

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.

Stories of Addiction

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Arts

In

Psychology

Peter Robert Ashton

2011

Abstract

This thesis examines lay understandings of addiction in the context of academic and clinical understandings and how these discourses are encapsulated in the treatment modalities available to persons experiencing addictive behaviour. It examines the tensions that exist in the treatment sector due to diverse 'expert' understandings of the addictive process and the very 'construct' of addiction. Participants' narratives exposed the mutually constitutive nature of lay and professional discourses but also suggested that such use of narratives in clinical settings may have utility in the alleviation of addictive behaviours. However, the predominance of the medical model of addiction within the New Zealand treatment sector, and an increasing focus on highly manualised brief treatment modalities, may not be conducive to solutions that are deemed 'creative' rather than 'corrective' and give 'voice' and credence to the understandings of clients.

Acknowledgements

Completion of this thesis has been a journey in which many people have provided direction, support, and encouragement.

Firstly, I wish to acknowledge my academic supervisor, Professor Andy Lock, who provided oversight and direction at critical phases of this study and particularly when I was uncertain of which route to take. His guidance in the final stages of this research was crucial to its completion. It is appropriate to also mention the many lecturers at Massey University who have contributed throughout my rather late engagement in academic pursuits. In this regard, I would like to acknowledge Ann Flintoft who inspired my interest in the alcohol and other drug field and encouraged me to take up employment as a clinician.

The assistance of Health and Disability's Upper South B Ethics Committee is acknowledged. Ethical approval was granted (Ethics Reference URB/10/07/025) by that committee on 18 October 2010 (Appendix 1). Approved documentation included Information Sheet V.2 (Appendix 2) and Consent Form V.2 (Appendix 3).

My employers, Rata Alcohol and Other Drugs Service, West Coast District Health Board, provided facilities for participant interviews and enabled compliance with the ethical requirements of Health & Disability Ethics Committee. The Manager of Rata Alcohol and Other Drug Service, Dr Margaret Adams, has been a source of constant support, encouragement and motivation throughout my postgraduate studies and clinical practice. Monthly supervision with Dr Philip Townshend provided a sense of direction regarding the scope of this research.

The encouragement of the management and staff of Te Rau Matatini inspired me to consider addictive behaviours, and particularly gambling, outside of those involving the psychoactive substances with which my employment is associated. The financial assistance by way of a scholarship was appreciated and instrumental in broadening my horizons.

My family has been a constant source of support and inspiration throughout my studies. My brothers and sister, and their families, have been unerring in their encouragement. My mother, Alma, has unceasingly believed in my abilities to complete this project and been a constant source of inspiration and encouragement despite her declining health in recent years.

In more recent times, Julie has taken on the difficult role of motivator and support team. Your love and encouragement has helped bring this study to fruition.

Finally, I wish to acknowledge the wonderful people who unselfishly gave their time to participate in this study. Their willingness to share intimate details of their lives was prompted by a collective desire to assist others who may, in future, present to treatment services. I hope this study will contribute to discussion on the future of addiction treatment and do justice to my participants' wishes.

My sincere thanks to you all.

Table of Contents

Abstract	
Acknowledgements	
Table of Contents	
Chapter One: Statement of Topic an Outline	1
1.0 Introduction	1
1.1 Concept of Addiction	2
1.1.1 Definition	2
1.1.2 The Multidisciplinary Conceptualisation of Addiction	3
1.1.3 Diagnostic Criteria of Addiction	4
1.1.4 Substance and Behavioural Addictions	5
1.2 Research Questions and Aims	6
1.2.1 New knowledge and Contribution to the Profession to Emerge from Studying the Topic	7
1.2.2 Knowledge to be Gained by the Researcher, the Research Question, and the Terms of the Study	7
1.3 Autobiographical	10
1.4 Social Implications and Relevance of the Topic	11
1.5 Summary	12
Chapter Two: Addiction Services in New Zealand	13
2.0 Introduction	13
2.1 Structure and philosophical orientation	14
2.2 The Addiction Workforce	14
2.3 Strategic Direction	16
2.3.1 Focus on Co-existing problems (CEP)	16
2.3.2 Integration of AOD and MH services	16
2.3.3 Health Practitioners Competency Assurance Act (2003) (HPCA)	17
2.3.4 Divestment of AOD Services	17
2.4 Summary	18

Chapter Three: Review of the relevant literature	19
3.0 Introduction	19
3.1 Research/Clinical Models of Addiction	20
3.1.1 Genetic/Physiological models	20
3.1.2 Social/Environmental models	21
3.1.3 Personality/Intrapsychic models	22
3.1.4 Coping/Social learning models	22
3.1.5 Conditioning/Reinforcement models	23
3.1.6 Compulsive/Excessive behaviour models	24
3.1.7 Comparison of Explanatory Models	24
3.1.7.1 Disease versus Adaptive model	25
3.1.7.2 Attempts to Integrate Models	26
3.2 Lay Constructions of Addiction	27
3.2.1 Discourses of Addiction	27
3.2.2 Constructivism	29
3.3 Self and social Identity	29
3.4 Recovery	32
3.5 Summary	33
3.6 Reflections on the integration of clinical and lay constructions into current treatment	34
3.7 How the review and reflections informed this study	35
 Chapter Four: Methodology	 42
4.0 Introduction	42
4.1 Methodological Orientation	42
4.1.1 Qualitative Inquiry	42
4.1.2 Phenomenological Approach	44
4.1.3 Psychological Constructivism	44
4.2 The Researcher	45
4.2.1 The Qualitative Researcher	46
4.2.2 The Challenges	46
4.2.3 The Dual Role: Clinician and Researcher	46
4.2.4 Reflexivity	47
4.3 Data Collection	47

4.3.1	Ethics	47
4.3.2	Procedure	48
4.3.2.1	Recruitment	49
4.3.2.2	The Participants	49
4.3.2.3	The Interview	
4.4	Data Analysis	50
4.4.1	Thematic Analysis	50
4.4.2	Lower Order Coding	51
4.4.3	Analytical Coding	52
4.4.4	Reliability and Validity	52
Chapter Five: Results and Discussion		53
5.0	Introduction	53
5.1	The Stories	54
5.2	Attributions of Aetiology	79
5.3	Participants constructions of addiction	85
5.4	Participants constructions of recovery	94
5.5	Meta-themes	99
5.6	Narrative Expression versus Comprehensive Assessment	106
Chapter Six: Conclusions		113
6.1	Summary	113
6.2	Recommendations	120
6.3	Limitations of the Study	121
6.4	Implications of the Study	121
6.5	Concluding Comments	122
References		125
Appendices		133

Chapter One **Statement of Topic and Outline**

1.0 Introduction

This thesis is about how addicted persons story their experience of addiction. There are a number of strands to any account people can offer of any experience. While experience is located in the individual and has an element of subjectivity to it, any story necessarily draws on the ideas available in the language and culture that has socialised that subjectivity into the person they believe themselves to be: that is, the discursive resources available to them. In addition, the addicts who tell their stories of their addiction reported in this thesis have all been clients of the addiction services offered by the health system in New Zealand, and thus, in addition to the general discourses that might be used to frame their accounts and understandings, there is also the more specialised set of resources that they have been introduced to by their counsellors. Finally, in this vein, it is important to remember that, when people draw on these diverse resources to formulate their accounts, they are not ‘cultural dopes’. That is, discourses are not swallowed and regurgitated ‘hook, line and sinker’, but are both adopted and resisted critically and creatively.

From these considerations, this thesis faces a number of challenges that take it beyond the relatively simple task of obtaining peoples’ stories and investigating their vicissitudes. It is necessary to establish the kinds of resources that are available for these accounts to be framed. This thesis concentrates on the framework of ideas about addiction that arise from the research literature that inform the professional knowledge of alcohol and other drug (AOD) practitioners, and myself as an AOD practitioner, and the structural characteristics of the health system in which this knowledge is employed in the performance of counselling and treatment. These ideas provide a context for interpreting the stories that comprise the empirical data in this thesis, *and* for a reflection on them as to whether they are assisting in the goal of successful counselling. There is then, of necessity, a reflexive and evaluative component in this thesis.

If life were simpler, this thesis could have a simple structure. The research question would be ‘how do addicts make sense of their experience of addiction’. Here’s how the data was obtained, and why. Here’s the sense that can be made of it. But widening the study to include the professional discourses that have framed the counselling process, and the structural requirements of the system within which this counselling is conducted, complicates the structure of this thesis, and does not make for a linear narrative.

The addiction research and treatment sectors do not subscribe to a unified ‘philosophy of addiction. Theories governing the addictive process encompass explanations derived from numerous domains of medicine, psychology and sociology’, as well as ‘folk/ideological’ notions developed in popular social discourse. Additionally, the very concept of addiction is contested with some research and treatment communities resisting the inclusion of behavioural addictions, unrelated to the ingestion of psychoactive substances, and the necessary expansion of existing frameworks to encompass compulsive behaviours.

1.1 Concept of Addiction

1.1.1 Definition

I have learned through hard experience that there can be no productive interchange about addiction unless people can agree on exactly what the central word in the discussion means.

(Alexander, 2008, p. 270)

Adams (2008) notes that the scientific and clinical concept of ‘addiction’ is little more than a century old and was used to describe the state of habitual inebriation experienced as loss of control by persons unable to desist from heavy and regular alcohol use. Alexander (2008, p. 30) contends that societal alarm at the ruinous effects of alcohol, and subsequently opium, resulted in the meaning of ‘addiction’ being “... simultaneously narrowed, moralised, and medicalised ...”. Whereas its traditional meaning (derived from the Latin verb *addicere* and noun *addictionem* and endorsed by the Oxford English Dictionary from 1884 to 1989)

suggested a devotion to a cause as much as servitude to a habit, the term became inextricably restricted to alcohol and drug use with implications of destructive consequences for both the individual and society (Coombs & Howatt, 2005). This inability to extricate from such use has subsequently been conceptualised as “... a compulsion, a habit, a behavioral disorder, a disease, or a medical condition.” (Adams, 2008, p. 4).

1.1.2 **The Multidisciplinary Conceptualisation of Addiction**

Addiction science is multidisciplinary with its component disciplines advocating their own “assumptions, theories, models, and tools” (Editor, 2005). Miller and Kurtz (1994, p. 159) suggest that “... key constructs from these models are incompatible and contradictory, as reflected in current confusion about the nature, causes and treatment of alcoholism.” The major models of addiction have tacit assumptions regarding attributions of blame, locus of control, and self-efficacy.

Larkin, Wood and Griffiths (2006) contend that the term ‘addiction’ has three levels of meaning with the first being epitomised by notions of moral failing and marginalisation by ‘normal’ society. Stigmatising and pejorative labels have explicit meanings in the language and daily discourses of that society and locate marginalised individuals within a counter-culture (e.g., “junkie”, “addict”). Labels similarly pervade the second level at which addiction is conceptualised pathologically within a ‘disease’ conceptualisation; while the Alcoholics Anonymous movement utilises the term ‘alcoholic’, the medical model adopts labels of pathology such as ‘dependence’ (on psychoactive substances) or ‘impulse control disorder’ (for behavioural addictions such as gambling). At the third level of meaning: “What an addict learns in his failed attempts to quit, is that he is what his culture labels an addict ... there is an idea about what it means to describe oneself as addicted which is ‘out there’ in the world and cannot easily be changed” (Larkin et al., 2006, pp. 208-209). This notion represents the essence of ‘addiction’ in that it is implicit in those persons’ understanding and use of the term.

