to help me stay sober on a daily basis”*



*“ For me the enjoyment of spiritual fun activities changes my recovery battery”*



*“ I find having a daily plan gives my recovery structure and purpose”*



*“ It is a huge help to have nice things to do until you become settled in your sobriety”*





*“ A truly spiritual way to start a day & evidence of the hand of God”*



*“ Nature, God, faith, balance”*



*“ Taking time to appreciate the flowers”*



*" I love fishing"*

#### 4.4 Findings from the Journals

The findings from participants' journals reflected the 12 main themes found in the focus groups. A total of 245 references were made to recovery: The main themes identified were as follows; working a recovery programme of change ( $n = 66$  entries), interacting with higher power ( $n = 33$  entries), exercise and healthy living ( $n = 19$  entries), the importance of service to others ( $n = 17$  entries), hobbies and interests ( $n = 9$  entries), specific distractions in early recovery ( $n = 8$  entries), the value of sober activities ( $n = 7$  entries), the importance of family support and involvement of which one participant stated dealing with their family was hard ( $n = 6$  entries), and the importance of education about addiction ( $n = 4$  entries).

Regarding specific terms repeated by multiple participants there were eight references made to working a programme and having a sponsor. Seven references were made to attending 12 step meetings. Five references were made to reading core recovery literature and living one day at a time. Four references were made to exercising, sustaining higher power contact, reciting daily "help me stop" prayers, maintaining a gratitude list, the importance of education about addiction and service to others. Three references were made to keeping it simple, reading 12-step material, maintaining a daily journal, pursuing abstinence, being grateful, sponsorship of others, and having sober social events to attend. Two references were made to made to: belonging to a fellowship, reaching out for help from people in 12-step fellowships, making friends in 12-step fellowships, the importance of support, having good sleep routines, believing in a higher power, morning and night prayers, being quiet and listening, the inspiring poem 'Desiderata', being accepting of being an alcoholic, accepting personal wrongs, following a continuing care plan, helping other alcoholics, meeting 12-step friends outside of meetings, and being aware of HALT (hungry, angry, lonely, tired) triggers.

Because of the potential value of this information to the treatment and recovery setting a table listing these has been included in Appendix D of this thesis.

The next chapter covers a discussion of these study findings in light of relevant literature.

## **Chapter Five: Discussion**

### **5.1 Introduction**

This chapter details a discussion of the dimensions of recovery identified in the study findings in light of relevant literature on this topic.

### **5.2 Focus Group Findings**

The ADWRNZ focus group findings identified that successful recovery was reliant on both individual and environmental factors congruent with the International Classification of Functioning, Disability and Health (ICF), which recognises the environmental and contextual impacts on individuals (World Health Organization, 2001). The following recovery areas identified in the focus groups were as follows:

#### **Acceptance of a AOD Problem**

The ADWRNZ study participants identified that 'breaking through their denial' was part of the process of getting help for their addiction problems. Twerski (1997) explains that denial is a number of psychological defences that minimise a person's awareness of AOD related consequences. Some of these processes include confusing the cause of problems, rationalisation and failing to process emotions associated with AOD consequences, and minimising the consequences resulting from AOD use. Rapp, Carr, Lane, Wang and Carlson's (2006) study also found that lack of 'problem recognition' was the reason why people failed to get help for their addiction problems and the level of 'problem recognition' in turn predicted the desire to change. Baumeister's Crystallization of Discontent theory (Kingemann et al., 2001) states that people will aim to maintain the beliefs they hold by rejecting evidence that conflicts. Whereas Rinn, Desai, Ronsenblatt and Gastfriend's (2002) study found that denial or lack of awareness of addiction problems was attributed to cognitive deficits rather than an defence system. DiClemente, Schlundt and Gemmell's (2004) well known model of change in the addiction field explains that denial is a process where people work through a number of stages before actively addressing their addiction problems, beginning with 'pre contemplation' or lack of awareness of their addiction problem. Kingemann et al.'s (2001) study showed that self-appraisal broke down denial and increased awareness and motivated change towards recovery, and Sobell, Ellingstad and Sobell's (2000) and Rushing's (2008) studies found that negative impacts were reasons why people initially addressed their AOD problems. ADWRNZ study participants

correlated acceptance of the severity of their AOD problems with the level of recovery solutions they applied and that for some people in recovery awareness of their AOD problems was initiated in part by authority figures pointing out they needed help for their drinking problem. Nevertheless, ADWRNZ study participants' awareness of their AOD problems was an important step in pursuing a recovery lifestyle.

### **Identification with other people with AOD problems**

Identification with other people who have an addiction problem was a significant factor for participants in acknowledging their AOD problems and pursuing a recovery lifestyle. Moos (2008) proposed that identification with others is an active ingredient that still needs to be further investigated in 12-step fellowships, Majer et al.'s (2002) study found that poor identification with abstinent peers results in lower levels of self-efficacy to pursue abstinence when compared with those who identify strongly with their peers.

### **Addressing one's preconceived ideas and dealing with stigmatisation**

The ADWRNZ study participants highlighted the need to work through preconceived ideas as part of the process of addressing one's addiction problems, including what a person with an addiction looks like and how 12-steps help groups work. Participants' apprehension over identifying with addiction and 12-step groups is not surprising considering Room's (2005) and Schomerus et al.'s (2011) studies, which found addiction-type conditions in general are highly stigmatised and addicts are marginalised in society. Hoffman and Froemake (2007) went as far as suggesting that people with addiction problems are often seen as 'social outcasts'. What was significant in the ADWRNZ study is that study participants had not considered, prior to addressing their addiction problems, that people with an addiction could still have careers, families, and hold dominant roles in society. Over half of the study participants stated their preconceived ideas prior to entering 12-step fellowships were that being an 'alcoholic' or 'addict' meant living on the street and drinking out of a brown paper bag.

### **Media campaigns influence on a person pursuing recovery**

One study participant stated that television advertising was significant in motivating her to address her drinking problems. Wakefield, Loken and Hornilk (2010) and Elder, Shults, Sleet, Nichols, Thompson and Rajab (2004) state television campaigns that highlight alcohol problems are common, and in addition Galanter and Kleber (2008) state there is evidence that media based alcohol or drug harm prevention campaigns are effective. The

focus of these campaigns is to remediate specific behaviours, as evidenced by the focus of these campaigns on 'the consequences of behaviour [which in turn helps people] to understand better what must be prevented' (Galanter & Kleber, 2008, p. 686). This was true for the ADWRNZ study participant who attributed a TV campaign to her pursuing a recovery lifestyle where she related to being trapped beneath a glass and saw the disapproval of her partner enacted in the TV campaign.

### **Being educated about addiction**

For four ADWRNZ study participants education about the disease of addiction was a further motivator in pursuing a recovery lifestyle. Galanter and Kleber (2008) state that education is used in a number of ways to address addiction problems. Hoffman and Froemke (2007) advocate the importance of education about the disease concept of addiction especially as in the past five years there has been fresh neurobiological evidence resulting from the development of PET scans supporting addiction as a brain disease versus a moral shortcoming.

### **Verbally acknowledging one's AOD problems**

The ADWRNZ study found that for a number of participants an initial step in accepting their AOD problems was verbally acknowledging both being an alcoholic or addict as well as what recovery may require as a solution. Galanter and Kleber (2008) state this is why in 12-step meetings the regular acknowledgment of being an alcoholic or addict is practiced at each meeting.

### **Acceptance includes problem solving and emotional processing**

Bussing, Matthiessen and Mundle (2008) formulated a questionnaire to assess the acceptance process associated with addiction. Their findings showed that the acceptance process involved both active problem solving and emotional processing. The ADWRNZ study findings also found addressing one's addiction was an active process with study participants stating that a spiritually-based recovery was not a passive activity. Though study participants did not directly associate acceptance with processing the emotional impacts of their drinking or using, there was significant discussion regarding the importance of processing feelings with sponsors and peers in staying sober, with one study participant going as far as to say, 'addiction was a cancer of the emotions'. It would be reasonable to conclude from the ADWRNZ study findings that emotionally processing

the impact of one's alcohol and drug use was part of the acceptance and engagement process in pursuing a recovery lifestyle.

### **The timeframe of the acceptance**

The timeframe of the acceptance process varied for different participants. Some accepted their addiction on attending their first 12-step meeting, hearing others tell their story, and reading recovery based literature. Others, even years later, noted that acceptance was still a fluid process changing based on how they were feeling and thinking on given days; this was particularly true for younger participants.

### **Spirituality**

For all ADWRNZ study participants acceptance of an AOD problem also meant being open to a spiritual dimension of life. Participants spiritual experiences and practices ranged from out-of-body blinding light encounters, to a sense that one was on the right path, relief or peace, slowly learning to trust in a higher power, daily prayer, or a sense of an ongoing spiritual connection to their higher power, to being open-minded to whatever higher power realities there may be. Most study participants did not fully understand these experiences however this did not stop them accepting this reality. Importantly, these spiritual experiences were a significant motivator for pursuing a recovery lifestyle. De Leon (2000) explains that Bill Wilson, one of the founders of the 12-step movement, attributes his recovery as having begun after experiencing an out-of-body spiritual experience in a hospital bed while detoxing and which he termed a spiritual awakening. Interestingly Brown, Whitney, Schneider and Vega (2006) point out that when a person is addicted to a mood-altering substance, this can be understood as a negative form of spirituality where the mood-altering substance becomes the higher power, meaning the solution or the thing that a person looks to for support and strength. Baker, Sellman and Horn's (2006) New Zealand study and Rushing's (2008) US study show that a high number of recovering people attribute pursuing a recovery lifestyle to spiritual experiences/encounters. Robinson et al.'s (2007) study also found that spirituality and religiosity increased for people pursuing change from AOD misuse during the first six months of abstinence even after controlling for AA involvement. What the ADWRNZ study findings also show is the power of experience to bring about change. The influence of 'experience' should not be surprising, considering that for a number of people the motivation for using alcohol or drugs is to have an 'experience' (Hoffman & Froemke, 2007). Overall observation of the

ADWRNZ study findings suggests that experience-based learning was very important for all study participants. The effectiveness of experience-based learning is not new. Kolb's (1984) work about learning theory states, " Learning is the process whereby knowledge is created through the transformation of experience" (p.38). What Kolb proposed is that learning is more effective when it is not just a conceptual process, but rather, is based on experience and reflection on that experience.

Kelly, Stout, Magill, Tonigan and Pagano's (2011) research into the behavioural change mechanism found that AA attendance was associated with increases in spiritual and religious practices especially for people who had few spiritual and religious practices before entering the 12-step fellowship. Drawing from a number of authors, Kelly et al. (2011) proposed a number of reasons that spiritual practices may aid recovery. Firstly, spiritual and religious practices may build an overriding recovery schema that affects behaviour and motivation. Secondly, spiritual and religious practices may result in ascribing alternative meaning to stressful events. Thirdly, spiritual and religious practices may increase a sense of belonging thereby increasing the sense of support when dealing with stress. And finally, that spirituality could be seen as an array of positive emotions including joy, forgiveness, empathy, etc.

It is also worth noting that the ADWRNZ study supports Neff and MacMaster's (2005) study that spirituality has a community context versus being purely individualistic in nature, and they argued that within the 12-step setting that "spiritual transformation at an individual level takes place in a social context involving peer influence, role modelling, and social reinforcement" (p.669).

Finally, not all participants had spiritual encounters; some participants stated their trust in a higher power was more of the 'educational variety' (Alcoholics Anonymous World Service Inc, 2010, p. 169), that is, as people change they also learn, and that application of learning results in lifestyle change. This term comes from the Alcoholics Anonymous core text, which explains that it is not a requirement for people to have a spiritual encounter to develop a trust in a higher power and pursue a recovery lifestyle.

### **Recovery Fellowships**

For all study participant's spirituality included a community dimension. Participants also stated that the type of 12-step or church community environments they first encountered when addressing their alcohol or other drug problems were important to their continued

involvement in these settings, with a number of study participants stating that their ability to cope with criticism or expectations was extremely poor when first entering these fellowships. The overall experience of ADWRNZ study participants was of a non-judgmental environment with low expectations and a lot of positive role models they could observe. One study participant noted the absence of materialism was enticing. Others remembered the stark contrast these recovery environments had to their using environments. Though a number of existing studies have shown the value of supportive relationships in a newly recovering person's life (Hser, 2007; Laudet, 2006, 2007; Moos, 2008; Sobell, Cunningham & Sobell, 1996). Krentzman et al.'s (2012) study discovered that membership in 12-step fellowships increased abstinence rates at one year for both males and females. Furthermore, despite the fact that 12-step fellowships have been criticised because men dominated the initial movement, Krentzman et al.'s (2012) findings found that overall women actually achieved higher levels of sobriety than men.