Academic interest in the latter level of meaning has resided primarily within the disciplines of sociology and constructivist psychology. However, as Larkin et al., (2006, p. 209) lament, the

qualitative research into the experiences and contextual influences of addictive behaviours “... present a challenge to the ‘hard core’ of the disease model which has not yet been taken up.” Instead, the disease and medical models, and the research initiatives of the natural sciences, continue to dominate the discourses of treatment providers with addiction being considered within a framework of physical withdrawal and/or tolerance and an expectation of physiological deterioration.

1.1.3 **Diagnostic criteria of addiction**

Clinical diagnosis and medical research in the addiction sector has, in recent decades, been directed by the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders” (DSM). Significant revisions in DSM since 1980, largely based on Edwards and Gross’s (1976) conceptualisation, have resulted in a shift to a model of substance dependence (DSM-III-R, 1987) which has prevailed through to the current DSM-IV-TR (2000) version and the other major diagnostic system (ICD-10). Dependence is defined in DSM-IV-TR (2000) as “... a maladaptive pattern of substance use, leading to clinically significant impairment or distress ...” with ramifications across domains of health, familial, employment and social relationships, and often expressed in financial and legal difficulties.

While the syndrome is described in terms of dyscontrol, salience, and compulsion to use, the presence of the ‘physical’ characteristics of tolerance and withdrawal (while often evident) are no longer necessary for a diagnosis of dependence. Although the generic term of ‘substance dependence’ remains clinically associated with those physiological features, despite them not being manifested in the advanced use of some substances, this reduced emphasis on biological considerations, since 1987 (DSM-III-R), represents a fundamental shift from earlier clinical conceptualisations of addiction.

Though ICD-10 and DSM-IV-TR utilise the term ‘dependence’ in accordance with longstanding WHO recommendations, ‘addiction’ continues to have usage within the scientific and treatment sectors as well as in the social world (Miller, Strang & Miller, 2010). While disparity of meaning might be expected between such varied contexts, inconsistencies also

exist within clinical and scientific sectors. Neurobiological advances in addiction-related brain pathology are better explained by ‘addiction’ processes other than the physiological changes denoted by the ‘dependence’-related notions of tolerance and withdrawal (National Addiction Centre/Matua Raki, 2007).

1.1.4 **Substance and behavioural addictions**

Specialist treatment providers (MOH-Funders) frequently differentiate substance-based addictions from the so-called behavioural addictions. Miller et al. (2010, p.7) observe that addiction continues to be “... regarded by many as a discrete disease entity, a debilitating disorder rooted in the pharmacological effects of the drug, which is remorselessly progressive.” Such description, necessarily, relegates gambling, internet, and the myriad of other non-substance dependencies to ‘habituation’, regardless of emerging biological explanations. Despite this, some commentators have used the term “process addiction” to distinguish several behaviours (including compulsive shopping, sex addiction, eating disorders and workaholism) as ‘diseases’ which may respond to similar treatment modalities as those used for psychoactive substance addiction (Smith & Seymour, 2007, cited in Miller et al., 2010).

Keane (2004) notes that, while a DSM-IV-TR diagnosis of dependence must specifically relate to the use of one or more psychoactive substances, the actual diagnostic criteria could apply equally to non-psychoactive substances and behavioural addictions such as gambling. In arguing for an expanded conceptualisation of addiction which might include disorders such as food and sex addictions, Keane (2004) posits that the diagnosis process is entirely reliant upon the client’s expression of their subjective feelings of compulsion and its harmful consequences. Accordingly, she supports Peele’s (1985) critique of simplistic and reductionist medical and disease conceptualisations of addiction which fail to recognise addiction as any experience of “... a serious over-involvement with a single mood-altering activity ...” (Keane, 2004, p. 193). Alexander’s (1988, p. 48) adaptive model expands upon this contention and suggests that addiction does not represent a disease or pathology but “... assumes that addicted people are responding adaptively within the limitations of their own abilities, perceptions, and

environments.” Such environments are regarded, in Alexander’s (1988) conceptualisation, as innately inadequate rather than a latent or potential source of stress..

That such emergent explanations, and many of the behaviours themselves, are products of contemporary technological advances (e.g., “pokie” machines) indicates that our understandings of ‘addiction’ are changing over time as well as social and cultural context. Keane (2004, p. 193) states “The reliance of addiction discourse on evaluations of harm, feelings of compulsion (of not wanting to want what you want) and over-involvement highlights its inevitable enmeshment with cultural norms and ethical judgements about what people should value and what makes life meaningful.”

In accordance with Truan’s (1993) contention that addictions are ‘social constructions’, habitual alcohol and drug use have traditionally been societally conceptualised as both sinful conduct and disease (Thombs, 2006). The models espoused by Keane (2004), Peele (1985), and Alexander (1988), are included within the ‘addiction as maladaptive behaviour’ vision that has gained prominence in recent decades, and represent an expanded conceptualisation of addiction that incorporates behavioural and non-psychoactive substance addictions. Klingemann & Bergmark (2006, p.1233) observe that “Lay theories and personal experience with the problem shape whether and how addiction is stigmatized in the lay communities (e.g. whether drug users are blamed for being addicted) and consequently the probability that professional treatment might be taken into consideration as well.” Accordingly, it is conjectured that treatment providers must be cognisant of such constructions, at both societal levels and in the world of the individual client, in order that interventions are meaningful to the client.

1.2 Research Questions and Aims

This thesis examines the social contexts of drug dependency and behavioural addictions and, therefore, adopts a qualitative design. It is about ‘meeting people where they are at’ (Marlatt, 1996). It seeks to discover how participants conceptualise their own addictive behaviours recognising that they are social beings and that their conceptualisations represent constructions

of a phenomenon with which they have had personal and often traumatic experience as active agents, but about which their interpretations have been influenced by an array of historical, social and cultural influences. It endeavours to locate the meanings of those experiences, the salience and importance attributed to elements from both their intrapersonal and interpersonal daily lives

1.2.1 New Knowledge and Contribution to the Profession to Emerge From Studying the Topic

A focus of this paper is the practical implementation of existing research into practice settings. It is not anticipated that this research will generate new theory but rather that it will provide impetus for the interpretation of clients' needs, and development of mutually agreed treatment plans, within mutually-understood but more diverse theoretical frameworks. In extrapolating themes from participants' stories, and examining their compatibility (or otherwise) with various theoretical perspectives, it is hoped that a more diverse repertoire of behavioural-change interventions will emerge.

1.2.2 Knowledge to Be Gained By the Researcher, the Research Question, and the Terms of the Study

Three themes guide the intended research:-

1. Increasingly, addiction treatment takes the form of brief therapies using highly-manualised and prescribed formats. In the absence of appropriate social networks, clients may be directed to AA-type support groups (including Gamblers Anonymous) or residential programmes which, in the New Zealand addictions field, are dominated by 12-step philosophies.

The 12-step Model (also known as the Minnesota Model and encapsulating Disease Models of addiction) is the most widely used model despite its proponents consciously rejecting efficacy research. Expected outcomes of treatment include acceptance of an alcoholic/addict identity,

acknowledgement of a loss of control/powerlessness over the abused substance or behaviour, and adherence to abstinence as a treatment goal. The recommended route to ‘recovery’ includes selection of a sponsor, attendance at several meetings per week, and long-term, even lifetime, commitment to the recovery process.

Though many individuals may benefit from engagement with a ‘fellowship’ the model does not have universal utility. Advocates and lay promoters of local groups may characterise all substance misuse as dependence, that is, problem drinkers can be ‘lumped in’ and encouraged to identify with their more addicted fellows. Additionally, naturally-occurring resilience may be stifled by ‘recovery’ models that accentuate powerlessness.

Such support networks may be at variance with brief therapies that emphasise empowerment or even harm reduction and controlled use strategies. Individual treatment plans, though supposedly based on a comprehensive assessment and formulated collaboratively between client and ‘practitioner’ may be dominated by service-delivery constraints, as well as scientifically and socially-derived conceptualisations of addiction.

Lay theories of addiction are socially constructed (Truan, 1993). Alexander (2001, p. 1) contends that existing models that guide “the four pillars” of drug addiction approaches, i.e., treatment, prevention, law enforcement and harm reduction, fail to address the political and economic precursors to addiction.

Governments, worldwide, deploy drug policies that have little to do with the actual harm caused by particular drugs. Cultures are fixated with the need to define their barriers; when ‘traditional’ means of discrimination (race, gender, religion, sexuality, social class etc.,) are denied them, mental illness and drug use become ‘useful’ alternative determinants of inclusion or exclusion (White, Evans, & Lamb, 2009; Corrigan Watson & Miller, 2006). ‘Social distancing’ is most evident towards drug users, then abusers of alcohol, and finally those persons experiencing mental illness (Adlaf, Hamilton, Wu & Noh, 2009).

Models that fail to recognise the socio-cultural contexts of addiction promulgate the ‘research-practice’ gap that challenges the legitimacy of addiction treatment (Klingemann & Bergmark, 2006).

2. Culturally-derived treatments (e.g., Kaupapa Maori) may better recognise precursors to addiction and provide concrete examples of biopsychosocial models and interventions. Treatments are couched in the language and historical, cultural and social contexts in which addiction and remission occurs. Cameron, Manik, Bird and Sinorwalia (2002) observe that motivation for self-directed change (in alcohol use) for ethnic minorities was based on factors such as social networks, family status and honour whereas accommodation and psychological state were factors more evident in white, majority populations.

3. The phenomenon of ‘spontaneous remission’ indicates that addiction can be ended by naturally-occurring processes. Indeed, rates for spontaneous remission are comparable for those of supposedly efficacious therapeutic interventions. Cameron et al’s (2002) study found that changed psychological state predicted reduction or cessation of alcohol use in majority populations, a finding not inconsistent with Vaillant’s (1983) contention that many alcoholics ‘outgrow’ their problematic alcohol use.

Orford (2008, p.875) calls upon the addiction field to “... stop studying named techniques and focus instead on change processes ...” and recommends that “...science in the field should be brought up to date by acknowledging a variety of sources of useful knowledge.”

This study will seek to identify those components of client narratives that may have facilitated self-directed change processes within a small group representing problem gambling and substance misusing behaviours. It will examine the language of addiction and how such language portends self and social identities and consequent motivation and self-efficacy to initiate behavioural change. Finally, this research will seek to place such factors within the context of major models of addiction and provide comment on their adequacy within contemporary treatment modalities.

In essence, this research seeks to contribute to treatment modalities that are meaningful by couching explanations and treatment processes in terms with which clients can identify and relate. Perhaps, more significantly, it may inform my own development as a practitioner.

1.3 Autobiographical

This research had, as its genesis, a fascination with the stories that I have been privileged to share at an outpatient alcohol and other drugs (AOD) service. These stories were remarkable, not only for the emotional intensity with which they were told, but also for the diversity and depth of experiences that they portrayed. Despite the confines of brief intervention treatment modalities, clients shared vignettes of lives filled with despair, unfulfilled dreams, loss of relationships, families, jobs and sometimes the most basic of human needs such as shelter, sustenance and safety. These were journeys in which the ‘normal’ range of successes and failures, highs and lows, joys and sadness, would seem mundane; often, the day to day events described were the precipitants of emotional crises as coping resources failed them.

In accordance with prevailing counselling theory, I would endeavour to engender an atmosphere of empathy and ‘unconditional positive regard’ recognising the uniqueness of the client and their experiences. The value of the therapeutic relationship is almost universally acknowledged though addiction counselling has, at times in its recent past, adopted more confrontational attitudes towards achieving client change. Rothschild (2010, p. 138), in describing the harm reduction modality, states that “... respect for the patient and mutual trust are fundamental to the success of the treatment and it is striking that it needs to be made explicit when speaking of substance use treatment.” The therapeutic relationship is regarded as at least as important as the treatment method employed (Norcross and Wampold, 2011).

As an alcohol and other drugs practitioner, practicing within New Zealand’s tertiary healthcare sector, I am required to provide evidence-based interventions with particular emphasis on brief treatment modalities. In addition to facilitating ‘stabilisation’ processes, such as detoxification and accompanying post-detoxification treatments, or provision of pharmacological interventions, I am expected to incorporate community-based psychosocial interventions

incorporating Motivational Interviewing (and Motivational Enhancement Therapy), Cognitive Behavioural (CBT)-type approaches, and a variety of social-behavioural initiatives.

Frequently clients have been through previous treatments delivered in either outpatient or residential treatment facilities. Often, such clients have been referred by authorities such as Community Probation and Psychological Services. In addition to being coerced to attend, such clients are often frustrated at having to ‘repeat’ the same old ‘lessons’ that have failed to ameliorate their substance misuse, appear unrelated to their offending, or represent interventions regarded, by them, as unnecessary or unwanted.

Others, who have attended intensive and lengthy residential programmes, express desperation in that they have relapsed into substance misuse despite having experienced daily and comprehensive abstinence-based interventions. Their inability to maintain abstinence was not seen merely as a lapse, or even relapse, but a personal failure witnessed by, or to be hidden from, the ‘fellowship’ that supports the 12-step treatment modalities.

Such stories awakened an abiding interest in the language associated with addiction, and disquiet at the ease with which clients were given, and adopted, diagnoses of pathology. While accepting that the entry criteria for secondary and residential services require that a person ‘have an alcohol or other drug dependency’, I continued to baulk at the assertion, heard at clinical meetings as much as from clients, that he or she ‘is an alcoholic’. In recognition of the hopelessness/helplessness which can accompany such perceived failure, or the frustration experienced by those who had ‘seen all this stuff before’, I would endeavour to present alternative or hope-imbuing perspectives drawn from the myriad of addiction models.

1.4 Social Implications and Relevance of the Topic

A prominent member of the New Zealand judiciary, District Court Judge John Walker, stated that alcohol and drugs contribute to 80 per cent of all cases before district courts, are rarely not implicated in serious violent offending, and demonstrate ‘the very large hole’ in the resources of the addiction treatment sector.

The New Zealand Law Commission's (2009, 37) Issues Paper on liquor legislation states "... we have become concerned at the lack of policies, facilities and programmes around the country in relation to assessment and treatment for people with alcohol problems. Gaps in treatment availability have been identified as a problem for people with alcohol-use disorders ... and suggestions to improve treatment would require additional government investment ...". The lack of adequate funding in recent years has been blamed for the closure of ten AOD residential treatment facilities including the internationally-renowned Queen Mary Hospital (Brooking, 2009).

The National Committee for Addiction Treatment (NCAT) (2008) estimated that a 100 percent increase in funding for the addiction treatment sector would enable approximately 50,000 people to access treatment, despite a conservative estimate of 160,000 people needing to access treatment for substance abuse; Slack (2009) has estimated up to 667,000 New Zealanders in harmful use of alcohol and drugs. Similarly, NCAT (2010), in calling for an expanded, better-resourced, and integrated addiction treatment sector, estimates that some 60,000 New Zealanders are experiencing problematic gambling at any one time.

1.5 Summary

An under-resourced New Zealand addiction treatment sector, like its overseas counterparts, struggles to separate itself from a predominantly disease conceptualisation of addiction. As the National Addiction Centre/Matua Raki (2007) concludes,

The treatment of addiction is different from most other health endeavours because of traditional moralistic attitudes towards drug use. These moralistic attitudes drive unrealistic treatment expectations, to the extent that sometimes it has seemed that the only worthwhile treatment outcome from addiction treatment has been complete abstinence from all drugs.

The Structure and philosophy of the New Zealand treatment sector is considered in Chapter Two

Chapter Two: Addiction Services in New Zealand

2.0 Introduction

At political and policy-making levels, the New Zealand Government has expressed commitment to an expanded and more effective treatment sector for substance-related and gambling addictions.

Over the next five years the Government will continue to improve the quality of, and access to, drug treatment services. Treatment interventions are vital to the limitation of problems arising from substance use.

Ministerial Committee on Drug Policy (2007, p.17)

It is important to ensure that services are available and accessible for those that require them wherever they may be in the country.

Ministry of Health (2006, p.20)

The New Zealand addiction treatment sector encompasses two philosophically-opposed perspectives. The disease model of addiction is regarded as one of the most influential theoretical orientations in the addiction field, with its tenet of ‘recovery’ being contingent upon total and sustained abstinence, and is supported by the Alcoholics Anonymous (AA) movement. By contrast, proponents of ‘harm reduction’ models, with regard to alcohol use, contend that moderate consumption can be an acceptable treatment outcome if psychological dependence on use is reduced in addition to reduction of associated risks to wellbeing (Stevens and Smith, 2000).

With practitioners in the addiction treatment sector coming from diverse backgrounds and disciplines including medicine (psychiatrists, doctors, and nurses), psychology and social work, in addition to the (reducing) pool of those who have transitioned from being clients themselves, a variety of orientations may underlie the treatment philosophy espoused by any

treatment provider. Accordingly, as Dowd (1999) suggests, the range of possible therapeutic practices and strategies offered to a presenting client may be quite diverse while still complying with an overall service framework.

2.1 Structure and philosophical orientation

The National Committee for Addiction Treatment (NCAT) interprets the above, and analogous policy statements, as support for the wider introduction of treatments aligned to harm reduction philosophies, for both substance and gambling addictions, with greater inter-sectorial collaboration addressing ‘the whole person’ (NCAT, 2008). “An optimal addiction treatment system includes a range of treatment options of varying intensity provided in various settings and utilising a range of treatment modalities.” (NCAT, 2008, p. 6).

2.2 The Addiction Workforce

In 2004 the National Addiction Centre (NAC) conducted a telephone survey of a sample of the alcohol and other drug (AOD) workforce in New Zealand, with inclusion criteria being that all respondents were paid workers whose roles involved 70 per cent, or greater, client contact. Significant changes from the results of an identical survey conducted in 1998 included:-

- A stable but aging workforce. The percentage of workers under the age of 35 years has more than halved.
- A significant reduction in those identifying themselves as “ex-drinker”.
- The emergence of “AOD Clinician” or “Addiction Clinician” as a self-selected professional identity while other professional identities remained relatively stable (percentages shown are from the 2004 survey); Counsellor/therapist (53%), Nurse (16%), Social worker (11%), Psychologist (5%), Medical Practitioner (3%).
- A more than doubling of addiction workers with postgraduate qualifications and a drastic drop in those workers with secondary qualifications or less. A significant increase in AOD-specific postgraduate qualifications was evident however those

currently undertaking formal non-AOD education exceeded those taking AOD-specific education.

- Increases were noted in the percentage of workers employed in District Health Board and outpatient work settings while a significant reduction was noted in the percentage of workers employed in residential post-detoxification facilities.

However, between 2007 and 2011, Midlands District Health Boards (2011) have noted a significant shift, in the provision of addiction services, from District Health Board (DHB) to non-governmental organisation (NGO) and identify the risk that DHB's may increasingly marginalise addiction treatment.

The NAC (2004) report noted that support worker and consumer advisor roles were emerging within the workforce; it might be conjectured that workers without formal qualifications, allowing membership of professional associations, might access such roles. The recent (at the time of the 2004 survey) establishment of the Drug and Alcohol Practitioners Association of Aotearoa New Zealand (DAPAANZ) was reflected in those workers identifying membership of a professional association as well as in the emerging self-identified professional identities of "AOD Clinician" or "Addiction Clinician".

Subsequent to this survey, DAPAANZ developed the professional identity of "AOD Practitioner" with criteria for members to achieve registration and elevation from "Associate Practitioner" and "Support Worker" status. This development, along with increasing attention to the Health Practitioners Competency Assurance Act (HPCA) (2003) and professional associations 'protecting their turf', will cause many of those previously identifying themselves as 'Counsellors' or 'therapists' to adopt DAPAANZ identifiers.

More recently, DAPAANZ has proposed integration of the addiction workforce with appropriate expansion of competency frameworks to include problem gambling and smoking cessation. While there has been consensus towards 'amalgamation' among workers from the latter sectors, it is relevant that 20 per cent of respondents from a survey of problem gambling

workers identified concerns that the AOD sector's predilection for the 'disease model' might pervade treatment modalities for clients with problem gambling.

2.3 Strategic Direction

Three influences may direct the 'medicalisation' of the AOD workforce with consequences on clinical formulations of 'addiction' utilised in treatment settings.

2.3.1 Focus on Co-existing Problems (CEP)

New Zealand's Ministry of Health (MOH) has been making concerted efforts at integrating AOD and mental health (MH) services to persons with co-existing problems (co-existing substance use and mental health problems). While clinical practice guidelines have been available for over a decade MOH (2010, p. iii) has noted that "... poor communication and coordination ..." between the AOD and MH sectors has resulted in a failure to deliver satisfactory and integrated services to clients with co-existing problems. The development of 'CEP-capable' services, by District Health Boards, has been identified as a priority with funding implications for services, however, implementation has often been ad hoc and used as the basis to pursue other agendas. Aitken (2011, p.4) suggests that such initiatives have been very "... poorly thought out with many unintended consequences."

2.3.2 Integration of AOD and MH services

Under the guise of increasing CEP capability, several of New Zealand's District Health Boards have integrated AOD services into their MH services. Rather than providing specialist teams which can work collaboratively on behalf of clients DHB's are engaged in restructuring that may compromise clinical treatment development for clients with primary and secondary addiction issues. Aitken (2011) fears that addiction services will be diminished within such units, with an inevitable loss of services to consumers, if leadership of these integrated entities does not have adequate understanding of addiction issues.