### **Expectations within recovery fellowships**

It would be unfair to say that 12-step and church-based environments had no expectations of how successful recovery occurred; however this knowledge was passed on through non-aggressive methods such as people sharing from their own experiences in an enabling and empowering atmosphere.

### **Honestly about the realities of early recovery**

The ADWRNZ study findings showed that participants described a high level of honest self-reflection in relationships with other recovering people. Participants used terms such as 'authentic' to describe these relationships. The ADWRNZ study further identifies how communicating honestly about the realities of early recovery was positive in supporting realistic expectations about early recovery. One ADWRNZ study participant shared how, when talking to their sponsor about their sleeping and fatigue only weeks into early recovery, they were told, "Oh that's normal", then, when asking how long it would last, their sponsor answered "Oh, about two years" [in a matter-of-fact manner]. This type of honesty was exhibited regarding other recovery realities including dealing with challenging emotions and the possibility of relapse in early recovery.

### **What defines a community**

One of the questions that the study findings did raise was: are the recovery environments that participants described a social or community system in their own right? Perfas (2004), citing Norlin and Chess (1997), explains what characteristics determine a social system or community in its own right. Social systems are open and fluid in that individuals influence and are influenced within the social system, there are general patterns of behaviour pertaining to that system, and there are observable behaviours at different levels in the social system. For example, at an individual and group level, individuals are able to operate independently in a mutually beneficial manner within the system, and the total system engages in activities to achieve a common purpose. Utilising these criteria, the environments that study participants described would then qualify as a fully functioning social or community system operating within the larger New Zealand community social system.

### **Power of communities to bring about individual change**

The power of social systems (community) to be therapeutic is also not new. Perfas (2004) states that the basic concepts of Therapeutic Communities were present in the first Christian and Monastic faiths. De Leon (2000), a known authority in this field, explained that though different to 12-step fellowships, therapeutic communities in the treatment setting of AOD have a lot of similarities because their development was heavily influenced by the 12-steps. De Leon explains that many of the 12-step principles align with the objectives of therapeutic communities. These include breaking through denial, working on change, self-examination, socialisation, personal honesty, asking for help, and helping others. Certainly all of these aspects fundamental to a therapeutic community were present in the ADWRNZ study findings. It would be fair to conclude then that therapeutic communities are not just limited to the professional setting and that there are therapeutic communities in the non-professional arena. Furthermore, the ADWRNZ study findings would suggest these communities are also highly effective.

### **Belonging to a fellowship**

Belonging to a fellowship was another important dimension of participant's recovery environments. Paris and Bradley's (2001) study identified a 'lack of belonging' in study participant's narratives related to the misusing of alcohol, and Laudet's (2007) study also found one of the benefits of a recovery lifestyle was having friends and a social network.

The ADWRNZ study also supports the findings of Laudet, Morgen and White's (2006) study that "social supports, spirituality, life meaning, religiousness and 12-step affiliation buffer stress significantly and enhance quality of life among recovering people" (p. 62) and "emphasizes the need for recovering persons to establish a social network of persons who can provide encouragement, acceptance, and a sense of belonging" (p. 57)

### **Ecology of recovery**

Another issue that needs to be raised in this discussion is highlighted in a recent paper by White (2009). He states that the 'ecology of addiction recovery' is of growing interest in the alcohol and drug treatment setting, meaning the focus of recovery is shifting from the individual to their relationships with the physical, social, and cultural environment. White (2009) states that in this view there are parallels between 'wounding and healing' of the individual and the environment that he or she lives in as result of AOD dependence. White (2009) poses that severe alcohol and drug problems can be viewed as a "breakdown between the individual, the family, and the community" (p. 150).

The World Health Organization's (2001) release of the International Classification of Functioning, Disability and Health (ICF) also recognises individuals in their wider context.

The ADWRNZ study found that the type of environment a person recovers in was important to their recovery success. However, more investigation needs to be undertaken regarding the impact of family and other community members for a person recovering from AOD dependence.

Although Todd et al.'s (2002) study identified the lack of family involvement as being a barrier for people addressing their substance abuse problems, yet only a marginal number of ADWRNZ study participants referred to family involvement being important. This may be because the 12 step fellowships had become a family-like support network for a number of study participants or merely that some study participants chose not to mention this aspect of their recovery.

### **Church based recovery environments**

One study participant utilised a church-based rather than a 12-step recovery environment, which allowed for a unique opportunity to discuss the similarities between the two based on her experience. These similarities included the importance of her higher power encounter, the non-judgmental reception she received when returning home, people she met who operated in a sponsor-type role, addressing her egocentricity, and being able to

both receive from and participate in her church fellowship. These findings suggest that the presence of important recovery ingredients explored in this study may be present in a number of community settings.

### **Sponsorship**

All 12-step based ADWRNZ study participants had a sponsor who they spoke to regularly, often weekly, to help them work through the 12-steps. Working the 12-steps was associated with 'working a strong recovery programme'. Sponsors were referred to in terms of leadership, mentoring, and accountability. For many people this included both verbal discussions and written assignments that helped study participants personalise the 12-steps as they relate to their own experience. Existing studies have already identified having a sponsor as beneficial to the recovery lifestyle (Morgenstern et al., 1996) (Moos, 2008). Sponsors were also people whom study participants could call to talk through problems with, as well as obtain advice from. Interestingly Sobell, Cunningham and Sobell's (1996) and Bischof et al.'s (2007) studies found social support was the key ingredient in natural recovery, meaning recovery from AOD misuse without formal treatment or attending recovery orientated fellowships.

### **Working a Programme**

For all ADWRNZ participants belonging to a fellowship included working an active recovery programme. Two study participants stated that for them part of working a recovery programme meant achieving specific daily recovery-oriented tasks toward bigger goals of recovery. For example, listing one's resentments each day as part of completing steps four and five. For others, maintaining a gratitude list, taking responsibility for actions, asking for help, recognising hurtful behaviour, living one day at a time, trusting their higher power for the outcome of every day challenges, and stopping critical thoughts towards others was all part of working a strong recovery programme.

### **Recovery lifestyle much more than attending meetings**

The ADWRNZ study and Majer et al.'s (2011) quantitative study both found that a recovery lifestyle involved much more than just attending 12-step meetings. Having said this, attending meetings was a regular activity, with some study participants attending daily and others four times a week. Both studies identified a number of 12-step related activities including working with a sponsor, reading 12-Step material, involvement in service work, and calling other recovering people when needing help. Majer et al.'s (2011) study also

found these activities correlated to high sobriety rates; the ADWRNZ study findings appear to support this. This ADWRNZ study also added a number of other 12-step loosely-related activities that study participants also correlated highly to their on-going abstinence. These included accepting the disease of addiction, higher power encounters and openness to spiritual dimensions of life, having a routine, managing risky drinking or using situations, and learning to process and work through uncomfortable feelings as they occur.

### **Structure and routine**

For a number of study participants, working the 12-steps provided the structure that they required. Moos (2008) suggested that structure is one of the 12-step fellowships' active ingredients. Laudet et al.'s (2007) study found recovering people stated that having direction and achieving goals were one of the noted benefits of a recovery lifestyle. The honesty practiced by a number of study participants when working certain steps with their sponsor also had positive benefits. These included being able to free oneself of fear, shame and guilt, which had often been carried for years because of actions they had done in the past.

### **Following directions**

Another aspect of having a sponsor and working a programme was following someone else's directions and doing differently to what a person had done prior to entering recovery. This is because following one's own will and impulses had resulted in life unmanageability explained in step one of the twelve steps. Surrendering their will to others and a programme appeared to be how these study participants were able to disengage from the problematic behaviours associated with alcohol and drug use.

### **The practice of universal acceptance and trust**

All study participant's not only practiced acceptance of having a addiction but also practiced universal acceptance of what they could and could not change or influence. This may be a core requirement of successful recovery. Examples included accepting on-going fatigue and sleep disturbance experienced in early recovery, accepting newcomers' processes of accepting their addiction problems, and accepting troubling emotions. For most participants this included trusting in wider support system and higher purpose (see next section Higher Power and Spirituality).

Cognitive Behavioural Therapy has for a long time identified unrealistic expectations and beliefs as part of the addiction cycle (Froggatt, 2003) (Miller, 2009). Ego deflation is

referred to in both 12-step and Christian teachings as when a person's sense of self-importance is at odds with the reality of what they can and cannot control. The net result is distress and isolation from those around them. The 12-step community utilises a term 'ego run riot', which is viewed as being at the core of one's drinking or using. This is where an individual's self-importance is elevated to a point where they perceive that life, people and situations should abide by their expectations. The net result is significant disequilibrium and distress. As one study participant said '*I need to stop directing the show!*' The ADWRNZ study showed that addressing one's egotistical tendencies was a core goal of early recovery for these study participants. A number of ADWRNZ study participants explained one of the ways they did this was by accepting their individual limits over life situations. Furthermore, addressing egotistical tendencies was an on-going monitoring process still practiced by all study participants at the time of the study even though one participant was in their twentieth year of sobriety. A possible aim of addressing an egotistical worldview may be to assist individuals to change their thinking patterns and resulting expectations so that emotional distress and counterproductive behaviours are reduced. Froggatt (2003) gives an example of a demand-type thinking pattern is 'things should always go well for me'. Though it may be desirable that life be always harmonious, this type of rigid thinking creates unnecessary painful emotions due to constant disappointment caused by life circumstances not meeting this expectation. If the same person's belief was 'I would prefer that life went well, however at times life has challenges', the resulting emotions would be more tolerable as their expectations would be more in line with reality. In short: Change the way you think and you change the way you feel. Though this sounds easy in principle, changing these beliefs is not easy. What is noteworthy about these study participants is that the 12-step recovery environment resulted in exactly these types of cognitive shifts. This may be because the 12-step fellowships address the more pressing underlying issue of an individual versus an integrated community worldview and the 12-step setting allowed individuals to experience the benefits of a recovery-oriented community.

Another question that the ADWRNZ study raised was the role of self-efficacy and self-mastery. Majer et al.'s (2004) study explored the relationship between optimism, self-efficacy and self-mastery in recovery success finding the all these aspect where important to successful recovery. The ADWRNZ study findings can only add that self-mastery should not be confused with self-will. Self-will means 'I can control my addiction by

myself', whereas self-mastery means 'with the help of others I believe I can manage my addiction'. Majer et al.'s (2011) recent study explored the correlation between 12-step activities and self-efficacy in successful recovery (abstinence). The findings showed greater levels of 12-step activities did indeed improve recovery outcomes; furthermore, more time in recovery also resulted in higher level of self-efficacy and stability. The ADWRNZ study findings also support all these findings.

### **Helping others**

The ADWRNZ study highlighted that helping others is not only beneficial but may be necessary for recovering people's success in maintaining sobriety. Engaging in service activities had a number of positive benefits for study participants. These included creating a sense of belonging and value, reinforcement of one's choice to pursue a recovery lifestyle, redirecting one's focus from oneself, and guarding against relapse. A number of study participants referred to helping others as part of the three-sided triangle of unity, service and recovery taught in 12-step fellowships. One study participant explained that helping others helped him feel better when he was having a particularly bad day. SAMHSA (2008) research on this topic identified that newly recovering people found it beneficial being able to both contribute to the community as well as receive help from the community they are involved in. Majer et al.'s (2011) study also correlated helping others to successful recovery outcomes.

### **Managing feelings**

The ADWRNZ study findings highlighted that returning feelings can be very challenging for newly recovering people. Paris and Bradley's (2001) study discussed earlier also identified that feelings are a difficult commodity for newly recovering people and the loss of emotions due to anesthetising with alcohol or other drugs when in active substance use. Galanter and Kleber (2008) also identified learning to process feelings as an important skill to learn in early recovery. Savage (2007) associated negative feelings with the occurrence of relapse. Mitchel (2001) identified agitation, guilt and anger as some of the negative symptoms of early AOD recovery.

The ADWRNZ study found a number of dimensions to successfully managing emotions in early recovery. These included acknowledging and accepting the presence of uncomfortable feelings. Study participants stated that they processed their feelings by talking with their sponsor and sharing about their feelings in 12-step meetings. The

ADWRNZ study showed that 12-step fellowships appear to accept this reality of challenging feelings in early recovery, which appeared to aid study participants in dealing with their emotions. Specifically there was an expectation gained from peers that it is normal for newly recovering people to have strong emotions, and that one of the skills that newly recovering people need to learn is to process and work through these emotions rather than avoid them as they did when engaged in heavy alcohol or drug use. Learning to process feelings in a 12-step setting may also have mental health benefits. Kelly, Stout, Magill, Tonigan and Pagano's (2010) study of 1706 recovering alcoholics over a 15-month period found AA involvement also reduced the prevalence of depression and increased participants' overall well-being. This study showed "AA association with reduced drinking and reduced depression is encouraging" (p. 633).