2.3.3 **Health Practitioners Competency Assurance Act (2003) (HPCA)**

District Health Boards are increasingly specifying that only those applicants holding professional registrations that meet HPCA criteria will be employed to work within their addiction workforces. With DAPAANZ registration not meeting HPCA criteria, there is an expectation that the majority of such roles will, in future, be filled by medical staff and, particularly, nurses regardless of their expertise in addiction treatment (Todd, 2011). Such moves towards medically-trained ‘generalists’ is contested in a recent study suggesting that “... therapeutic effectiveness is not a global construct...”; Drug and Alcohol Findings (2011) review of Kraus, Castonguay and Boswell’s (2011) study of effectiveness in substance use treatments cautions that “... social workers and mental health counsellors find these issues especially hard to deal with.”

The National Committee for Addiction Treatment has stated that “A multi-disciplinary workforce is essential to respond to the diverse needs of people seeking help for addiction-related issues. NCAT supports the trend towards registration of specialist addiction practitioners.” (NCAT, 2008, p.4). However, Midland District Health Boards (2011, p. 15), in also stressing the need for a “... competent ‘multidisciplinary’ workforce ...”, states “The latest trends in recruitment for AOD positions suggest a greater emphasis on clinical staff who meet HPCA requirements and less emphasis on AOD qualifications and experience.”

2.3.4 **Divestment of AOD Services**

Restructuring within the health sector has resulted in some other DHB’s divesting their addiction services completely to NGO’s. Aitken (2011, p.4) suggests that current financial imperatives are prompting “... a tendency to look for cheaper options rather than the best option” and fears that culturally-oriented Kaupapa Maori services may be an early casualty. Undoubtedly, NGO’s operate on a lower cost structure than DHB addiction services but such a transition will have an inevitable impact on the pool of addiction expertise as clinicians choose to exit the sector rather than significantly compromise their own circumstances.

2.4 Summary

The professionalisation of the addiction workforce, over recent years, has resulted in the loss of persons with intimate experience of addictive behaviours from the addiction sector. Though such persons have frequently attended 12-step oriented residential programmes their personal transitions to wellness can bring valuable understandings to the wider addiction workforce. While some DHB's have, so far, continued to employ such persons within important consumer advisor and support worker roles, their experiences of addiction and change processes are less available to clients within a clinical setting.

The restructuring of DHB services portends a further and significant loss of addiction expertise and, arguably, reversion to a narrow and mono-disciplinary approach to addiction treatment that Todd (2011) describes as "short-sighted". That such an eminent commentator on addiction issues predicts the erosion of a dynamic and highly-skilled multidisciplinary treatment sector suggests that restructuring initiatives reflect short-term expediencies far more than the provision of improved and cost-effective treatment for clients. After all, the percentage of addiction workers undertaking non AOD specific postgraduate qualifications suggests that AOD workers are actively pursuing studies in related and complementary disciplines and achieving the CEP capabilities that, supposedly, are at the heart of MOH directives.

Over the last decade, a steady transition towards community-based models of care and the professionalization of the addiction workforce increased its capability to deliver multidisciplinary 'best practice' outpatient models of care. However, MacEwan (2011) contends that the 'legitimising' of the sector actually resulted in the introduction of an acute model of care aligned to primary care medicine. The current recruitment prerogatives of DHB's may portend a continued medicalization of addiction treatment with implications in terms of narrowed theoretical perspectives being brought to treatment modalities.

Chapter Three Review of the Relevant Literature

3.0 Introduction

I can go for years using the word ‘dog’ without getting into arguments about what dogs really are, etc. This is not the case, however, with addiction. We have fundamental disagreements on how to correctly use the term, model the phenomenon, and characterise its possible/likely etiology: Is addiction a choice, a self medicating behavior, a moral failing, a drug hijacked brain, a learned/conditioned behavior, an ‘addictor’ induced dysregulation of the drive-reward system, or a genetically reward deficient nervous system crossing paths with a rewarding behaviour or substance? Is it driven more by positive reinforcement, or opponent process, or by some hedonistic imperative? Are disparate addictions etiologically distinct or similar?

Cannavo, 2010, cited in Koski-Jannes, 2010, p. 1)

Arguably, persons presenting to specialist addiction services might anticipate a consistency and sense of ‘authority’ in the treatment modalities offered to them. While the ‘consistency’ might be evident, by virtue of the predominance of treatment programmes oriented to a medical model of addiction, diverse orientations within the addiction research community belie the ‘evidence based’ discourses that they are likely to encounter. The ‘disciplinary’ discourses that reside within the sector invariably generate disparate notions of ‘recovery’. Additionally, it is necessary to consider how popular discourses of addiction are socially mediated and how such discourses might impact on the treatment expectations of persons experiencing addictions.

3.1 Research/Clinical Models of Addiction

Consistent with research objectives, the literature review began by examining the dominant models of addiction and the historical, social, and cultural contexts in which they gained prominence. Specifically, I sought to identify models demonstrating coherence between substance and behavioural addictions. The terms ‘models of addiction’, ‘processes of addiction’, ‘models of addiction treatment’ and ‘processes of addiction treatment’ were used to search major psychological and medical journal databases as well as reviewing publications by well-known addiction researchers.

Researchers, based on their professional and disciplinary orientation, deploy a variety of categorisations to describe and organise the multitude of addiction models, frameworks and approaches which appear in the literature. The summary provided by DiClemente (2003) is both comprehensive in addressing the etiological hypotheses proffered by Cannavo (2010, cited in Koski-Jannes, 2010), explaining the ‘traditional’ models of addiction, and informative in organising a raft of psychological approaches many of which are variants of each other or address a theoretically specific (one-dimensional) causal pathway. Accordingly, the following discussion on explanatory models follows DiClemente’s (2003) classifications.

3.1.1 Genetic/Physiological models

Genetic models of addiction are based on the premise that heritable mechanisms either cause or predispose addiction in some individuals (Peele & Alexander, 1985). Family history and male gender have been identified as significant risk factors for drug dependence with some researchers estimating that approximately 50% of the risk for adolescent substance use disorders is genetically influenced (Yule & Wilens, 2011). Goodman (2009) suggests that, in a diathesis- stress schema of aetiology, genetic factors determine a biological vulnerability or predisposition which manifests during critical developmental stages. Stressful environmental cues later in life expose this neurobiological vulnerability contributing to an increased risk of an addictive disorder.

Physiological theories are premised on biological adaptation resulting from chronic exposure to substances. According to Halpern (2002, p.2) clinical studies suggest that “... repeated exposure to highly addictive substances alters, perhaps permanently, a number of molecular and neurochemical indices, thereby changing physiologic homeostasis ...” and “... shifts signal transduction pathways within neurons, thereby altering gene expression.” Thus addiction, according to physiological theories, is associated with “... frank biological abnormalities that cannot be explained by a simple hypothesis of ‘choice’” (Halpern, 2002, p. 2).

Whereas Halpern (2002) confines his explanation to the biological impacts of substance use, Goodman (2009) suggests that ‘the addictive process’ represents a shared biological vulnerability for all addictive behaviours and involves impairment to motivation-reward, affect regulation, and behavioural inhibition functions. Likewise, Merlo and Gold (2008) believe that all addictions may be constituted by a common molecular pathway. However Larkin and Griffiths (2002) argue that the predictive capacities of genetic and biological theories are low.

3.1.2 **Social/Environmental models**

This perspective posits that the development and maintenance of addiction occurs in the context of societal influences and norms, group and peer pressures, social policies and accessibility, and family systems. The latter recognise the nurture-oriented influences of dysfunctional parenting and adult role-modelling of addictive behaviours. Thus a propensity for addictive behaviours at an individual level is impacted by external environmental influences including poverty and other adverse components of a social and cultural milieu (Alexander, 2008). As such, social models recognise the multifaceted nature of addiction and a synthesis of etiological causes including biological, psychological and moral/spiritual. It is more comprehensive than a medical model formulation which is dominated by physiological processes in a unitary disease state conceptualisation.

3.1.3 **Personality/Intrapsychic Models**

Unlike Alexander's (1988) conceptualisation, in which 'genetic unfitness' is postulated as just one of several predisposing influences contributing to maladaptive adaptation, adherents of personality-based models suggest that addictive behaviours represent a symptom of distinct intrapsychic conflict expressed as a disorder of personality. While, as DiClemente (2003) affirms, proponents can cite the frequent correlation between the presence of antisocial personality disorder and drug abuse, there has been little progress in identifying and categorising the distal issues or conflicts that can predict addictive behaviour. However, certain traits, including impulsivity, hyperactivity, and non-conformity may represent important variables in a broader and more comprehensive conceptualisation of predisposition.

3.1.4 **Coping/Social Learning Models**

Coping models of addiction propose that addictive behaviours provide a relatively instantaneous relief or escape from emotional distress in the form of irritation, anxiety, anger, frustration, boredom or depression and are consistent with or emotion-focussed responses to stress. Effectively, the person exemplifying a coping model uses addictive behaviours as a distraction from distress and the need to address the stressful event or circumstance. Over time, the use of such distractions becomes the automatic response to such stressors. DiClemente (2003) suggests that alcohol use under such circumstances typifies the coping model due to its perceived tension-reduction and stress response dulling characteristics. In such a case, the psychoactive properties of the substance are attributed with alleviation of anguish whereas, in behavioural addictions, total immersion in an activity, such as gambling, is necessary to achieve distraction from distress. DiClemente (2003) argues that the coping model of addiction has limited utility as an aetiological theory in that individuals who demonstrate functional and comprehensive coping strategies in various (particularly vocational) life domains still succumb to addictive behaviours. However, in alleviation of addictive behaviours, the model has particular relevance in that addiction frequently contributes to a limited range of coping responses being deployed.

A social cognition model (as proposed by Bandura, 1986, cited in DiClemente, 2003) emphasises expectancies, social influence (media, peers and significant others), and vicarious learning in the development of addictive behaviour. Expectancies have important aetiological implications as demonstrated by lay conceptualisations of alcohol use and its perceived role in alleviating anxieties in social settings. Individuals with high expectations of alcohol's utility for reducing inhibitions, and facilitating social interaction, are considered more likely to develop unhealthy engagement with this substance. DiClemente (2003) suggests that expectancies around the role of (financial) wealth in achieving life satisfaction are integral to the popularity and growth of lotteries. Media images of happy lottery winners enjoying the fruits of their win promulgate expectancies around the (statistically-unlikely) outcomes from gambling. Similarly, the media's role in celebrity culture, and venerating the 'glamorous', is frequently cited in encouraging the development of eating disorders.

Such cultural considerations may exacerbate peer group influences in the both the initiation of substance use and other potentially problematic behaviours, while vicarious learning processes are also evident in the social learning mechanisms evident within family, extended family, and wider social settings.