One study participant explained how along with returning emotions when first getting sober she did not know who she was any more. This experience was well supported by others in the focus groups. Lewis and Brown (1999) and Weegmann and English (2010) also highlight that identity renewal was a central task for recovering people.

### **Managing thinking**

Galanter and Kleber (2008) and Miller et al. (2009) show that research also supports learning thinking-type coping strategies as an important factor in successful recovery. This includes understanding specific thinking patterns associated with relapse. This may explain why one of the ADWRNZ study participants stated '*it's not about the drinking, but the thinking*', which was acknowledged as significant by all other study participants.

### **The realities of relapse**

A number of ADWRNZ study participants stated that this was not their first attempt at recovery highlighting that relapse is a common occurrence in the recovery movement. Miller et al. (2009) state that relapse is the most common outcome of addiction treatment and needs to be a focus of interventions. There are a number of studies that have explored relapse (Galanter & Kleber, 2008). What was of interest was how ADWRNZ study participants talked about possible relapse; their view consisted of the real possibility that they may relapse. This honest view appeared to strengthen their resolve to pursue a recovery lifestyle.

One study participant detailed his demise when using another mood-altering substance he had not considered he was dependent on when first pursuing a recovery lifestyle. Charney

et al.s (2010) study explored the occurrence of early recovery relapse. Their findings also showed the occurrence of relapse was more prevalent in people who reported non-dependence on another mood-altering substance during the assessment phase of their treatment and then used this secondary mood-altering substance which resulted in re-using the original substance the person was dependent on.

### **Triggers for relapse identified**

A number of triggers for relapse were identified in the ADWRNZ study findings. These included isolation, boredom, not being honest about one's motivations when associating in an environment where alcohol or drugs are present, failing to manage emotions, and not being fully committed to working a strong recovery programme. For some ADWRNZ study participants their initial challenge in addressing their drinking was walking past the local bottle store. There are a number of studies that have explored impulsivity associated with addiction. (Galanter & Kleber, 2008; Hoffman & Froemke, 2007) For some study participants their initial strategy in earlier recovery was to avoid easy alcohol or drug access so their impulsivity to drink or use was not triggered.

### **Relationships with others including those still using AOD**

The ADWRNZ study showed that, for a number of these recovering people, being particular about how, where and when they associated with non-recovery people was important. One study participant described how he had to leave his partner who was still drinking. Some study participants stated that old friends often did not understand the life choices they were making. Older participants tended not to associate where alcohol or other drugs were present whereas younger study participants tended to practice rigorous self-honesty and self-efficacy not to use alcohol or other drugs in environments where alcohol or drugs were present. An example was: participants who entered environments where drinking or drugs were present all had clear prior plans on when and how they would leave if needed. For some newly recovering people, alcohol or drug rich environments were places that reinforced their decision not to use alcohol or other drugs, and many study participants felt uncomfortable in environments where excessive alcohol and other drug use occurred. For others, being sober, clubbing and dancing with other people in recovery was an invigorating activity they enjoyed. A number of existing studies have also found that cutting off drinking and using peer relationships is a common practice for those pursuing a recovery from addiction problems (Sobell et al., 2000) (Hser, 2007)

(McGovern et al., 2005). Hser's (2007) study found continuing involvement with peers still using alcohol or other drugs resulted in relapse. However this was not always the case in the ADWRNZ study findings. Not all ADWRNZ study participants abandoned their drinking or using friends; what was more prevalent was study participants' practice of self-honesty about their vulnerability to relapse at given times which operated as a protective factor against relapse. A number of study participants explained how important it was to have a non-alcoholic drink, others found lollies helped with cravings.

Overall, study participants either no longer associated with heavy drinking or drug users, or spent significantly less time than they used to when drinking or using and this time was well planned in advance.

### **Hobbies, Interests, and Exercise**

For a number of ADWRNZ study participants another aspect of working a successful recovery programme meant developing or re-engaging in hobbies and interests. These ranged from cooking and sewing to fishing, bush walks and sports. Some study participants stated that hobbies and interests were needed to replace time spent drinking or using drugs. Study participants were also clear that they enjoyed life more now sober than they ever did when they were drinking or using drugs. One study participant termed the phrase that he '*used to be out of it, now he is into it*', meaning life itself. All study participants stated having fun as being important. A number of study participants explained how, when they first got sober, they were unsure whether they could indeed have fun without alcohol or other drugs. Another point that needs to be noted is the high degree of humour that study participants displayed in the focus groups. Often this was focused at themselves or at the alcoholic or addict in general. It is also important to note that a significant amount of associating with peers in 12-step and church fellowships occurred in a social environment: having a coffee out, watching a movie, or going fishing.

As Galanter and Kleber (2008) state, along with Read et al.'s (2001) and Brown et al.'s (2009) studies, that exercise was important for a number of study participants and attributable in part to the success of their recovery experience. The ADWRNZ also found support for exercise being important in recovery. Brown et al.'s (2009) pilot study showed exercise gave some promising results in relation to sobriety levels. However, Read et al.'s (2001) study did not find a correlation between exercise and sobriety rates. Having said this, the benefits of exercise in recovery being inconclusive does not mean that it should

not be encouraged as improvements to overall well-being resulting from exercise are well documented (Brown et al., 2009).

One study participant noted that for her all hobbies, interests and exercise needed to be undertaken in a non-impulsive manner as she had made the association between impulsivity and relapse. Interestingly Charney et al.'s (2010) research also linked impulsive behaviour with early relapse.

## **Other areas of consideration**

### **Cultural understanding**

As explained in the literature review, Tapa Wha and Te Wheke are Maori models used to explain a Maori perspective of health. What was interesting is that all four pillars of the Tapa Wha model were present to varying degrees in the ADWRNZ study findings. These included the importance of spiritual, mental, physical, and family. Family, though not discussed in much detail in the study findings, was also seen in this context of the 12-step fellowship. The Te Wheke model gives further explanation of a Maori worldview and uses an octopus-like model consisting of eight 'tentacles': spiritual, mind, physical, extended family, immediate family, well-being of individual and family, acknowledgement of the life force in all things, the unique identity of individuals and families, the breath of life given by forebears, and healthy expression of emotion (Pere, 1995). The only aspect of this Te Wheke model that was not supported by study findings was the breath of life given by forebears. However the knowledge passed on by departed alcoholics could loosely be seen in these terms.

### **Recovery Capital**

Laudet and White (2008) explored whether the amount of a person's 'recovery capital' resulted in achieving recovery, life satisfaction and reduced stress. Recovery capital refers to resources both internally and externally utilised by the person to sustain recovery. These include the amount of time in recovery, the stage of recovery (e.g. 18 to 36 months), recovery-orientated support, general support (e.g. family & friends), spirituality, life meaning, religiousness and 12-step affiliation. This study recruited 312 people living in New York who were poly-substance users. The findings supported the initial hypothesis of the study that the level of recovery capital did indeed increase recovery outcomes, life satisfaction and reduced stress. Though the ADWRNZ study did not explore which areas of recovery capital predicted recovery, life satisfaction or reduced stress, all the recovery

capital domains were present in the ADWRNZ study findings. Further research would be needed to isolate which of the domains or combination of domains identified in the ADWRNZ study findings correlate to positive recovery outcomes.

### **5.3 Journals and Cameras**

The findings from the journals showed similar themes as were identified as being important for recovery as those discussed in the focus groups. These included working a programme, being involved in a fellowship, interacting with a higher power, personal attributes, exercise and healthy living, service to others, hobbies and interests, specific distractions, the value of sober events, counselling, family support and involvement, and education about addiction. However the findings from participants' journals listed more specific behaviours, attitudes and activities to add to the information gathered in the focus groups. This level of detail potentiality provides useful information to people who work in both recovery and treatment settings and has been included as Appendix D.

The value of counselling and treatment were new areas of recovery identified as important for three study participants. Galanter and Kleber (2008) point out that treatment in varying forms is important in getting well for many people with AOD dependence. Family support and involvement were new areas of recovery identified as important by four participants. Breaking through denial, preconceived ideas and managing emotions were not raised as topics in the participant journals. There was no direct reference to addressing egocentricity or practicing self-honesty, however by referring to trusting in a higher power and working with sponsors it is reasonable to conclude in light of other study findings these recovery areas were present in the journal findings.

The photos taken by study participants emphasised the importance of nature, hobbies, fitness, reading recovery material and home in individuals' recovery lifestyles. Because the study had the requirement to not include identifiable pictures of people or institutions in photos this would have influenced the type of photos taken.

### **5.5 ADWRNZ Model**

The ADWRNZ model on p.94 is an attempt to present the successful recovery ingredients found in the ADWRNZ study. The outer circle represents the recovery community, the inner circle represents the individual and their core needs. All the boxes intersect both the inner and outer circle representing the need for both the individual's and recovery

environment's participation for the recovery ingredients to be effective. The recovery ingredients consistently found in this study were:

- The importance of acknowledgement and acceptance of one's alcohol or drug problems and knowing and accepting what was required to maintain recovery
- A non-demanding recovery and example-laden environment
- Identification with others where there is an opportunity to hear and share experiences and observe role models
- The practicing of honesty about one's vulnerability
- Following a 12-step recovery programme with regular scheduled recovery activities
- Openness to spirituality and spiritual encounters
- Opportunities to learn to process feelings and a range of triggers
- Development of a collective worldview that addresses one's egocentricity
- Opportunity to contribute and receive from the recovery community
- Utilisation of a sponsor or support person who has personal recovery experience
- Reconnecting with or developing new hobbies, interests and exercise regimes.

Figure 5.1



## **5.6 Personal Application of Study Findings**

Analysing the data from the ADWRNZ study has achieved a number of outcomes for the researcher. These include gaining a greater depth of understanding regarding the recovery lifestyle. At a personal level, and as a result of reflection on my practice, I have gained a number of new perspectives. Firstly, that 12-step facilitation based treatment is an introduction to the 12-step community, and the effectiveness of this approach is not completely achieved unless people fully engage in the 12-step community. Secondly, my support of people choosing a 12-step recovery process has grown to utilise interventions that support the more subtle dimensions of the 12-step fellowships. For example, prior to the ADWRNZ study, my understanding and support of 12-step fellowships was very concrete, encouraging consumers to go to meetings and get a sponsor. Now I can see the benefits of utilising interventions that support consumers developing a collective versus individualist worldview. This includes the power of a community setting to meet recovering people's core needs of belonging and purpose, to bring about significant changes in a person's worldview resulting in beliefs that are more in keeping with the limits of what a person can and cannot control, and provide the ongoing support needed in recovery from AOD dependence.

## **5.7 Benefit of Focus Groups**

Study participants commented that they found the focus group process very rewarding and insightful. They said that in all the 12-step and church meetings they had attended they had not talked so openly about higher power experiences. The benefits of meeting together and talking about their recovery experiences for people who have a number of years in recovery was so powerful that the focus group participants felt it would be of benefit to repeat the process of the focus groups in a 12-step setting.

## **5.8 Conclusions**

In summary, the findings from this study have shown that, for some people, recovery from AOD dependence is a dynamic process that has its foundation in authentic relationships within a community setting where recovery supportive norms are practised with peers. This requires community norms that ultimately allow a person to balance their self-reliance and self-interest by trusting in a higher power, helping others, and receiving help through recovery-oriented teachings and practices. More specifically, community norms and practices that allow opportunity for: spiritual experiences, peer identification and

sponsorship, fellowship, self-appraisal, support of realistic early recovery experiences, a structured recovery pathway e.g. the 12-steps or other spiritual teachings, developing strategies to guard against relapse, processing feelings, and developing a fulfilling lifestyle in the absence of either alcohol or other drug use. Finally, the conception of the ADWRNZ model is an initial step in developing an abstinence-based recovery in the New Zealand context that could inform future practice and research.

The next chapter covers the conclusions, limitations, implications and recommendations for recovering people, AOD professionals, legislation and funders.

## **Chapter Six: Limitations, Conclusions, Implication and Recommendations**

### **6.1 Introduction**

This chapter provides a final conclusion, implications, and recommendations resulting from this study supported by other relevant research and authoritative literature. The development of an abstinence-based recovery model in the New Zealand context from ADWRNZ study findings and opportunities for further development have also been proposed.

### **6.2 Limitations of Study**

Because this study only involved 11 participants the generalisability of the findings to others' experiences in recovery is limited. Larger New Zealand-based studies on the topic are needed to confirm the validity of these findings.

A weakness of this study is that the insights of recovery and well-being were gained from an abstinence-based recovery perspective. This decision was made for the safety of the researcher and other participants due to the risks of having study participants who were currently using alcohol or other drugs, albeit in a reduced capacity, attending the focus groups. This in no way implies a harm reduction approach to AOD use is not a valid form of recovery. Furthermore, because abstinence was chosen, study participants were disproportionately associated with 12-step movements. Having said this, the design of the study aimed to capture not only support group involvement but also a holistic view of recovery including other areas the participants found important, or even fundamental, to their recovery and well-being during their first two years of recovery from AOD dependence.