3.1.5 **Conditioning/Reinforcement Models**

While conditioning and reinforcement effects in addiction receive considerable attention in many treatment modalities, and are well supported by research, they do not adequately explain many features of acquisition or resolution of addictive behaviours. DiClemente (2003) argues that reinforcement theory represents a significant commonality between behavioural and substance-based addictions and is typified by the entrenched patterns of behaviour which develop around slot machine ('pokie') use. Whereas the reinforcement effects in such gambling are maintained by a variable-ratio reinforcement schedule, in substance-related addictive behaviours the physiological mechanisms of tolerance and withdrawal are included in the response/reward processes. According to opponent process theory, the experience of withdrawal symptoms, with effects that are inconsistent with those obtained when engaging in the behaviour, encourage resumption of the behaviour.

Conditioning approaches, focussing on the presence of situational cues, provide further substantiation of the link between behavioural and substance-based addiction; visual and other sensory cues can invoke powerful anticipatory responses from individuals who have problematic substance or other addictive behavioural issues. Yet some of these cues are situation-specific; tobacco users may not consider smoking in particular settings (inside their home) while, as DiClimente (2003) suggests, behaviours in eating disorders are often characterised by particular types of food and dining settings.

DiClimente (2003) also suggests that classical conditioning models have extended beyond the physiological responses, observed in animal studies, and are considered complimentary to social learning perspectives including expectancy effects.

3.1.6 Compulsive/Excessive Behaviour Models

Orford (1985) has proposed a psychological explanation (excessive appetites) as an alternative to the biological perspective of biochemical imbalance and the analytic account which describes addiction as a manifestation of entrenched conflicts. Orford's (1985) model suggests an escalating psychological attachment to appetitive behaviours that can lead to excess in behaviours as diverse as substance use, eating, gambling, and sexual activity. Compulsive approaches to addiction focus on the repetitive nature of the activity and the perception that the individual has lost control of the behaviour. Whereas a biological explanation might suggest a pharmacological resolution, using psychoactive medication, an analytic approach would, predictably, warrant a psychotherapeutic approach. In the excessive appetites conceptualisation, Orford (1985) admits to the presence of social learning processes which suggest decisional balancing and 'self-constitution' components in the treatment regime.

3.1.7 Comparison of Explanatory Models

As DiClimente (2003) observes, several of the models above add explanatory power to existing models rather than constituting 'comprehensive' explanations in their own right.

Notably, a number of these models do not rely upon the properties of a psychoactive substance and have utility in explaining behavioural addictions. However, Stall and Biernacki (1986, p. 18) argue that “... most scientific conceptions in the area have been framed within some variation of a disease theory ...”, with attributions of deficits in the form of “... personality disorder or metabolic deficiency ...” and denial of those mechanisms by which most people achieve resolution without resort to professional treatment.

3.1.7.1 **Disease versus Adaptive Model**

Alexander (1988) uses a framework evaluation to compare the disease model with an adaptive model of addiction. Like the disease model, the adaptive model also establishes a set of organised causal relationships and recognises inadequate nurturing as a possible predisposition. However, it substitutes ‘genetic unfitness’ (physical or psychological vulnerabilities) for ‘genetic predisposition’ and suggests ‘environmental inadequacy’ as a further and significant source of vulnerability. Exposure to such influences is considered to contribute to a lack of competencies which may result in an individual being unable to function in their social world with resultant isolation and deterioration in their sense of wellbeing. As a consequence, such individuals seek out alternative and sometimes dysfunctional ‘adaptations’ which, at least, allow them to function, albeit at less than their optimum capabilities. Such means, including engagement in addictive behaviours, are still ‘adaptations’ because they represent a better option than complete disengagement (through isolation and despair). As Alexander (1988) contends, the ‘addict identity’ is preferable to ‘no identity’, and engagement in addictive behaviours can shield the individual from the abhorrence of social isolation and self-hatred.

Alexander’s (1988) model, as developed further in his later works (Alexander, 2008) is, unashamedly, critical of the social environment in which all forms of addictive behaviour develop. Hence, ‘environmental inadequacy’ is deemed to be causal in the addiction process (and resultant from it) whereas the disease model posits that social problems are, typically, a consequence of the development of addiction. More significantly, the adaptive model considers that people are ‘making the best of what they have got’ in terms of their personal

resilience and other attributes, beliefs and values, and social circumstances. In contrast to the disease model, the adaptive model denies the existence of a disorder or pathology.

3.1.7.2 **Attempts to Integrate Models**

Adams (2008) notes that the World Health Organisation, some sixty years ago, sought to achieve some accord between seemingly divergent theoretical perspectives in order to address a lack of diagnostic and measurement criteria. Its (1952) definition of Alcoholism concluded:

“Alcoholics are those excessive drinkers whose dependence on alcohol has attained such a degree that it shows a noticeable mental disturbance or interference with their bodily or mental health, their interpersonal relations and their smooth social and economic functions, or who show the prodromal signs of such development. They, therefore, require treatment.”

Peele (1985) has suggested that theorising on alcohol usage preoccupied early addiction research due to the social and political pressures exerted by temperance movements. Whereas, opiate use throughout much of the nineteenth century was considered to be acceptable recreational or medicinal use, problematic use being confined to ‘the Chinese’, alcohol was deemed responsible for neglect and violence within families, immoral behaviours, ill health, and poverty.

The WHO (1952) definition recognised the impact of substance (alcohol) misuse on various life domains including relationships, vocational pursuits and the economic and social wellbeing of those closest to the ‘afflicted’. While it alluded to wider social and cultural spheres, it still located the problem within the individual (though less so with the substance) and how usage of the substance impacted that individual’s environment.

It was not until the 1980’s, and the acceptance of the biopsychosocial model, that the concept of interaction with that environment was accepted as a vulnerability for addictive behaviours and that social dynamics offered an alternative explanation to prevailing medical and

psychological perspectives of dysfunction at an individual level. The biopsychosocial model suggested a reciprocal cause and effect relationship between the afflicted individual and his/her environment; the environment could be instrumental in the development and maintenance of addictive behaviours as well as being impacted by it.

Alexander's (2008) conceptualisation addresses the biology/culture dualism that Koski-Jannes (2010) suggests is inhibiting integration between disciplinary perspectives of addictive behaviours. In her address to the SSA Annual Symposium, in 2010, Koski-Jannes also identified the realism/constructivism debate.

3.2 Lay Constructions of Addiction

3.2.1 Discourses of Addiction

In relating Foucauldian notions of discourse to 'addiction' Bailey (2005, p. 536) states "... 'addiction' is not something we are trying to discover, it is something that we create through the ways we consider it as a society." Such discourse has implicit and explicit rules about what and how ideas may be expressed and represented, and the manner in which 'expertise' accords professionals an (often) unquestioned position in such discourses, and a rationale for decision-making. Accordingly, notions of power and freedom permeate the discourses by which the self is constructed; "... people's sense of who they are, of what is possible for them, and of how they act does not operate in a vacuum but rather comes from a shared understanding of these parameters." Bailey (2005, p. 537).

Such understandings are necessarily influenced by popular discourses, as expressed within everyday social interactions, but reflect changes in societal attitudes towards various forms of consumption and behaviour. Several commentators (Berridge, 1999; Peele, 1985; Alexander, 2008) have written of the changing attitudes towards opium use from social acceptability (and legality) in the early nineteenth century to the portrayal of regular users as deviant by the early twentieth century. Corresponding to this shift in attitudes was a conceptual change, expressed in popular literature, from opiate use being 'a habit' to it constituting 'a disease state'. Bailey

(2005) suggests that the development of the 12-step (AA) philosophy added a third perspective, the 'addict identity', to the prevailing discourses on addiction. Whereas such attitudinal change to opium use occurred over a full century, the availability and pervasiveness of modern popular media enables immediacy to the dissemination, and influence, of contemporary societal attitudes.

Torronen's (2003) examination of Finnish newspaper editorials, between 1993 and 2000, provides evidence of the dynamic nature of contemporary societal attitudes towards alcohol. Whereas editorials in 1996 and 1997 reflected societal concerns about the patronising controls of a centralised power, and demands for a liberalisation of alcohol policy, editorials from the ensuing two years espoused concerns that public order had been sacrificed, in the name of ideological freedom. The Finnish experience of alcohol policy reform provides powerful evidence that societal constructions are dynamic and that the discourses that influence, and result from, such constructions reflect both 'expert' and 'popular' opinion. Although professional discourses were primarily concerned with the physiological harm of excessive alcohol use the media also portrayed public concerns at the irresponsibility demonstrated by some groups of alcohol users (particularly the young) and the compromised security of public places.

The Finnish experience, therefore, is of the tensions between notions of societal freedom and control/self-control. Valverde (1998, cited in Bailey, 2005) examines such conflicts at the level of the individual suggesting that, similarly, 'freedom' is equated directly with 'self-control'. But the notion of control imposes implicit moralistic assumptions upon the concept of addiction, "... a failure of the self in its imperative to exercise control over bodily desires and functions." (Bailey, 2005, p. 539). Notably, such conceptualisations explicitly deny the substance, or target of the behaviour, any agency in the development of addiction. The individual is engaging in the activity due to their own inherent 'failure to exercise control', not due to the insurmountable and pervasive effects of a potent addictive substance, and, therefore, must bear attributions of blame. However, the popular media also extols consumerism, with excesses in certain activities or consumption (Bailey, 2005, suggests eating chocolate, and shopping as examples) being described as 'addictions' generally devoid of moralising

overtones. Accordingly, certain activities are regarded as ‘normal’ within the discourses of modern society while others are demonised. As Alexander (2008, p.37) observes “... whereas today’s popular media terrify us with images of the most dangerous drug addictions, they usually reassure us with good humoured portrayals of addictions to food, consumer goods, sex, religion, television, video games, and so on.”

3.2.2 Constructivism

Raskin and Lewandowski (2000) describe constructivism as the meanings derived from personal experience, social interactions, and cultural influences that contribute to human understanding. According to this epistemological perspective, personal constructions are a ‘guide to action’ in a world that can never be fully understood. The constructivist perspective questions the impartiality of DSM-IV-TR diagnoses of disorder, its pretence of a capacity to differentiate normality and abnormality, and predictive claims bordering on a position of righteousness. Constructivist arguments against DSM-IV-TR, and its nosological contemporaries, include an observation that disorders, classified as objective entities, are as much a product of political manoeuvrings and negotiation as neutral scientific endeavour. Constructivism encourages a multiplicity of constructions, the proffering of alternative explanations; by contrast DSM-IV-TR privileges certain explanations and is reductionist in orientation.

According to Bailey (2005, p. 536) popular and ‘expert’ (scientific and professional) conceptualisations of addiction exist in contrast to, and in tension with, popular discourses. Such ‘everyday’ discourses may challenge the models that direct traditional treatment modalities, with their implicit attributions of power, control, and blame and constitute “... a means for the reassertion of self-identity”.

3.3 Self and Social Identity

Basaglia (1987) is credited with observing, as cited by Borg and Davidson (2008, p. 129), that symptoms “... divorced from their natural occurrence within the social world ... come to be

taken merely as reflective of diseases that are categorized in texts on psychopathology. It then only takes one additional small step in this same direction to equate the person with the illness, subsuming his or her humanity entirely.”