It is clear that people entering into a recovery lifestyle have a variety of previous experiences. Because this study did not investigate previous life experiences, skills, or treatment, it is unknown how many pre-existing skills people already had when entering a recovery lifestyle. For example, basic life skills, such as daily hygiene, may have been assumed as a given, therefore its importance would be understated in the study findings.

It is also important to note that, for a number of the study participants, this was not their first attempt at pursuing a recovery lifestyle, so their insight into the first two years of their recovery may have resulted in part from previous attempts at abstinence. It would be

misleading to think that the findings from this study were derived purely from participants' first two years experience and resulting learning.

This study did not screen for dual diagnosis. Dual diagnosis is the term used to describe having both an alcohol or other drug use disorder and a co-existing mental health condition. According to the Ministry of Health's (2010) publication 'Service Delivery for People with Co-Existing Mental Health and Addiction', 40% of people with a substance use disorder diagnosis also had a co-existing diagnosed anxiety disorder, and 29% of people with a substance use disorder diagnosis also had a diagnosed mood disorder.

Because of this, it is possible that some study participants were recovering simultaneously from other mental health disorders. This could result in a disproportionate focus on certain aspects of the recovery lifestyle that may be more associated with the management of another condition.

Because all study participants, bar one, who enrolled in the study were active members of 12-step fellowships the findings support 12-step fellowships. People who may have had a negative experience of 12-step fellowships and ceased attending are not represented in this study.

Because the questionnaire did not assess for well-being prior to recovery, no comparison could be made. Having said this, the information gathered from the focus groups and journals indicated strongly that all study participants' well-being had improved as a result of their recovery lifestyle.

Another limitation of this study is its individualistic focus. The 'ecology of addiction recovery' is of growing interest in the AOD treatment setting, but the parallel recovery processes of family and other community members were not explored in this study.

### **6.3 Conclusions**

The study made significant progress in answering the research question posed in this thesis:

What enabled a small group of people with AOD dependence to achieve and maintain abstinence and improve their well-being in the first two years within the New Zealand context?

Answering this question was made possible by working with study participants who had two or more years sobriety and who were engaged in a recovery lifestyle, and through the

data gathered from the study participant questionnaire, focus groups, journals and cameras. Emerging themes about recovery that came out of the focus groups were then collated, and the data gathered from the study participants' journals and cameras was amalgamated into existing themes or new themes were created where necessary. With the emerging themes identified, these could then be compared and contrasted to existing international and national literature on the themes recognised as important in AOD recovery. Finally, initial steps were made to developing a model of abstinence-based AOD recovery in the New Zealand context.

Many of the recovery ingredients themselves, such as higher power encounters, could require a study of their own due to the complexity of the dynamics that may be occurring. Hopefully this study will provide a future starting place for more detailed and robust studies on the specific recovery areas identified in this thesis.

A number of implications and considerations for health professionals have been raised as a result of this study. These include:

- addressing barriers and type of environment people with AOD problems need when accessing help
- the value of a person with AOD dependence being able to identify with others with AOD dependence
- the effectiveness of experience based learning versus purely cognitive or education type interventions
- the role of public education in instigating a person addressing their AOD problems
- problem recognition being an initial step in recovery
- the motivational impact of spiritual encounters are for a number of recovering people
- how community reinforcement can be used to promote change
- the value of the 12 steps or a structure process to bring about change
- the importance of developing self-awareness in early recovery not just avoidance of risky places
- the realities of relapse
- the role of egocentricity in dependence treatment
- the significance of helping others and pursuing hobbies is to some people's long term recovery

Association with 12-step and church-based fellowships and their related practices have been shown to be beneficial to a number of people in recovery with AOD dependence. The ADWRNZ study participants found these fellowships to be dynamic communities where needs of belonging, relationship, purpose, value, structure, contribution, identification, positive role models, being able to change behaviours, and process challenging emotions are met. The ADWRNZ study showed that for these study participants successful recovery was reliant on community dynamics, where authentic relationships exist with other recovering people, rather than an individualistic pursuit of recovery. There is still much to learn from support groups and church fellowships about AOD recovery that could assist treatment professionals. Treatment professionals need to take advantage of this rich New Zealand community resource both in learning from these communities to improve AOD treatment and in utilising these communities as allies in the treatment of these conditions.

#### **6.4 Implications of this Study Findings for Treatment Professionals**

##### **Misconceptions and stigma**

This study is a reminder to treatment professionals that misconceptions and stigma are often barriers to addressing addiction problems. This was true for many of this study's participants. The implication for treatment professionals is that it may be worth exploring consumers' misconceptions of addiction and how people with addiction problems present in the initial stages of treatment interventions.

The AOD treatment community also needs to remain diligent in taking whatever opportunities there are to educate the wider New Zealand public about addiction in the hope of reducing misconceptions others may have about people with AOD problems. Stigma about AOD problems is still prevalent in society and continued education is needed to reduce the barriers for people with AOD problems accessing AOD treatment services. Interestingly, as Todd, Sellman and Robertson's (2002) study of AOD users accessing treatment services in New Zealand also identified, judgmental attitudes exist amongst treatment professionals and are barriers for people considering addressing their AOD problems.

## **Confrontation**

Some study participants described an inability to cope with conflict and confrontation when first exploring a recovery lifestyle, and so the use of non-confrontational methods such as Motivational Interviewing is recommended when initial contact is made with people considering addressing their AOD problems.

## **Identification with others with AOD problems**

This ADWRNZ study also showed that being able to identify with other people with AOD problems was a significant motivator for study participants in addressing their AOD dependence, emphasising the need for interventions by treatment professionals that encourage identification with peers who are also in recovery. Furthermore, experience-based learning appeared pivotal in recovering people's change process. The questions for treatment providers when working with recovering people, are interventions used intended to increase positive experiences of recovery and sobriety, or is the dominant thrust of interventions cognitively-inclined, designed to persuade a person towards a better lifestyle? The whole area of experience-based learning still needs further investigation.

## **Education about addictive disease**

The ADWRNZ study supports education about addictive disease being a useful tool in promoting change regarding AOD related problems. This occurred through mass media campaigns, individually in the treatment sector, and through peers. There is still much debate over what effective education strategies are, and further investigation is required.

## **Problem recognition**

In addressing AOD problems the requirement of 'problem recognition' at both an intellectual and emotional level is supported by ADWRNZ study findings and the level of problem recognition determines the level of recovery solutions people tended to apply. The implications for practitioners are that intellectual and emotional acknowledgment as part of the acceptance process is important in addressing one's AOD problems. The timeframe of accepting one's addiction was varied amongst participants, and for some recovering people acceptance may be a process they need to work on as part of their ongoing recovery.

## **Spirituality**

Spiritual encounters and spirituality were shown to be a significant motivator for some recovering people in pursuing a recovery lifestyle. Acknowledgment of how important spiritual encounters are for some recovering people may be the positive reinforcement they need to pursue a recovery lifestyle. Galanter and Kleber (2008) warn that caution should be taken when people report a relationship with an external entity, as a number of people with AOD problems also have dual diagnosis. Therefore, due to perceived similarities between a spiritual vision and a psychotic hallucination, further careful assessment is necessary.

## **Honesty about the realities of early recovery**

An insight gained from 12-step fellowships is that honest sharing about and acceptance of common problems in early recovery may have a number of possible implications for the treatment sector. Specifically, when newly recovering people are facing challenges, the best approach may not be to try to 'fix' the problems early recovery people may experience. For example, treating fatigue and poor sleep patterns with medication, which is often ineffective long term, versus teaching good sleep hygiene practices and educating people regarding the realities of early recovery. A 'fix it' approach to the presenting problems newly recovering people commonly experience may be unintentionally detrimental by supporting unrealistic expectations, which in turn may result in distress. Interventions that encourage communicating honestly about the realities of early recovery for many recovering people may have better long-term outcomes. Therefore, treatment professionals facilitating groups with people in early recovery should encourage personal sharing about significant early recovery experiences including the realities of possible fatigue and difficulties dealing with strong emotions.

## **Acceptance and surrender**

This study reinforced a number of the objectives of 12-step facilitation. Galanter and Kleber (2008) state the goal of twelve-step facilitation is acceptance and surrender. This means accepting one's loss of control over the fact that one has an addiction, as well as the resulting behaviour when one drinks. Surrender means not relying on willpower alone but realising that more support is needed to overcome one's drinking or using. Examples of support include: 12-step meetings, having a sponsor, and a belief in God.

## **Cognitions, behaviour, social support and emotions**

This study supports Galanter and Kleber's (2008) recommendations that addressing one's cognitions, behaviours, social support, and emotions are also important objectives AOD recovery. Addressing cognitions and behaviour is important because certain thinking or behavioural patterns are part of the drinking/using cycle. Addressing a person's social supports is important because avoiding dangerous situations and developing positive social supports improve recovery outcomes. Processing and managing emotions such as anger in a healthy manner is important as this helps to guard against relapse.

## **Vigorous self-honesty about one's vulnerabilities**

The importance of vigorous self-honesty about one's vulnerabilities, not just avoidance of alcohol or drug saturated environments, was one of the findings of this study. The implication for the treatment sector is that interventions need to support both recovery strategies: avoiding high-risk situations and also developing the self-awareness to act when a person is feeling vulnerable to relapse.

## **Relapse**

This study supports what treatment professionals already know, that relapse is often a part of a person's process in finally entering a stable abstinence-based recovery lifestyle.

## **A way of living**

The ADWRNZ study highlighted that for all study participants working on the 12-steps and a recovery lifestyle is an on-going process and a way of living more than a one-off recovery event. This is a reminder of the chronic nature of AOD dependency. Treatment professionals do not have a monopoly on the effective treatment of AOD addiction as these community-based fellowships have also been shown to effectively treat this problem.

## **Helping others**

All study participants displayed attitudes and beliefs that were centred on helping others as well as meeting their own needs. This study has shown that helping others has a number of benefits for recovering people including: giving a sense of purpose, belonging, and reducing self-obsession. Therefore treatment centres should consider providing opportunities for clients to support other recovering people if they do not already. The only caution that needs to be considered is that focusing on other things (helping others) can

be a defence mechanism to not give attention to one's own AOD problems (Twerski, 1997).

### **Developing or re-establishing hobbies and interests**

This study showed that developing or re-establishing hobbies and interests was important in replacing time spent drinking or using drugs. Therefore providing opportunities for developing hobbies and interests in treatment settings and Continuing Care Planning would also be advantageous.

### **Theoretical understandings and models**

A number of the theoretical understandings and models have been explored in light of the study findings. These include Baumeister's Crystallization of Discontent Theory, Chaos and Complexity Theory, DiClemente's Model of Change, Social Control Theory, Social Learning Models, Motivational Interviewing, Cognitive Behavioural Therapy, 12-Step Facilitation, Contingency Management models, Community Reinforcement models, and Tapa Wha model. To varying degrees all of these theories and models provide a conceptual framework for understanding aspects of the recovery process that study participants worked through in establishing a recovery lifestyle for AOD dependency.

### **Recovery ingredients**

As discussed in the literature review of this thesis, Moos (2007, 2008) proposed a number of successful ingredients found in different treatment approaches for people with substance use disorders. These included:

- Bonding or support, structured monitoring, and goal direction (Social Control Theory)
- Observing peers' norms, expectations of positive and negative effects, and role models (Social Control and Social Learning Models)
- Collaborative relationship between the consumer and counsellor (Motivational Interviewing)
- Self-efficacy, general self-confidence, substance-specific and general coping strategies, positive expectancies for no substance use (Cognitive Behavioural Therapy)
- Specific kinds of rewards including those related to regular drug testing or certain behaviour demonstrated (Contingency Management & Community Reinforcement)

Moos (2007) also listed a number of possible active ingredients in 12-step facilitation approaches. These included group involvement, mixing with 12-step friends, having a sponsor, reading 12-step materials, and 12-step focus on abstinence. He also noted that people within 12-step programmes tended to endorse 12-step beliefs, and that their self-efficacy and coping skills also improved during TSF treatment

The ADWRNZ study found evidence in varying degrees for all these successful treatment ingredients in study participants' descriptions of what they attributed to their successful recovery lifestyle.

### **Training**

It is the researcher's view that there is a lack of training in the benefits of 12-step and church-based fellowships for people pursuing a recovery lifestyle. Because of this, training institutions could find ways to work more collaboratively with recovery fellowships and ensure that there is sufficient education in the many dynamics that occur within these fellowships including a sense of belonging, identification, structure, purpose, support, and emotional processing.

### **Passing on information gained from this study**

It is the researcher's belief that making this study's findings available would be beneficial to the recovery community and the health professionals that work with them. Because of this it is this researchers commitment to producing a DVD about New Zealanders' experiences of the first two years abstinence-based AOD recovery from the findings in this study.

### **Utilising 12 step community resources**

A further consideration is as 12-step support groups are self-funded, utilising this community resource would potentially assist treatment professionals who already have limited financial resources. In '100 ways to support the recovery sector in the Mental Health setting', Slade (2009) offers a number of suggestions that may be applicable to the AOD treatment sector. These include: treatment professionals supporting peer-run programmes, actively promoting the volunteer recovery sector, supporting people to share their recovery stories with other recovering people, and facilitating speakers from recovery fellowships sharing in the treatment setting. Furthermore, Slade (2009) poses a framework for treatment professionals to support personal recovery that includes four main

components: Firstly, the installation of hope, helping a newly recovering person to believe that recovery is possible. Secondly, helping the newly recovering person to build a positive self-identity and image. Thirdly, supporting newly recovering people to develop a sense of purpose and to set goals. And finally, encouraging personal responsibility for an individual's recovery. Walitzer, Dermen and Barrick's (2007) study explored the effectiveness of three approaches when referring clients to 12-step fellowships: an Intensive Alcoholics Anonymous facilitation (DAA), MI referral style to AA facilitation (MI), and a treatment as usual (TAU) control group. This study found the DAA groups had higher AA meetings attendance, more active involvement in AA, and greater sobriety rates than the TAU and MI groups. The DAA approach included encouraging study participants to keep a journal of their 12-step experiences to discuss in counselling sessions, giving participants 12-step literature, and facilitating discussions about active involvement in 12-step fellowships.

There may also be an argument that for a person to benefit from 12-step fellowships they have to have strong spiritual beliefs. However Tonigan's (2002) study found that "AA attendance ... was significantly associated with increased abstinence and reduction in drinking intensity regardless of God belief" (p.??). Clients that may not benefit from 12-step fellowships are those utilising a reducing drinking or reducing harms approach due to the strong conflicting abstinence message in 12-step fellowships. Finally, there are also a number of tested assessment tools that have been formulated to help practitioners use 12-step support groups.

Some of these include:

- The Survey of Readiness for Alcoholics Anonymous (Tonigan et al., 2002, p. 534)
- Alcoholics Anonymous Involvement Scale (Kingree, Thompson & McCray, 2007)
- Alcoholics Anonymous Affiliation Scale (Tonigan, Conner & Miller, 1996)
- Spirituality Self Rating Scale (K. Humphreys, Kaskutas & Weisner, 1998)

### **Model of recovery**

Finally, as result of the ADWRNZ study findings, the initial steps to developing an abstinence-based model of recovery in the New Zealand context were formulated. Further research is recommended to develop this model and ascertain its validity with other populations in the New Zealand context.

## **Conclusion**

In conclusion, the power of a community such as a 12 step groups or a church settings to bring about personal change has been found to be remarkable. It is the researcher's belief that these dynamic recovery communities resulted in a number of behavioural changes and shift in participant's outlook on life that would take years of counselling or therapy to achieve.

There is much to learn about how community and individually based interventions can be used to improve the outcomes for people with AOD dependence in the New Zealand context. This study has provided a platform to promote this important discussion.

## **6.5 Recommendations**

### **Considerations for people pursuing an abstinence-based AOD recovery.**

- Utilising 12-step based fellowships has been shown to be an effective AOD recovery pathway.
- Misconceptions about addiction and people with an addiction are common.
- Acknowledging, accepting and processing the effects of one's addiction both intellectually and emotionally has been shown to be important for successful recovery. Sponsors within the 12-step community, or a church fellowship, or AOD professionals can help with this.
- A lifestyle of AOD misuse can result in isolation, therefore having a sense of belonging, gaining support from others and contributing in recovery supportive fellowships have all been shown to increase positive recovery outcomes.
- Education about addictive disease has been shown to improve recovery outcomes.
- For some people, spiritual encounters are common and an important motivation for long-term recovery. For others, utilising a spiritually based recovery programme is more learning and educationally based. Both are effective recovery pathways.
- Within 12-step fellowships the realities of early recovery are often talked about freely; accepting these realities and developing realistic expectations has been shown to reduce distress.
- Sharing with another trusted recovering person (sponsor) about things one has done when drinking or using drugs has been shown to bring a great sense of relief and to be an important part of progressing in one's recovery.

- Vigorous honesty about one's vulnerabilities to drink or use other drugs is a protective factor. For some people this may mean total avoidance of dangerous situations whereas for others this may mean leaving events earlier depending on one's vulnerability on a certain day.
- Addressing one's previous self-reliance and developing a wider support network in the future has been shown to be a core task of successful recovery.
- Helping others as part of recovery has been shown to be personally beneficial in assisting positive recovery.
- Re-establishing or developing hobbies and interests has been shown to be an important part of building a successful recovery lifestyle.

### **Summary of recommendations for AOD treatment professionals**

The following recommendations or considerations for professionals working with people in recovery from AOD dependence (addiction) are supported by both ADWRNZ study findings and literature reviewed as part of this thesis.

Practitioners should:

- support involvement in 12-step fellowships as this has been shown to be a valid pathway of recovery.
- assess potential consumers regarding possible misconceptions they may have about addiction or people who have addictions.
- avoid direct confrontation in initial interactions with people engaging in AOD services; Motivational Interviewing has been suggested as a suitable engagement intervention.
- include strategies to aid new consumers identification with peers in recovery; 12-step fellowships are a community resource that can help with this.
- ensure the people pursuing AOD recovery have received education about addictive disease as this has been shown to assist in the acceptance of one's AOD problems.
- be aware that lack of problem recognition is a barrier for people addressing their AOD problems. Acceptance of AOD problems requires both intellectual and emotional processing of the impacts of AOD use. Acceptance of one's addiction and what is involved in maintaining recovery can be an ongoing process.

- be aware that spiritual encounters and spirituality are both commonly important and a significant motivation for some people pursuing a recovery lifestyle. Interventions should support these encounters and associated beliefs.
- promote peer honesty with consumers about the challenges of early recovery as it has been shown to reduce distress by helping to establish realistic expectations of AOD recovery.
- help consumers realise their limits and need for ongoing support as an important objective in aiding successful AOD recovery and avoiding being overly self-reliant.
- utilise strategies that increase consumers' awareness of behaviours and thinking patterns associated with AOD use as this is important to developing successful recovery.
- be mindful that people's vulnerability to AOD relapse fluctuates, ongoing personal self-monitoring is an important skill to develop. For some people this will mean total avoidance of dangerous situations whereas for others developing a well thought though exit plan has been shown to be an effective management strategy.
- be honest about the realities of relapse and help consumers to have realistic expectations and to encourage vigilance when pursuing AOD recovery.
- utilise opportunities for consumers to help others as this has been shown to increase meaning and purpose and reduce egocentricity. The only caution is that helping others other can also be an avoidance strategy to shift the focus from one's own AOD problems.
- ensure recovery lifestyle planning includes the reestablishment or development of hobbies and interests.
- note that as recovery from AOD dependence has been shown to not be an individual pursuit alone, interventions need to support positive community and peer interactions.

In conclusion, finding improved ways of supporting people who are recovering from alcohol or other drug dependence can only have positive benefits to recovering people themselves, the significant others supporting them, and society as a whole. These studies, and those like it, are invaluable in assisting professionals to practically support people in AOD recovery.

## References

- Adamson, S., Sellman, D., Deering, D., Robertson, P., & De Zwart, K. (2006). Alcohol and drug treatment population profile: a comparison of 1998 and 2004 data in New Zealand. *Journal of the New Zealand Medical Association*, 119(1244), p. electronic journal.
- Adamson, S. J., Sellman, J. D., & Frampton, C. M. A. (2009). Patient predictors of alcohol treatment outcome: A systematic review. *Journal of Substance Abuse Treatment*, 36(1), 75-86.
- Alaszewski, A. (2006). *Using diaries for social research*. London: Sage Publishing.
- Alcohol Advisory Council of New Zealand. (2005). The burden of death, disease and disability due to alcohol in New Zealand. *Occasional Publication, No. 23*. Retrieved March 18, 2011, from <http://www.alac.org.nz/research-resources/research-publications/burden-death-disease-and-disability-due-alcohol-new-zealan-0>
- Alcohol Advisory Council of New Zealand. (2011). NZ Statistics. Retrieved February 28, 2011, from [http://www.alac.org.nz/NZStatistic\\_170201.aspx](http://www.alac.org.nz/NZStatistic_170201.aspx)
- Alcohol Advisory Council of New Zealand; Ministry of Health; New Zealand Police; Accident Compensation Corporation. (2010). *Alcohol quick facts*. Retrieved March 22, 2011, from <http://www.ndp.govt.nz/moh.nsf/indexcm/ndp-publications-alcohol-factsheets>
- Alcoholics Anonymous General Service Office. (2011). *Welcome to alcoholics anonymous*. Retrieved January 9, 2012, from <http://www.aa.org/subpage.cfm?page=74>
- Alcoholics Anonymous New Zealand. (2010). Alcoholics Anonymous. Retrieved January 12, 2012, from <http://www.aa.org.nz/home>

- Alcoholics Anonymous New Zealand. (2004) *15-21 march 2004 survey of Alcoholic Anonymous members currently attending meetings*. Wellington: Alcoholics Anonymous General Service Office.
- Alcohol Drug Association New Zealand. (2011). *Addiction treatment directory*. Retrieved March 22, 2011, from <http://www.adanz.org.nz/ADANZ/Home>
- Alcoholics Anonymous World Service Inc. (2001). *Alcoholics anonymous: The story of how many thousands of men and women have recovered from alcoholism* (4 ed.). New York: Alcoholics Anonymous World Service, INC.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4 ed.). USA: American Psychiatric Association.
- American Society of Addiction Medicine. (2011). *Public policy statement: definition of addiction (long version)*. Retrieved October 2, 2011 from <http://www.asam.org/research-treatment/definition-of-addiction>
- Anonymous. (2009). What triggers addictive behavior? Retrieved June 17, 2010, from [http://addictionrecoveryguide.com/message\\_board/index.php?act=ST&f=10&t=62946&s=47745b196693125a83a4c04ddea7f84a](http://addictionrecoveryguide.com/message_board/index.php?act=ST&f=10&t=62946&s=47745b196693125a83a4c04ddea7f84a)
- Baker, M., Sellman, D., & Horn, J. (2006). The spiritual characteristics of New Zealanders entering treatment for alcohol / other drug dependence. *Alcoholism Treatment Quarterly*, 26(4), 137-155.
- Barry, J. M., Avshalom, C., HonaLee, H., Richie, P., Michael, R., & Terrie, E. M. (2009). Predictive value of family history on severity of illness: The case for depression, anxiety, alcohol dependence, and drug dependence. *Archives of General Psychiatry*, 66(7), 738-747.

- Baumeister, R., Heatherton, T., & Weinberger, J. (1994). *The crystallization of discontent in the process of major life change. Can personality change?* Washington DC: American Psychological Association.
- Best, D., Harris, J., Gossop, M., Manning, V., Man, L., & Marshall, J. (2001). Are the twelve steps more acceptable to drug users than drinkers? A comparison of experiences of the attitudes to alcoholics anonymous inpatient detoxification. *European Addiction Research*, 7(2), 69-77.
- Bischof, G., Rumpf, H.J., Meyer, C., Hapke, U., & John, U. (2007). Stability of subtypes of natural recovery from alcohol dependence after two years. *Addiction*, 102(6), 904-908.
- Boysen, G., & Vogel, D. (2008). Education and mental health stigma: the effects of attribution, biased assimilation, and attitude polarization. *Journal of Social and Clinical Psychology*, 27(5), 447-470.
- Brown, A. E., Whitney, S. N., Schneider, M. A., & Vega, C. P. (2006). Alcohol recovery and spirituality: strangers, friends, or partners? *Southern Medical Journal*, 99(6), 654(654).
- Brown, B., Abrantes, A., Read, J., Marcus, B., Jakicic, J., Strong, D., Oakley, R., . . . Gordon, A. (2009). Aerobic exercise for alcohol recovery: rationale, program description, and preliminary findings. *National Institute of Health*, 33(2), 220-229.
- Bryman, A. (2008). *Social research methods*. New York: Oxford.
- Büssing, A., Matthiessen, P., & Mundle, G. (2008). Emotional and rational disease acceptance in patients with depression and alcohol addiction. *Health And Quality Of Life Outcomes*, 6(4), 1-11.