Walters (1996, p. 10) suggests that identity can be defined as “... the unique set of characteristics by which a person comes to recognize him or herself. Being both perceptual and interpersonal in nature, identity is conceived as a perception derived from image, self, and relational schema that then merge to form an organized sense of self.” Ellemers, Spears and Doosje (2002) suggest that such sense of self constitutes a continuous and unitary awareness of oneself whereas social identities can vary according to the various networks, defined and delineated as well as abstract and ambiguous, with which an individual engages. Biernacki (1986, cited in Kellogg, 1993, p. 235) contends that each of these social networks share particular, interests, experiences, and worldviews as well as “... prescriptions for thought and behaviour.” While Ellemers, Spears and Doosje (2002) suggest that the level of commitment to any one group or network determines the relevancy of the associated social identity to any individual member, engagement with the group will elicit varying affective and behavioural responses according to the perceptions of security and acceptance (to the self) derived from participation. According to Koski-Jannes (2002”, p.186) variation of group engagements and change in social identity are reciprocal in causality; “... by the presentation of self in public a person creates one’s *social identity*, whereas one’s *personal identity* is the product of appropriations and transformations of culturally defined identity resources.” Kellogg (1993) proposes that individuals’ identities reflect an amalgam of self-definitions and group norms that appear, to the individual, to have relevance to their social contexts. Necessarily, association with different social worlds can create conflicting ‘identities’, the salience of each being determined by their relevance to particular situations, however Kellogg (1993) suggests a hierarchical organisation that determines overall patterns of perception and behaviour. Resolution of such identity issues has been seen as an imperative in the resolution of opiate addiction (Biernacki, 1986, cited in Kellogg, 1993). Stall and Biernacki 1986, p. 19) further suggest that “... the process of public renegotiation of a stigmatized identity underlies the spontaneous remission phenomenon.”

Walters (1996) considers identity to be instrumental in the facilitation of addictive behaviours. In an initiation phase, substance use or behavioural patterns such as eating irregularities or gambling may be predicted by a perceived lack of identity, desire to be part of a reference group, or insecurities regarding possible acceptance by such a group. Interaction and identification with 'street' users, he contends, corresponds to an escalation of drug usage, maintenance of addictive behaviours, and increasing self-identification with associated group norms and activities. Similarly, identity issues are conjectured to be instrumental in the relapse process alongside "... negative affect, craving, external influences, social pressures, and availability ..." (Walters, 1996, p. 11). An 'addict identity' is implicated in the 'abstinence violation effect' (Marlatt & Gordon, 1985, cited in Walters, 1996) whereby a lapse into addictive behaviour is considered to precipitate an inevitable relapse.

Walters (1996, p.14), having reviewed opposing arguments on labelling theory, concludes "Labelling may ... lead to divergent outcomes based on how the individual constructs reality. Consequently, self-labelling may assist clients who place themselves at the mercy of powerful internal and external influences while hindering clients who perceive themselves to be active agents of change." Accordingly, belief in a disease state and self-labelling are consistent with 12-step programmes though Walters (1996) argues that the success of such modalities may owe as much to self-selection processes and the social supports provided. Additionally, the paucity of longitudinal outcome data, and the lack of controls for 'spontaneous remission', are considered to preclude any real determination of the effective variables in such treatments. However, Young (2011) suggests that engagement with AA is consistent with development of a 'relational identity' that is conducive to positive outcomes; Motivational Interviewing (MI) attends to personal identity and CBT is oriented to a social identity.

Walters (1996), in advocating 'controlled use' approaches, also believes that treatments appropriate to client identity can facilitate amelioration of addictive behaviours. However, Harre (1983, cited in Koski-Jannes, 2002) cautions that marginalised individuals, such as isolated individuals experiencing addiction, may not easily attain an acceptable social identity.

3.4 Recovery

The '12-step' conceptualisation of recovery, exemplified by a complete and sustained cessation of the addictive behaviour, has undoubtedly influenced societal notions of, and discourses about, alleviation from an addictive process. Similarly, adherence to a disease conceptualisation of addiction, by a large section of the treatment sector, dictates that abstinence is a requisite goal for clients.

However, the United Kingdom Drug Policy Commission (UKDPC) Consensus Group has developed a vision of 'recovery' that is inclusive of the more traditional (12-step) conceptualisation but still addresses the multifaceted nature of addictive behaviours. In accordance with the group's mandate, the (2008) vision specifically addresses problematic substance use. However, the twelve key features have utility as a treatment outcome for all addictive behaviours:

1. *Recovery is about building a satisfying and meaningful life, as defined by the person themselves, not simply about ceasing problem substance use.*
2. *Recovery involves the accrual of positive benefits as well as the reduction of harms.*
3. *Recovery includes a movement away from uncontrolled substance use and the associated problems towards health, wellbeing, and participation in society.*
4. *Recovery is a process, not a single event, and may take time to achieve and effort to maintain.*
5. *The process of recovery and the time required will vary between individuals. It may be achieved without any formal external help or may be associated with a number of different types of support and interventions. No 'one size fits all'.*
6. *Aspirations and hope, both from the individual drug user, their families and those providing services and support, are vital to recovery.*
7. *Recovery must be voluntarily-sustained in order to be lasting, although it may sometimes be initiated or assisted by 'coerced' or 'mandated' interventions within the criminal justice system.*

8. *Control over substance use is a key part of recovery, but is not sufficient on its own. Positive health and well-being and participation in society are also central to recovery.*
9. *Control over substance use means a comfortable and sustained remission from compulsion to use, which in many cases may require abstinence from the problem substance or all substances, but may also encompass consistently moderated use and abstinence supported by prescribed medication, peer groups and families.*
10. *Positive health and well-being encompasses both physical and mental good health as far as they may be attained for a person, as well as a satisfactory social environment.*
11. *People do not recover in isolation. Recovery embraces inclusion, or a re-entry into society, the improved self-identity that comes with a productive and meaningful role, and also the idea of 'giving back' to society and others, such as family members, who may have been adversely affected by the individual's substance use.*
12. *Recovery-oriented services need to support the aspirations of each individual to assist individuals build recovery across all the above domains.*

3.5 Summary

There is a vast body of literature pertaining to addiction with authoritative works being found within the journals of multiple medical and psychological disciplines. Necessarily, these articles adopt stances oriented to their particular disciplines with assumptions implicit upon their own epistemologies. By virtue of the selection criteria deployed, much of the literature considered was oriented to particular disciplinary approaches and, to varying extents, questioning of other or alternative models of addiction. As Adams (2008, p. 4) suggests "... definitions of the concept have fluctuated between medical interpretations of disease or dependence and psychological interpretations of compulsion or behavioural disorder, and sometimes more commonplace understandings of it as a bad habit or compulsive drive." Such conceptualisations have arisen in research and treatment contexts and have implicitly located the expression of substance use or behaviours within the individual and his psychological and physiological state. As such, theoretical approaches tended towards reductionist explanations owing much to the disciplinary orientation of theorists.

3.6 Reflections on the integration of Clinical and Lay Constructions into Current Treatment

This research seeks to challenge the efficacy of models of addiction which govern and direct much of the existing treatment sectors; consequently, this review focussed on literature and studies that either exemplified or challenged disciplinary approaches. It did not, for example, delve into advanced neurobiological literature which might inform but seldom be the subject of individual client treatment sessions; such literature is founded upon tacit assumptions consistent with biological or physiological approaches.

The review further focussed on processes which facilitate client change whether inside or outside of treatment settings. It did not consider literature pertaining to pharmacological interventions which are the within the repertoire of treatment providers (including primary care or GP settings), but did seek to incorporate the psychological or support mechanisms which accompany such treatments and which might be replicated or better explained by client narratives of self-directed change. Hanninen and Koski-Jannes (1999) considered client narratives employing a narrative analysis to identify 5 different story-types among the self-narratives of 51 persons who had been free of their addictions for a minimum of three years. The story types were, respectively, named the AA story, the growth story, the co-dependence story, the love story, and the mastery story.

Much of the literature identified the multi-faceted nature of addiction which crossed disciplinary boundaries and demanded a more comprehensive and inclusive model. West's (2006) "Synthetic Model of Motivation" is proffered as a psychologically-oriented basis for a comprehensive model of addiction and into which other theoretical perspectives can be incorporated. While it has appeal, in that it directs adherents beyond the narrowly-focussed 'doctrines' which have long directed 'traditional' treatment models, it's very inclusiveness may appear daunting to practitioners seeking to deliver effective interventions. Like similar models, it expands our horizons and challenges both researchers and practitioners to think 'beyond the square' and outside of their own preconceptions. Bio-psychosocial models, of addiction challenge practitioners to consider multiple domains during the assessment phase of

an intervention and enquire beyond the presenting condition and those precipitants and predispositions suggested by traditional models. Likewise, such models enable practitioners to guide and ‘target’ interventions towards psychological, social and environmental

3.7 How The Review and Reflections Informed This Study

Hanninan & Koski-Jannes’ (1999) study was ‘defining’ in terms of inspiring and directing this research. It exemplified the pursuit of archetypal story patterns, with potential applications in therapeutic settings, in the autobiographical narratives of persons who have experienced addictive behaviours.

While this study identifies similar stories among clients who have more currently experienced problematic substance use or gambling behaviours, it will also examine:

- how narratives incorporate and relate to the major models of addiction which implicitly attribute responsibilities for the development and alleviation of problematic behaviours, and how such models influence the social environments in which self-identities are created.
- how individual narratives may direct the processes of change within an individualised treatment plan
- how language contributes to the creation and reinforcement of self and social identities (alcoholic, addict, junkie, problem gambler etc.,) in the manner of ‘discursive parasites’ (Lock, Epston & Maisel, 2004).

The literature review has guided this research towards a more comprehensive interpretation of ‘context’ based on three abiding concerns. **Firstly**, while bio-psychosocial models expand the breadth of enquiry during assessment, they do not, of themselves, ensure that such enquiry or resultant interventions extend beyond superficial levels. Barclay (2009) suggests that attempts to examine the ‘social’ domain are often restricted to the acquisition of demographic-type data,

and an examination of ‘social risks’ within a limited exploration of family dynamics. While, typically, clients would be encouraged to disclose and interpret their ‘presenting problem or situation’ in their own words, contextual social, cultural and historical information is often provided in a ‘question and answer’ format. The ‘mix’ of structured verses unstructured format can be governed by time constraints, particularly in brief treatment modalities and settings, with subsequent interventions being determined by the applicability of diagnoses of pathology.

Assessments are, in essence, an interpretation of a client’s status at the time of presentation (Aitken, 2011). Based on a (supposedly) semi-structured ‘interview’ – personal experience suggests that such assessments increasingly involve question and answer formats along with pen and paper screening tools.

The clinician has multiple considerations. Notwithstanding Rothschild’s (2010) psychodynamic perspective that the ‘self’ is revealed during intensely stressful times, clinicians are often pre-occupied with stabilisation issues and attempts to ensure the safety of the client, and those with whom he/she may associate (Barkley, 2009).

1. Community treatment models increasingly demand that clients ‘recover’ in the community or, at the very least, continue to function without harm to self or others until improvement occurs or appropriate (and scarce) residential treatment services are available
2. Clinicians (and their employing services) are increasingly held accountable when such harm occurs. The risk profile of the client can take precedence as does the completion of appropriate ‘intake’ documentation.