- Chan, F., Cardoso, E., & Chronister, J. (2009). *Understanding Psychosocial adjustment to chronic illness and disability*. New York: Springer Publishing Company.
- Charney, D. A., Zikos, E., & Gill, K. J. (2010). Early recovery from alcohol dependence: Factors that promote or impede abstinence. *Journal of Substance Abuse Treatment, 38*(1), 42-50.
- Clough, P., & Nutbrown, C. (2002). *A students guide to methodology*. London: Sage Publishing Company.
- Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education*. USA: Routledge Taylor & Fancis Group.
- Community Alcohol & Drug Services. (2011). Frequently asked questions. Retrieved November 3, 2011, from <http://www.cads.org.nz/More/FAQs.asp> - HarmRed
- Conyers, B. (2009). *Everything changes, help for families of newly recovering addicts*. Minnesota: Hazelden.
- Cowan, C. (2008). *Supporting the journey of recovery in mental health, a guide for support workers, family/whanau and friends*. Wellington: Dunmore Publishing Ltd.
- Davidson, C., & Tolich, M. (1999). *Social science research in New Zealand, Many pathways to understanding*. Auckland: Longman.
- DeLeon, G. (2000). *The therapeutic community; theory, model, and method*. New York: Springer Publishing Company.
- DiClemente, C. C., Schlundt, D., & Gemmell, L. (2004). Readiness and stages of change in addiction treatment. *The American Journal on Addictions, 13*(2), 103-119.
- Ebaugh, H. (1988). *Becoming an ex: The process of role exit*. Chicago: University of Chicago Press.

- Elder, R., Shults, R., Sleet, D., Nichols, J., Thompson, R., & Rajab, W. (2004). Effectiveness of mass media campaigns for reducing drinking and driving and alcohol-involved crashes: A systematic review. *American Journal of Preventive Medicine, 27*(1), 57-65.
- Enoch, M.A. (2011). The role of early life stress as a predictor for alcohol and drug dependence. *Psychopharmacology, 214*(1), 17-31.
- Eriksen, B. (1986). Social skills training in groups for alcoholics: one-year treatment outcomes for groups and individuals. *Addictive Behaviors, 11*(3), 309-329.
- Erney, J. (2005). *A call for change toward a recovery-oriented mental health service system for adults*. Harrisburg: Pennsylvania Office of Mental Health and Substance Abuse Services.
- Faull, K., & Hills, M. D. (2006). The role of the spiritual dimension of self as the prime determinant of health. *Disability and Rehabilitation, 28*(11), 729-740.
- Froggatt, W. (2003). *Choose to be happy*. Auckland: Harper Collins Publishers.
- Galanter, M., Dermatis, H., Bunt, G., Williams, C., Trujillo, M., & Steinke, P. (2007). Assessment of spirituality and its relevance to addiction. *Journal of Substance Abuse Treatment, 33*(2007), 257-264.
- Galanter, M., & Kleber, H. (2008). *The American psychiatric publishing textbook of substance abuse treatment*. Washington: American Psychiatric Press, Inc.
- Gardiner, P. (2006). *Harm minimisation - is it working?* Retrieved June 14, 2011, from <http://www.nzcpr.com/guest19.pdf>
- Gordis, E. (1997). NIAAA publication *Alcohol Alert* (36 ed). Retrieved April 28, 2010, from <http://pubs.niaaa.nih.gov/publications/aa36.htm>

- Hester, R., & Miller, R. (2003). *Handbook of alcoholism treatment approaches: Effective alternatives*. USA: Allyn & Bacon.
- Hoffman, J., & Froemke, S. (2007). *Why can't they just stop? Addiction, new knowledge, new treatments, new hope*. USA: Holtzbrinch Publishers.
- Hser, Y. (2007). Predicting long term stable recovery from heroin addiction: findings from a 33 year followup study. *Journal of Addictive Diseases*, 26(1), 51-60.
- Hulse, G., White, J., & Cape, G. (2002). *Management of alcohol and drug problems*. Melbourne: Oxford University Press.
- Humphreys, K., Kaskutas, L., & Weisner, C. (1998). The alcoholics anonymous affiliation scale: development, reliability, and norms for diverse treated and untreated populations. *Alcoholism: Clinical and Experimental Research*, 22(5), 974-977.
- Humphreys, K., Wing, S., McCarty, D., Chappel, J., Gallant, L., Haberle, B., Horvath, T., ... Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, 26(3), 151-158.
- James, W. (2011). *Varieties of religious experiences*. New York: Penguin Book.
- Janis, I., & Mann, L. (1968). *A conflict-theory approach to attitude change and decision making*. New York: Academic Press.
- Jason, L. A., Olson, B. D., Ferrari, J. R., Majer, J. M., Alvarez, J., & Stout, J. (2007). An examination of main and interactive effects of substance abuse recovery housing on multiple indicators of adjustment. *Addiction*, 102(7), 1114-1121.
- Jeffrey, R. (2011). Revisiting the mind-body split. *Journal of Groups in Addiction and Recovery*, 6(4), 283-284.

- Kelly, J., Stout, R., Magill, M., Tonigan, S., & Pagano, M. (2011). Spirituality in recovery: a lagged meditational analysis of Alcoholics Anonymous' principal theoretical mechanism of behavior change. *Alcoholism: Clinical and Experimental Research*, 35(3), 1-10.
- Kelly, J. F., Stout, R. L., Magill, M., Tonigan, J. S., & Pagano, M. E. (2010). Mechanisms of behavior change in Alcoholics Anonymous: Does Alcoholics Anonymous lead to better alcohol use outcomes by reducing depression symptoms? *Addiction*, 105(4), 626-636.
- Kingemann, H., Sobell, L., Barker, J., Blomqvist, J., Cloud, W., Ellinstad, T., Finfgeld, D., . . . Tucker, J. (2001). *Promoting self-change from problem substance use: practical implications for policy, prevention and treatment*. Dordrecht: Kluwer Academic Publishers.
- Kingree, J., Thompson, A., & McCray, B. (2007). The predictive validity of the survey of readiness for Alcoholics Anonymous participation. *Journal of Studies on Alcohol and Drugs*, 68(1), 141-149.
- Kolb, D. (1984). *Experiential learning: experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice Hall.
- Krentzman, R., Brower, J., Cranford, A., Bradley, C., & Robinson, A. (2012). Gender and extroversion as moderators of the association between Alcoholics Anonymous and sobriety. *Journal of Studies on Alcohol and Drugs*, 73(1), 44-52.
- Kupfer, D., & Regier, D. (2010). American Psychiatric Association: DSM5 development. Retrieved November 7, 2011, from <http://www.dsm5.org/Pages/Default.aspx>
- La Grow, S. (1996). Rehabilitation: A call to limit the definition and expand the possibilities. *New Zealand Journal of Disability Studies* 2(1) 128-135.

- La Grow, S. (2008). Rehabilitation for return to work. Retrieved November 19, 2011, from <http://www.rehabilitation.org.nz/content/column/vocational-rehabilitation>
- Land, K.C., Michalos, A.C., & Sirgy, M.J. (2012). *Handbook of social indicators and quality of life research*. New York: Springer.
- Laudet, A. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Substance Abuse Treatment* 33(3), 245-256.
- Laudet, A., Morgen, K., & White, W. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug problems. *Alcoholism Treatment Quarterly* 24(1-2), 33-73.
- Laudet, A. B., & White, W. L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction, and stress among former poly-substance users. *Substance Use and Misuse*, 43(1), 27-54
- Litt, M. D., Kadden, R. M., Kabela-Cormier, E., & Petry, N. M. (2008). Coping skills training and contingency management treatments for marijuana dependence: Exploring mechanisms of behavior change. *Addiction*, 103(4), 638-648.
- Livneh, H., & Parker, R. M. (2005). Psychological adaptation to disability: Perspectives from chaos and complexity theory. *Rehabilitation Counseling Bulletin*, 49(1), 17-28.
- Majer, J., Jason, L., Ferrari, J., Venable, L., & Olson, B. (2002). Social support and self-efficacy for abstinence: is peer identification an issue? *Journal of Substance Abuse Treatment*, 23(3), 209-215.

- Majer, J., Jason, L., Ferrari, J., & Miller, S. (2011). 12-step involvement among a US national sample of oxford house residents. *Journal of Substance Abuse Treatment*, 41(1), 37-44.
- Majer, J. M., Jason, L. A., & Olson, B. D. (2004). Optimism, Abstinence Self-Efficacy, and Self-Mastery. *Assessment*, 11(1), 57-63.
- Mason, K., Hewitt, A., & Stefanogiannis, N. (2009). *Drug use in New Zealand: Key results of the 2007/08 New Zealand alcohol and drug use survey*. Wellington: Ministry of Health.
- McGovern, M., Wrisley, B., & Drake, R. (2005). Relapse of substance use disorder and its prevention among persons with co-occurring disorders. *Psychiatric Services*, 56, 1270-1273.
- McLennan, T. (2011). *What is recovery?* Paper presented at the Cutting Edge Conference 2011: Recovery and Wellbeing, Auckland.
- Miller, P. (2009). *Evidence-based addiction treatment*. Amsterdam: Elsevier.
- Miller, P., Strang, J., & Miller, P. (2010). *Addiction research methods*. Chichester: Addiction Press.
- Ministry of Health. (2007). National Drug Policy New Zealand. Retrieved November 3, 2011, from <http://www.ndp.govt.nz/>
- Ministry of Health. (2010). *Service delivery for people with co-existing mental health and addiction problems*. Wellington: Ministry of Health.
- Mitchel, D. (2001) *A ghost in the closet: Is there an alcoholic hiding?* Minnesota: Hazelden Information & Educational Services

- Moos, R.H. (2007). Theory-based active ingredients of effective treatments for substance use disorders. *Drug Alcohol Dependence*, 88(2-3), 109-121.
- Moos, R.H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction*, 103(3), 387–396.
- Morgenstern, J., Kahler, C., Frey, R., & Labouvie, E. (1996). Modeling therapeutic responses to 12-step treatment: Optimal responders, nonresponders and partial responders. *Journal of Substance Abuse*, 8(1), 45-59.
- Narcotics Anonymous Aotearoa New Zealand. (2004). *Fellowship statistics*. Retrieved January 12, 2011, from <http://www.nzna.org/professionals/fellowshipstatistics.shtml>
- National Committee for Addiction Treatment. (2011). Addiction is a family issue. Retrieved November 3, 2011, from <http://ncat.org.nz/files/NCAT-july-2011.pdf>
- National Institute on Drug Abuse. (2008). Using exercise to aid alcohol and drug recovery. Retrieved July 23, 2010, from <http://alcoholism.about.com/od/relapse/a/exercise>
- Neff, J., & MacMaster, S. (2005). Applying behavior change to understanding spiritual mechanisms underlying change in substance abuse treatment. *American Journal of Drug and Alcohol Abuse*, 31(4), 669-185.
- Orford, J. (2008). Asking the right questions in the right way: the need for a shift in research on psychological treatment for addiction. *Addiction*, 103(6), 875-885.
- Paris, R., & Bradley, C. (2001). The challenge of adversity: three narratives of alcohol dependence, recovery, and adult development. *Qualitative Health Research*, 11(5), 647-667.
- Pere, R. (1995). *Te Wheke: A celebration of infinite wisdom*. Gisborne: Ao Ako Global Publishing.

- Perfas, F. (2004). *Therapeutic community: Social systems perspective*. Lincoln: iUniverse, Inc.
- Pledger, C. (2003). Discourse on disability and rehabilitation issues: Opportunities of psychology. *American Psychologist*, 58(4), 279-284.
- Prochaska, J., & DiClemente, C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy*. Homewood IL: Dow Jones-Irwin.
- Rapp, R. C., Xu, J., Carr, C. A., Lane, D. T., Wang, J., & Carlson, R. (2006). Treatment barriers identified by substance abusers assessed at a centralized intake unit. *Journal of Substance Abuse Treatment*, 30(3), 227-235.
- Read, J. P., Brown, R. A., Marcus, B. H., Kahler, C. W., Ramsey, S. E., Dubreuil, M. E., . . . & Francione, C. (2001). Exercise attitudes and behaviors among persons in treatment for alcohol use disorders. *Journal of Substance Abuse Treatment*, 21(4), 199-206.
- Ridder, E., & Mohr, Y., & Health Research Council of New Zealand (2003). *Models of practice in alcohol and drug treatment services in New Zealand: A stocktake 'who receives what services from whom and how?'*. Auckland: Health Research Council of New Zealand.
- Rinn, W., Desai, N., Rosenblatt, H., & Gastfriend, D. R. (2002). Addiction denial and cognitive dysfunction: A preliminary investigation. *The Journal of Neuropsychiatry Clinical Neurosciences*, 14(1), 52-57.
- Robinson, E. A. R., Cranford, J. A., Webb, J. R., & Brower, K. J. (2007). Six-month changes in spirituality, religiousness, and heavy drinking in a treatment-seeking sample. *Journal of Studies on Alcohol and Drugs*, 68(2), 282(289).

- Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review, 24*(2), 143-155.
- Rushing, A. (2008). The unitary life pattern of persons experiencing serenity in recovery from alcohol and drug addiction. *Advances in Nursing Science, 31*(3), 198-210.
- SAMHSA. (2008). *Substance abuse in brief fact sheet: An introduction to mutual support groups for alcohol and drug abuse*. Rockville, MD: US Department of Health and Human Services.
- SAMHSA. (2011). *Recovery defined: a unified working definition and set of principles*. Retrieved 18 November, 2011, from <http://blog.samhsa.gov/2011/05/20/recovery-defined-a-unified-working-definition-and-set-of-principles/>
- Savage, E. (2007). Addiction recovery: Feeling feelings again. Retrieved June 17, 2010, from [http://www.associatedcontent.com/article/416177/addiction\\_recovery\\_feeling\\_feelings.html?cat=72](http://www.associatedcontent.com/article/416177/addiction_recovery_feeling_feelings.html?cat=72)
- Schomerus, G., Lucht, M., Holzinger, A., Matschinger, H., Carta, M., & Angermeyer, M. (2011). The stigma of alcohol dependence compared with other mental disorders: A review of population studies. *Alcohol and Alcoholism, 46*(2), 105-112.
- Simpson, T. L., & Miller, W. R. (2002). Concomitance between childhood sexual and physical abuse and substance use problems: A review. *Clinical Psychology Review, 22*(1), 27-77.
- Slack, A., Nana, G., Webster, M., Stokes, F., & Wu, J. (2009). *Costs of harmful alcohol and other drug use*. Wellington: Berl Economics.
- Slade, M. (2009). *100 ways to support recovery, a guide for mental health professionals*. London: Rethink

- Sobell, C., Cunningham, J., & Sobell, M. (1996). Recovery from alcohol problems with and without treatment: prevalence in two population surveys *American Journal of Public Health, 86*(7), 996-972.
- Sobell, L. C., Ellingstad, T. P., & Sobell, M. B. (2000). Natural recovery from alcohol and drug problems: Methodological review of the research with suggestions for future directions. *Addiction, 95*(5), 749-764.
- Standards New Zealand Paerewa Aotearoa. (2008). *Health and Disability Services Standards*. Wellington: Standards New Zealand Paerewa Aotearoa.
- Todd, F.C., Sellman, J.D., & Robertson, P.J. (2002). Barriers to optimal care for patients with coexisting substance use and mental health disorders. *Australian and New Zealand Journal of Psychiatry, 36*(6), 792-799.
- Tonigan, J.S., Conner, J., & Miller, W.R. (1996). Alcoholics anonymous involvement (aai) scale: reliability and norms. *Psychology of Addictive Behaviors, 10*(2), 75-80.
- Tonigan, J.S., Miller, W.R., & Schermer, C. (2002). Atheists, agnostics and alcoholics anonymous. *Journal of Studies on Alcohol, 63*(5), 534-541.
- Twerski, A. (1997). *Addictive thinking*. USA: Hazelden.
- Walitzer, K., Dermen, K., & Barrick, C. (2007). Facilitating Involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical trial. *Addiction, 104*, 291-401.
- Walkfield, M., Loken, B., Hornilk, R. (2010). Use of mass media campaigns to change health behaviour *The Lancet, 376*(9748), 1196.
- Wang, C. (2006). Youth participation in photovoice as a strategy for community change. *Journal of Community Practice, 14*(1/2), 147-161.

- Weegmann, M., & English, C. (2010). Beyond the shadow of drugs: Groups with substance misusers. *Group Analysis*, 43(1), 3-21.
- White, W. L. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36(2), 146-158.
- World Health Organization. (2011). Mental health: strengthening our response. Retrieved February 29, 2011, from <http://www.who.int/mediacentre/factsheets/fs220/en/>
- World Health Organization. (2001). *International classification of functioning, disability, and health (ICF)*. Geneva.

## Appendices

### Appendix A. Glossary of Terms (working definitions)

ADWRNZ:	Alcohol and Drug Recovery and Well-being in New Zealand Study
Dependency:	As defined by both the American Society of Addiction Medicine and the Diagnostic and Statistical Manual of Mental Disorders TR-IV where the criteria required to diagnose a person with dependence on a mood altering substance are listed – see page 53 (American Psychiatric Association, 1994).
Mood-altering substances:	Chemical substance used to alter a person mood or perception (Jeffrey, 2011).
Sobriety:	A state of being sober (Krentzman, et al. 2012).
Spirituality:	May involve religious or non-religious concepts of God. Also may involve relationships, connectedness, meaning, and values and beliefs (Faull & Hills, 2006).
AOD Recovery:	A chosen lifestyle to combat AOD addiction (American Psychiatric Association, 1994).
Well-being:	“life satisfaction, trust in others, positive emotions, meaning and purpose in life, and engagement and interest” (Land, Michalos, Sirgy, 2012, p.137).

## Appendix B. ADWRNZ Study Pack

Printed on Massey University letter head

### Information Sheet

My name is Dale Smith. I have eight years experience working in the rehabilitation field. I do not have an addiction to alcohol or drugs myself; however have experienced both professionally and in my immediate family, the impacts of addiction and recovery first hand. As part of further professional development I am working towards my Masters in Philosophy through Massey University. This entails undertaking research with people recovering from drug or alcohol dependence.

Lance M, who has three years abstinence-based recovery, has agreed to assist in this study. He is approaching people in abstinence-based recovery who he perceives meet the criteria for the study and may be interested in participating.

The explorative study question I am asking is: What does pursuing abstinence-based recovery and well-being involve during the first two years or more for a small number people who are recovering from a dependence to alcohol or drugs or both?

This will involve working with 8 -12 recovering people by way of focus groups, reflective journals, and cameras to capture their perspectives on the recovery lifestyle. The goal of this project is to produce an informative research report to be submitted for publication to a number of professional journals in the alcohol and drug treatment field.

If you have been given this information sheet you are being invited to participate in this study on the condition that you are eligible, based on the study criteria set out below. If you are interested in participating in this study please make contact with me by 9 May 2011.

Dale Smith

(09)5340784

0272801864

Dale@dalesmith.co.nz

## **Study recruitment method**

Lance M is handing out study information sheets to potential participants based on his limited knowledge of individuals' recovery in relation to the inclusion criteria set out below.

Lance M will direct potential participants to contact the researcher if they would like to obtain further information or be involved in the study.

Suitability of study participants will be ascertained by their completion of the dependence criteria and consent forms explained in the study information pack, which will be sent out to potential participants when they contact Dale Smith (researcher).

Though this study is positively focused on what works for people recovering from alcohol or drugs, it is inevitable that discussions of both the positive and negative aspects of recovery in the first two years will occur. Because this may be distressing for some people I would ask you consider carefully your participation in this study.

## **Study support and safety**

An independent and experienced counsellor is available if you need to discuss issues resulting from the study process. You will be given her contact details in the study pack which will be sent to you if you call Dale Smith (researcher) and ask to participate in the study.

## **Study Inclusion criteria**

- Study participants must believe they are pursuing a recovery-type lifestyle that is beneficial to their well-being.
- Study participants must have 2 years or more abstinence-based recovery. This length of time has been chosen because this study is querying recovering people's initial abstinence based recovery experience.
- Study participants must be over 21 years of age.
- Study participants need to be fluent English speakers; good writing skills are not necessary as a scribe will be used to record our discussions.
- Participants must meet 3 of the 7 dependence criteria for alcohol or drug dependence which is explained in the study pack you will receive if you choose to contact Dale Smith, the researcher.

## **Study exclusion criteria**

As I have worked as an Alcohol and Drug counsellor, any person that I (Dale Smith) have been a primary Case Manager for when I was working as an Alcohol & Drug Counsellor at Capri Trust between 2005 and 2009 would be excluded from the study. This is because this is an ethical issue and seen as a possible conflict of your interests.

## Study project procedure

- This study will involve between 8 to 10 hours of your time.
- You will need to sign confidentiality and participation agreements
- You will need to complete an individual questionnaire including general demographics and some recovery based information.
- You will be working in a group setting with 8 to 12 other recovering people. These group sessions will involve two two-hour sessions from 7.30-9.30pm on Thursday evenings of 19 May and 2 June 2011. This number of participants has been chosen to ensure that each person has the opportunity to share in depth what they perceive has been vital to their recovery and attaining well-being. A scribe will be present who has also signed confidentiality agreements to record the discussions.
- Further opportunity will be made for you to record your experiences by using a journal and digital camera outside of the focus groups; journal and camera will be provided. The number of entries or photos you take will be at your discretion (photos will not be able to include people, or identify specific Alcoholic or Narcotics Anonymous groups, or other treatment groups you may be involved in). The researcher will retain a copy of these items at the conclusion of the focus groups.
- The focus group sessions will be tape recorded and then transcribed to ensure that the fullness of what is discussed in the focus groups is captured.

Some of the suggested conversation starters that could be explored during the focus groups are:

- What sorts of activities contribute to or distract you from your recovery?
- What sorts of relationships contribute to or distract you from your recovery?
- Is spirituality important to your recovery, and if so what does that mean for you?
- How have hobbies and interests factored in the first two years of your recovery?
- What sort of recovery skills did you have to learn in the first two years of pursuing an abstinence-based recovery lifestyle?
- What other areas do you perceive were important to your recovery and well-being in the first two years of pursuing an abstinence-based recovery lifestyle?

Refreshments will be provided at the beginning of group sessions. A further 15-minute break will be scheduled after the first hour of each two-hour group session.

## **Future possible conflict of interest**

As I am the Clinical Director (on study leave) of Capri Trust you will also receive a written signed agreement from myself that if at any time in the future you desire to access services from Capri Trust or any other organisation that I may work for, the information given during this study will in no way be used to influence the services you may receive.

## **Study data management**

Because the study is designed to formulate themes of what abstinence-based recovery involves, individual personally identifiable information will not be recorded. Written data and any audio tapes will be kept in a locked cabinet. As stated earlier, the findings will be published in an academic research report as part of the examination process for my Masters qualification; a summary of this research report will also be submitted to a number of drug and alcohol rehabilitation based journals for possible publication and to each research participant.

## **Maintaining the anonymity of Alcoholics or Narcotics Anonymous Groups**

If you are involved in either Alcoholics or Narcotics Anonymous, the term 12-step support groups has been chosen to protect the anonymity of Alcoholic or Narcotics Anonymous. No information will be reported that will identify any specific Alcoholics or Narcotics Anonymous groups, its members or other support groups that you may be involved in.

## **Participant's Rights**

You have the following rights if you choose to participate in this research study:

*You are under no obligation to accept this invitation. If you decide to participate, you have the right to:*

- *decline to answer any particular question;*
- *withdraw from the study at any time;*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*

## **Study Contacts**

### **Primary Researcher**

- Dale Smith  
09 534 0784  
027 280 1864  
dale@dalesmith.co.nz

### **Research Assistant**

- Lance M.  
12-step group member

### **Supervisors**

#### **Dr Gretchen Good**

Programme Coordinator & Senior Rehabilitation Lecturer

BA *Mich. State*, MA *Boston College*, PhD Massey, Dip Int'l Teacher Training, CVRT, COMS

G.A.Good@massey.ac.nz

#### **Dr Marg Gilling**

Senior Research Lecturer

College of Education

M.Gilling@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 11/12. If you have any concerns about the conduct of this research, please contact Professor Julie Boddy, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 2541, email humanethicsoutha@massey.ac.nz.

## Alcohol of Other Drug Dependency Questioner

As dependence (addiction) to either alcohol / a drug / or both is a criteria for being part of the Alcohol and Drug Recovery and Wellbeing in New Zealand Study, this questionnaire has been designed to ascertain dependence (addiction) according to the American Psychiatric Association (1994). This criteria states a person must have experienced three of the following symptoms in the previous 12 twelve-month period.

**Please tick, if when you were actively using alcohol or drugs or both you experienced any of the following symptoms:** (Brackets indicate examples)

- Physical withdrawal (anxiety, shakes, sweats)
- Tolerance (increased use of substance over time and decreased effect)
- Inability to control use of the substance (unable to keep promises to self e.g. "I will not use tonight", however you end up drinking or using)
- Desire to cut down or stop your drinking or drug use
- An increasing amount of time spent using or thinking about using alcohol or drugs
- Abandoning of important obligations (family, work, and social commitments)
- Continued use of alcohol or a drugs despite negative consequences (problems at work, home, with the law, or your health)

Name \_\_\_\_\_

### General Questionnaire

Full name	
Gender	Male      Female      (please circle one)
Date of birth	
Contact details:  Home phone  Mobile  Email	
Ethnicity	
Level of education (if any)	
How long have you been in abstinence-based recovery?	
What are the mood altering	



## Alcohol and Drug Recovery and Wellbeing in New Zealand Study

### Informed Consent Agreement

I \_\_\_\_\_ (Full Name - printed) have read the Information Sheet and have had the details of the study explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

- I agree/do not agree to the focus groups being sound recorded.
- I wish/do not wish to have data placed in an official archive
- I agree to participate in this study under the conditions set out in the Information Sheet.
- I agree/do not to share personally identifiable information about other individuals or organisations gathered during this study.
- I agree/do not agree to the limits of using the camera provided as part of the study which include:
  - No photos including people
  - No photos that would identify specific 12-step community groups, other support groups, or organisations.