None of the above processes are contested here. The client’s wellbeing should be the focus of the attending clinician and appropriate documentation can be essential to crisis teams and to support referral to specialist clinicians and other services. Clients presenting in physiological or psychological distress may require ‘stabilisation’ through either medical or psychological interventions. However, it is suggested that such assessments inevitably adhere to a cursory

enquiry of dynamic verses static factors in the client's presenting experience. The biopsychosocial model has led to clinicians seeking to explore multiple biological, psychological and social domains with due consideration of the cultural environment in which the client dwells. However, Carandang (2009) suggests that without adequate analysis of all of these domains, and the dynamic interaction between them, the biopsychosocial model "... can devolve into anarchy and eclecticism ...". Arguably, 'dynamic' factors are assessed according to the client's explanation and interpretation at the time of initial presentation and largely accepted as 'stable' unless the client specifically demonstrates otherwise, or is encouraged to revisit the domain of enquiry. Barkley (2009, p. 347) describes the need to see our clients as '... citizens, as individuals located in a culture and engaged in a fluid, active relationship to our society in all its dimensions.' The reciprocal interaction of person and environment causes a constant state of 'dynamism'. An assessment focuses on the individual as the entity experiencing and responding to environmental stimuli with such stimuli being relatively constant for the purposes of determining 'where the client is at'. The environment is considered to be a reality about which the client's perceptions and interpretations are assessed according to the clinician's view of how that environment really is.

The client cannot be 'objective' or detached. He/she is a part of that environment and the environment does not exist or have meaning without engagement with and by the client. And the client is in and of that environment constantly, engaged in re-interpretations which, in turn, change their engagement with that environment. Presentations to specialist addiction services frequently occur at times of crisis either within the biological or psychological status of the client, or within their social world; despite Rothschild's (2010) erstwhile suggestion that the 'psyche' is most evident at such times, the attending clinician's priorities may be more oriented to issues of safety, stabilisation, and adherence to 'best practice' information gathering and recording. Such interpretations are fundamental to the Comprehensive Assessment but are value-laden according to the client's own 'worldview' at the time of the assessment and accordingly to the priorities accorded by the assessing clinician.

Secondly, specialist services in alcohol and other drug facilities, and the mental health facilities with which they are often aligned, have 'entry criteria' that means treatment is

contingent upon the client meeting a ‘threshold’. Specialist AOD services determine that clients exhibit ‘dependency’ upon a substance, or abuse of it, and that a diagnosis to that effect be made. In this context, Herman (2005, p. 374) argues that the disease label has “... a reality entirely apart from any given patient suffering from it and can serve as a basis for communication, consultation, prognosis, and treatment.” However, Weston (2005) contends that the utility of the disease term cannot extend beyond pathophysiology. “Illness, on the other hand, is the unique experience of a person who feels ill – the thoughts, feelings, and behaviour of a particular individual at a particular time and place (Weston, 2005, p. 389)

Regardless of the clinician’s personal perspectives on giving clients labels of pathology (e.g., substance abuse or dependency) the client’s access to treatment, other than a brief intervention which might be accorded a sub-threshold presentation, will be determined by the relevance of a set of criteria which is, in itself, a scientific/clinical construct beset by historically-constituted and value-laden ideology. It deploys questionable measurement of a construct (addiction) which continues to elude consistent operationalization within research and treatment sectors. Most significantly, as Peele (1985) has observed, the clinician’s determination of dependency is contingent upon the client’s interpretation of their own addictive behaviours, and elaboration of them in a stressful setting, meeting the clinician’s interpretation of the latest attempt at such operationalization (DSM-IVTR or ICD-10).

Armed with this ‘diagnosis’, and a ‘formulation’ of the client’s biological, psychological and social world, the clinician will take the client’s ‘case’, in absentia, to an intake or treatment planning forum. Typically, a multidisciplinary team will, on the basis of the diagnosis and formulation, determine acceptance into the service, a treatment programme in accordance with the service’s protocols and philosophical orientation. While a biopsychosocial philosophy will be espoused, treatment providers in New Zealand typically adhere to medical or disease orientations; residential services, while incorporating adopting behavioural perspectives such as contingency management, have typically been adherents of 12-step philosophies.

Outpatient AOD services provided by public health providers are increasingly being staffed by medically- trained personnel (nurses overseen by medical or psychiatric consultants) rather

than the ‘truly’ multidisciplinary team. While Thombs (2006) contends that many non-medically trained members of such teams were ardent supporters of the disease concept, having experienced ‘recovery’ through AA or 12-step programmes, they nevertheless included practitioners with direct experience of addictive behaviours and perspectives derived from their own experiences. More recently, many such practitioners have extolled harm reduction philosophies that provide a counter perspective to a medical/disease model orientation.

Services oriented to a medical/disease perspective, deploying brief cognitive-behavioural interventions, utilise referral to residential services for ‘motivated’ clients who have not responded to outpatient treatment. This link between medical/disease oriented outpatient services and residential services entrenched in 12-step modalities, promulgates the disease entity mentality which pervades treatment services. Public treatment services have traditionally had varying commitment to the treatment of co-existing problems often citing the non-medical training of their addiction workforce. Arguably, initiatives to provide comprehensive treatment for substance dependent clients with co-existing psychiatric issues, through a workforce orientation towards medically-trained rather than addiction-trained personnel, portends a comprehensive shift towards a medicalised disease approach to treatment.

In accordance with the medical model’s focus on a disease syndrome associated with the pharmacological effects of substances, outpatient addiction services (most usually DHB-provided) in New Zealand refer persons experiencing behavioural addictions, such as gambling, to non-governmental providers (i.e., behavioural issues are the domain of non-clinical/non-medical staff). Indeed, a recent survey of practitioners within the gambling treatment sector identified major concerns that professional amalgamation (in terms of practitioner registration) with other addiction practitioners could impose disease model treatment modalities upon them (DAPAANZ, 2010). Thus, as Miller et al. (2010, p.7) observe, addiction “...is regarded by many as a discrete disease entity, a debilitating disorder rooted in the pharmacological effects of the drug, which is remorselessly progressive.” Yet, well over seventy years ago Rado (1933, cited in Rothschild, 2010, p. 139) observed that “... not the toxic agent, but the impulse to use it, makes an addict of a given individual.”

Thirdly, current ‘best practice’ in numerous (and particularly) outpatient facilities focuses on brief treatment modalities targeted at specific and immediately identifiable problems. Peake, Nussbaum and Tindell (2002) caution that maladaptive, underlying issues may be ignored in favour of measurable, short-term, or superficial improvement achieved without ‘deep process involvement’. Such ‘deep process involvement’ is reserved for clients who attend lengthy residential programmes and is contingent upon their acceptance of 12-step modalities.

Rothschild (2010), in bemoaning the dearth of psychoanalytic treatment of substance misuse, suggests that such treatment approaches were suppressed by both the ‘war on drugs’ and the pre-eminence of the ‘disease model’. Both the societal and prevention-focussed ‘war on drugs’, and the ‘disease model’ with its 12-step solution, focus on the substance misuse and the effects of the substance itself rather than the complex meanings and the purposes of use. However she acknowledges that a “... traditional Freudian analyst, like the traditional substance use counsellor, was considered an authority figure who knew more than the patient and whose interpretations were key” (Rothschild, 2010, p. 140). Similarly, Lewis (2007, cited in Westerman, 2007) contends that, while cognitive-behavioural interventions attend to the ‘need-demand’ aspects of a client’s presentation (represented in Dewey’s formulation as ‘the psychophysical plateau’) the ‘mind plateau’ is the domain of narrative, phenomenological and psychoanalytic approaches. These commentators concur with Klingemann and Bergmark’s (2006) concerns regarding the ‘research-practice’ divide that is exposed in the addiction treatment sector.

Griffiths (2005, p. 195) contends that addiction “... is a multifaceted behaviour that is strongly influenced by contextual factors that cannot be encompassed by any single theoretical perspective.” If new and more comprehensive models of addiction are not being, or cannot be, incorporated into treatment models or translated into individual treatment plans, then clients are being done a substantial disservice and, potentially, significant harm. Service protocols in the service in which I am employed require that treatment plans are jointly developed with clients and reflect not only the client’s language but also their understanding of treatment interventions and processes. No longer are addiction treatments something that are ‘done to’

clients; Hughes (1976, cited in Neale, Allen & Coombes, 2005, p.1586) observes that clients “...are purposeful, goal-seeking, feeling, meaning-attributing and meaning-responding creatures.”

Rado’s (1933) observation locates addictive processes in the ‘impulse to use’ and, notwithstanding that his reference to a ‘toxic agent’ suggests a substance-related addiction, is creditable in that it shifts the focus to the individual and that individual’s psychological and social being. As such, it could apply as well to a behavioural addiction as to a substance-related one. That such profound observations have failed to gain traction until more recent times is a reflection of the ‘folklore’ - type / ideological basis that has prevailed throughout the addiction treatment sector.

The contentions of numerous commentators (Peele, 1985; Griffiths, 2005), that behavioural addictions such as gambling (and eating and sex) share commonalities with the substance-based dependencies, have been supported, ironically, by neurobiological advances over the past two decades. Similarly, and notwithstanding his focus on substance-based addiction, Baker’s (1988, p. 117) introduction to a special issue of *Journal of Abnormal Psychology* places addiction within the environment rather than the properties of a psychoactive substance:

“... addiction occurs in the *milieu externe*, not in the *milieu interne*. Addiction occurs in the environment, not in the liver, genes, or synapse. Certainly drugs exert effects on the liver and synapse, and certainly physiological systems must be understood in order to appreciate the nature of addiction. However, an individual chooses to take drugs in the world. The likelihood of a person trying a drug or eventually becoming addicted is influenced by his or her friends, marital happiness, the variety and richness of alternatives to drug use, and so on. Any complete addiction treatment or prevention programme must appraise drug use in the context of an individual’s general life situation, not just in the context of those behaviors or attitudes temporally or situationally associated with drug use.”

Chapter Four Methodology

4.0 Introduction and design

This study utilises qualitative enquiry methods to address the research questions. The research design is based on the premise that often divergent constructions of ‘addiction’ can undervalue the subjective experiences of those most impacted. Accordingly, study participants with recent experience of addictive behaviours were asked to relate their stories in order that their subjective understandings of etiologic and developmental aspects of the addiction process, and those factors contributing to individual resolution, could be added to discourses on addiction.

The research proposal was discussed extensively with my colleagues at West Coast District Health Board. In particular, the manager of Rata Alcohol and Other Drugs Service was supportive of the study and assisted in facilitating the approval of Operations Manager, Mental Health, West Coast District Health Board. Consultation with General Manager, Maori Mental Health, West Coast District Health Board, ensured that the research proposal addressed cultural considerations appropriately.