**Signature:**

**Date:**

.....

**Full name printed**

.....

Printed on Massey University letter head

## **Alcohol and Drug Recovery and Wellbeing in New Zealand Study**

### **Scribe Confidentiality Agreement**

I, \_\_\_\_\_(Full Name - printed)

agree to protect the confidentiality of study participants and not share any information gathered during the study process to another party.

**Signature:**

**Date:**

.....

.....





## Appendix C. The 12 Steps

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

Alcoholics Anonymous World Service (2001, p.59)

## Appendix D. Journal findings

Table 3		N of participants who mentioned topic
<b>Summary of findings from participants journals</b>		
Working a programme of change	Working the 12 steps as honestly and thoroughly as possible, cleaning house, trusting God, making amends with sponsor, understanding rules I live by	8
	Reading the 12 promises	
	Forgiving others	
	Daily readings or meditations	2
	Practising the principles contained in the 12 steps	
	Identifying character defects and working on them with HP help	
	Dealing with my life long problem of rejection	
	Changing behaviours and attitudes	
	First two years is full of life changing experiences, challenges and ups and downs	
	Accepting that recovering from addiction takes time	
	Learning to love myself	
	Action and making a decision to be sober	
	Operating in a calm and gentle manner	
	Slowing down	
	Keeping it simple	3
	Being quiet and listening	2
	Not over-doing things	
	Realising some people don't make it	
	Living a free, fun, happy life without the bondage of self	
	Doing the basics'	
Not intellectualising emotions		
Reading the AA Big Book	5	
Reading other AA literature	3	
Inspiring Poem: 'Desiderata'	2	

	Psalm 23	
	Watching 'The Secret', what you put out comes back to you	
	Daily journal	3
	Daily inventory	
	Planning and structure	
	Maintaining a gratitude list	4
	Living one day at a time	5
	Having a sponsor, role model, ringing a sponsor, having a close relationship with sponsor, seeing sponsor regularly and catching up, working the steps with sponsor, receiving advice and support, partnership with sponsor	11
Fellowships	AA meetings	7
	AA retreats	
	AA camps	
	Listening to AA speakers	
	Home group	
	Listening to others stories in meetings	
	Learning through others' sharing at meetings	
	Hearing others share	
	Synergy from being with large numbers of AA people	
	Appreciation of AA	
	Identifying with others	
	Wisdom from old timers	
	Having others who will listen, guide and love unconditionally	
	Not being alone	
	Belonging to a fellowship	2
	Reaching out for help from people in AA	2
	Support	2
	Speaking to another alcoholic every day	
	Reaching out even when I don't want to	
	Conscious contact with other alcoholics	

	Receiving help	
	Learning from my sponsees	
	Ongoing contact with other addicts	
	Having the trust and respect of others, and trusting and respecting others	
	Making friends in AA	2
Higher power	Believing in a Higher Power	2
	Staying in contact with my Higher Power	4
	God of my understanding	
	Writing to God	
	Morning and night prayers	2
	“Help me stop” daily prayers	4
	Prayer and meditation	
	Serenity Prayer	
	“Who am I to say there is no God?”	
	That there is a power greater than my disease	
	Belief that there is something bigger than me	
	God-focus before myself “thy will not my will”	2
	Handing my life over to the care of God is a great comfort	
	Need for Jesus and acceptance that I am loved by Jesus, valuable, precious, forgiven, cleansed and free	
	Not being alone anymore	
	Learning to trust God in the hard times	
	Trusting in spiritual promises	
	Natural inspiring places, Piha, helps me believe there is something bigger than me	
	Sunrise - spiritual, evidence that God is at hand	
	Having faith, a working faith	2
Believing that no human power could relieve my alcoholism		
Living a spiritual way of life		
Not dwelling on my thoughts, handing them over to God		

Attributes	Hope	8
	Encouragement	
	Love	
	Tolerance	
	Passion	
	Surrender	
	Confession	
	Believing this could work for me	
	Believing life can be fun	
	Celebration of sober birthdays	
	Making sacrifices	
	Having dreams and visions	
	New beginnings	
	Willingness	
	Sobriety/ abstinence	3
	Being present	
	Being open-minded	
	Believing that everything in the world is as it should be	
	Acceptance of being an alcoholic, acceptance of my disease	2
	Being grateful	3
Accepting I am right where I am meant to be, believing that I am not in AA by mistake		
Acceptance of my wrongs	2	
Acceptance that I can't fix myself and my way hasn't worked		
Recognising the process of recovery		
Excise and Healthy Living	Sports	
	Going to gym regularly	
	Tennis four times a week	
	Bush walks and tramping	
	Pilates	
	Cycling	

	<p>Exercise 4</p> <p>Walking and being with my dogs charges me spiritually</p> <p>Healthy eating</p> <p>Looking after my physical health</p> <p>Respecting my body</p> <p>Good nutrition</p> <p>Good sleep routines very important 2</p> <p>Music helped to process feelings of sadness and grief</p> <p>Fresh awareness of nature and beauty</p>
Service	<p>Helping other alcoholics 2</p> <p>Passing on what I have learned to newcomers</p> <p>Service</p> <p>Stability</p> <p>Responsibility and getting involved in helping others such as home groups</p> <p>Knowing my story could help someone else</p> <p>Sponsorship of others takes me away from myself and reinforces the 12 steps for me 3</p> <p>Mantra: "I have to give it away to keep it for myself"</p> <p>Helping others/ giving advice, guidance and support to others</p> <p>Service (incl. being a sponsor) 4</p>
Hobbies and Interests	<p>Doing craft activities</p> <p>Hobbies</p> <p>Sewing</p> <p>Cooking</p> <p>Small pleasures</p> <p>Reading books I enjoyed helped me to sleep</p> <p>Actively relax and restore myself</p> <p>Learning to rest</p> <p>Travelling</p>

Distractions	<p>Distractions: people who didn't believe in or understand the AA programme people who only want to drink or people who only want to use me</p> <p>Relapse = fear, confusion, guilt, unmanageability and return of the disease</p> <p>Letting go of bad people, habits and places</p> <p>Risky areas: isolating</p> <p>Being too busy</p> <p>Overeating or under eating</p> <p>Boredom</p> <p>Being aware of HALT</p>	2
Sober events	<p>Sober events</p> <p>Social sober events, dinner, coffee</p> <p>Meeting AA friends outside of meetings, regular catch-ups and coffee with others in recovery</p> <p>Fun activities</p>	3 2
Counselling	<p>Counselling for issues not appropriate to discuss in 12-step fellowship environment, looking at my past</p> <p>Talking about drinking with a counsellor</p> <p>Tools gained from a treatment centre</p> <p>Practising a Continuing Care Programme</p> <p>Treatment programme</p>	2 2
Family	<p>Staying close to family and friends</p> <p>Loving husband and children (supportive)</p> <p>Support of my family and friends</p> <p>Learning to love those close to me</p> <p>Being able to pass on what I have learned in recovery to my boys</p> <p>Dealing with family was hard</p>	
Education	<p>Learning about alcoholism, understanding alcoholism is a disease that affects mind and body, understanding and accepting why I will never control or enjoy my drinking</p>	4

## Appendix E. Example of focus groups A1 sheets

Step 4 with sponsor (5)  
- the worst stuff - things I'd never tell anyone - shame  
= sense of relief  
= confession

Step 5 "my head was quiet" = peace  
St. 9 = amazing experience

"When I have stuff to share I do it quickly" - get it out "if I am disturbed, something wrong with me; a behaviour of mine; I can see it as I say it"

Breaking down ego (St 4/5 + 2/1)  
- the more I've done + do if enables spiritual progress  
"I thought I was God" = "crazy"  
- a learning, and trust and acceptance process

"My way or the highway"  
1st time in life had to listen to others, take advice  
- tried it + it worked  
I have to put others ahead of my wants  
The less I try to control my life; the more balanced I am  
Service/Sponsorship is HUGE

Getting involved in AA 2x homegroups  
2x service - greeting  
- picking up bits

Coffee commitment @ a 7am meeting  
it was the most important job I'd ever had; I belonged; greeted people; they thanked me every meeting

A big lesson  
Service to my homegroup + other alcoholics = one of the major components of my recovery. It was reinforcement that I was doing the right thing/had the right message. Confidence - I felt worthy; encouragement

## Appendix F. Supporting Letter

17 February 2011

Mr Dale Smith  
3b Kallaroo Place  
Howick  
AUCKLAND

Dear Dale

**RE : Proposed Alcohol & Drug Recovery & Well-Being In New Zealand Study.**

Thank you for the opportunity to review the proposed nature of this study. I firmly believe that this will provide significant insight into the benefits and indeed the advantages of the Abstinence based programs New Zealand as opposed to the currently sponsored treatment plans based on the " Harm Minimisation " model.

I also believe that the information to come from this research will be of great importance to both the general recovery/treatment community and the 12 Step Fellowships in New Zealand, simply on the basis that all available resource and research information currently comes directly from the USA.

I have reviewed the basic requirements of the study that I believe will be important from the point of view of participants and the abstinence based groups associated with those participants.

I wish to highlight that I have been part of the AA and NA Fellowship for the last 6 years and am an active General Service Representative within this structure. I have also sought advice from mentors within my home group.

As such, Anonymity is essential and each participant from either of these fellowships will need to be assured that there Anonymity is respected along with the specific fellowship(s) that they belong to. It is recommended that the relevant fellowships be referred to as the "Associated 12 Step recovery group ".

Anonymity has been a core principle of Alcoholics Anonymous (AA) since it was founded in 1935. According to AA, anonymity protects members from the stigma attached to alcoholism and prevents AA's reputation from being tarnished by negative associations.

Further to this, I would like to highlight the following points :-

### **Function**

*When AA was founded, the social stigma attached to alcoholism was so great that few people would admit they had a problem or seek help for it. The founders of AA promised their members anonymity so that they could admit to their problem without fear of humiliation or public exposure. Although there is less stigma attached to alcoholism today, AA still offers anonymity to their members as a way of creating an atmosphere of trust and openness.*

### **Media Anonymity**

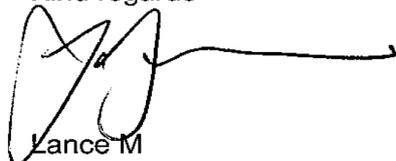
*As AA became more successful, some members began discussing their membership openly in the media as a way of raising public awareness of alcoholism and highlighting AA's success in treating it. AA's founders happily made these exceptions to anonymity. However, it was not long before some members were using their affiliation with the program for financial gain and the founders stopped making exceptions to the anonymity rule in order to protect AA's reputation.*

### **Considerations**

*According to Alcoholics Anonymous, it is up to each member to maintain anonymity. AA members are allowed to give interviews about their alcoholism as long as they keep their AA membership a secret. They may speak in public as AA members as long as they keep their names and faces secret*

I look forward to working with you further on this study and should you have any further queries then please do not hesitate to contact me.

Kind regards



Lance M

139a Waipuna Road East  
Mt Wellington  
Auckland  
New Zealand  
PH : 0800 400050

## Appendix G. Confirmation of Ethics Approval



MASSEY UNIVERSITY

21 April 2011

Dale Smith  
3B Kallaroo Place  
Botany Downs  
AUCKLAND 2010

Dear Dale

**Re: HEC: Southern A Application – 11/12**  
**Alcohol and drug recovery and wellbeing in New Zealand study**

Thank you for your letter dated 13 April 2011.

On behalf of the Massey University Human Ethics Committee: Southern A I am pleased to advise you that the ethics of your application are now approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

A/Prof Hugh Morton, Acting Chair  
**Massey University Human Ethics Committee: Southern A**

cc Dr Gretchen Good School of Health & Social Services PN371	dr marg gilling School of Educational Studies PN900
Prof Steve LaGrow, HoS School of Health & Social Services PN371	Prof Howard Lee, HoS School of Educational Studies PN900

---

Massey University Human Ethics Committee  
Accredited by the Health Research Council

Te Kunenga  
ki Pūrehuroa

Research Ethics Office, Massey University, Private Bag 11222, Palmerston North 4442, New Zealand  
T +64 6 350 5573 +64 6 350 5575 F +64 6 350 5622  
E humanethics@massey.ac.nz animaethics@massey.ac.nz gtc@massey.ac.nz  
www.massey.ac.nz