4.1 Methodological Orientation

4.1.1 Qualitative Inquiry

‘Qualitative research seeks to ascertain the social meanings that participants attach to drug use and the social processes by which such meanings are created, reinforced and reproduced.’ Neale, Allen & Coombes (2005, p. 1584). McKeganey (1995, p. 750), while admitting that qualitative research methods are seen by some as “... a soft option, producing anecdotal information of uncertain relevance to the serious business of science ...”, contends that quantitative methods are often less than adequate in examining psychosocial and social structural factors at the individual level of experience. People act with purpose “... in and on the world by creating objects of ‘meaning’ that are ‘expressions’ of how human beings exist in the world...” (Van Manen, 1990, p. 4). Griffiths (2005, p. 195), contends that addictive

behaviours, whether involving substance ingestion or not, share commonalities that demand an eclectic approach to research and states that “... many research paradigms are insular and inadequate in explaining addiction.”

Qualitative research methods are ideally suited to examining the development and maintenance of addictive behaviours within interpersonal and social contexts. This research investigates the participants’ subjective experiences and understandings of addictive behaviours and such interpretations are related to social and cultural influences.

Peele (1985, p.25) states “... addiction has always been defined phenomenologically in terms of the experiences of the sentient human being and observations of the person’s feelings and behavior.” However, the goals of this research are not limited to an understanding of participants’ conceptualisations of addiction or an explication of the change processes and the individual psychological, cultural and social contexts in which they occurred. This research is also concerned with bridging ‘the research-practice divide’ and particularly the practical integration of existing research to the clinical environment.

The literature review identified the vast body of addiction literature representing the theorising of eminent researchers who have sought to alleviate the distress of persons experiencing addictive behaviours; this research does not seek to add to that particular literature (as per Grounded Theory) but, rather, to assist in its incorporation into the work of clinicians (including myself) by examining the relevance and application to daily clinical practice. The need for comprehensive and inclusive models of addiction has been identified by eminent researchers from multiple disciplines; this research seeks to elucidate the dilemmas inherent in multifaceted conceptualisations and balance the scales of the realist/constructivist dualism which Koski-Jannes (2010) suggests exists within, and impedes, the addiction research and treatment sectors.

4.1.2 **Phenomenological Approach**

In accordance with Peele's (1985) assertion that addiction cannot be quantified or operationalized as a diagnosis without interpretation of the client's explication of their experiences, thoughts, and feelings it is appropriate to adopt a phenomenological approach to this research. Creswell (2007) suggests that such a methodological style is suitable for studying the stories of several persons who have recently experienced addictive behaviours. As Finlay (2008) observes, a phenomenological attitude demands that research be conducted with a spirit of openness and wonderment while pre-understandings are reflexively restrained. Research is conducted as a continuous questioning of the world in which we live and our experiences of that world (Van Manen, 1990). Similarly, a hermeneutic style is consistent with Packer's (1985, p.1086) approach to psychological research being "... to elucidate and make explicit our practical understanding of human actions by providing an interpretation of them". Hermeneutic phenomenology removes the focus from a biological entity, or subject, and celebrates the uniqueness of the "... incomparable, unclassifiable, uncountable, irreplaceable human being ..." (Auden, 1967, cited in Van Manen, 1990, p. 6). It demands thoughtfulness about how we consider others and act towards them.

4.1.3 **Psychological Constructivism**

The constructivist perspective considers individuals as meaning-generating beings who are engaged in a constant process of interpreting their world, their lives, and the lives of those around them. Chiari and Nuzzo (2010) find similarities in the metaphor of a 'construction system' of personal knowledge, as proposed by Kelly (1991, as cited in Chiari & Nuzzo, 2010) and the personal narrative approaches which accept that client's stories represent contextualised and personalised truths that direct their behaviours and interrelationships.

The literature identified the claim of many researchers that addiction is a social construction with multifaceted etiological considerations and tensions between disciplinary perspectives. There is widespread acknowledgement that addiction must be conceptualised in the context of

historically-situated cultural and social perceptions that define societal reactions and responses to addictive behaviours.

At the individual level, persons engaging with New Zealand's specialist treatment providers could expect their addictive behaviours to be assessed, conceptualised, and treated in accordance with a biopsychosocial framework which endeavours to address the multifactorial processes that maintain such behaviours. Arguably, the integration of biological, psychological and social perspectives in 'case conceptualisation' may occur at varying levels of complexity, according to provider/practitioner variables while treatment modalities may be influenced by provider/practitioner orientations. This research seeks to avoid such focus on reductionism and quantification.

By encouraging participants to share and explore their recent experiences of addictive behaviours I hope to gain insight into the processes by which addictive behaviours occurred, were maintained, and were ameliorated. Specifically, I seek to compare the explication of such experiences, and the meanings attributed to them, with those understandings that might have occurred in a typical clinical 'assessment'. Accordingly, participants were encouraged to tell their stories unencumbered, as much as possible, by predetermined formats or questions. As Steffan (1997, p. 99) suggests, "By contextualising meaningful events ... personal narratives contribute to the understanding of individual experience as part of general social relations and cultural values."

4.2 The Researcher

I am employed as an Alcohol and Other Drug Practitioner and am registered with the recognised professional organisation representing the addiction workforce (DAPAANZ). At the time of the study I was employed by Rata Alcohol and Other Drugs Service, West Coast District Health Board.

4.2.1 **The Qualitative Researcher**

Valle, King and Halling (1989), in explaining hermeneutical perspectives within existential-phenomenological approaches to psychology, cite Gadamer's (1995) contention that one's understanding of a phenomenon (or text or situation or person) is related to one's "...willingness and ability to reflect on one's *preunderstanding* ..." or presuppositions.

4.2.2 **The Challenges**

I acknowledge my own disciplinary orientation within a biopsychosocial philosophical approach to treatment delivered on behalf of a service framework guided by medicalised perspectives. I further acknowledge my own cultural, social and personal background, and experiences.

4.2.3 **The Dual Role: Clinician and Researcher**

This research was being conducted within a treatment facility and included participants who have had some engagement with that provider. The recruitment strategy allowed for past clients of mine to volunteer for the study and their participation became integral to the orientation of the research. In particular, I became increasingly interested in the insights to be revealed by adopting a narrative approach to interviews rather than the semi-structured format usually deployed during clinical assessments. The participation of past clients allowed unique opportunities to assess whether alternative modes of enquiry might have more utility in achieving a biopsychosocially relevant perspective of the client's world.

Conversely, I was very aware that the participation of previous clients could impact the findings with regard to lay conceptualisations of addiction. I considered the possibilities that:

- a) participants had been influenced by my own, or the service's, therapeutic orientation, or that

- b) I might have had preconceptions, obtained through earlier involvement, regarding participants' conceptualisations of addictive processes.

4.2.4 **Reflexivity**

Finlay's (2008, p.1) explication of the "phenomenological psychological attitude" suggests a synthesis of reductive focus, in which the Husserlian notion of reduction encourages complexity and expansiveness rather than narrowness, and reflexive self-awareness. The researcher adopting such an orientation alternates between bracketing understandings, as proposed by the existential and hermeneutic philosophers who have expanded upon Husserl's theorising on the reductive process, and "... exploiting them as a source of insight" (Finlay, 2008, p.1). The researcher cannot be detached in this process but is continually engaging with, and challenging, pre-understandings. As one enters the world of the interviewee, and their interpretations of their world and their experiences, the researcher must engage in a continuous process of distancing preconceptions, in order to fully understand the participant's worldview, and critically examining them in the light of new insight.

4.3 **Data Collection**

4.3.1 **Ethics**

The following ethical issues were identified during study's design phase:

- a) The facilities of a District Health Board were to be used in terms of advertising the research and display of recruitment materials, participant interviews, and storage of data. West Coast District Health Board agreed to provide an interview room and access to rest rooms in order that participants could provide their narratives in a safe and non-threatening environment.

The Manager of Rata Alcohol and Other Drugs Service (clinical psychologist), along with other staff of the service, were to be available to intervene in the event of any

participant exhibiting psychological distress. Additionally, a Psychiatric Emergency Team, Grey District Mental Health Teams (including psychiatrists, clinical psychologist, psychiatric nursing and allied health personnel) are located at the research locality. In order that any adverse outcomes, associated with the research, be detected at an early stage regular supervision was arranged between the Manager of Rata Alcohol and Other Drugs Service and myself.

- b) The possibility of a ‘conflict of interest’ situation was anticipated in that many of the clients of Rata Alcohol and Other Drugs Service are known to me.

Accordingly, and as identified in Massey University’s “Screening Questionnaire to Determine the Approval Process”, an application was made to Health and Disability’s Upper South B Ethics Committee. Approval was granted (Ethics Reference URB/10/07/025) by that committee on 18 October 2010 (Appendix 1). Approved documentation included Information Sheet V.2 (Appendix 2) and Consent Form V.2 (Appendix 3).

Ethics Reference (URB/10/07/025) was valid until 01 May 2011 however Lost documentation (in transit) resulted in delays in receipt of lodgement of the above approval with Massey University’s Ethics Office. All participant recruitment ceased during this period. An extension to Health and Disability’s ethics approval was sought to enable the research to resume and was granted on 12 April 2011.

4.3.2 **Procedure**

Upon receipt of ethical approval (and extension to approval) the data collection process began. At all times, the oversight of the Manager, Rata Alcohol and Other Drugs Service, ensured that processes were in accordance with the conditions of ethical approval.

4.3.2.1 **Recruitment**

A draft advertisement (Appendix 4) was created and discussed with Consumer Advisor, Community Mental Health, West Coast District Health Board. Upon approval, the advertisement was displayed in the reception area of Community Mental Health and Rata Alcohol and Other Drugs Service.

Prospective participants were requested to read an Information Sheet (Appendix 2) which explained the purpose of the research, the anticipated commitment of participants, and relevant ethical considerations. Volunteers who expressed continued interest in the study were requested to attend a brief meeting at which all aspects of the intended research were discussed and informed consent obtained (refer Appendix 3).

All participants were recruited in response to the above advertisement and by the snowballing effect. Recruitment efforts ceased once the requisite number of participants had been achieved in accordance with the terms of Health and Disability Ethical Approval (URB10/07/025).

4.3.2.2 **The Participants**

Two of the six participants identified as NZ Maori. The participants included two persons identifying as having experienced significant problems with gambling (as well as alcohol use), while one participant identified problematic gambling in the context of alcohol dependency and cannabis dependency. Three participants had experienced alcohol dependency with two of them having been opiate dependent (in full remission) and cannabis dependent (in partial remission).

Five of the participants were previously known to me with four of them having been clients. Notwithstanding the issues raised previously (the Dual Role of Clinician and Researcher) the inclusion of previous clients of mine was deemed advantageous in that unique comparative perspectives could be gained in terms of disclosure and insight using a narrative approach compared with clinical assessment.

4.3.2.3 **The Interview**

All participants signed the consent form (Appendix 3) prior to the interview. The purpose of the study was again explained and participants asked if they had any concerns regarding their participation. Participants were advised that they could terminate their narrative at any time and that they could take as long as they wished to tell their stories. A digital dictaphone unit was turned on and, in accordance with the advice of Health and Disability's Upper South B Ethics Committee, each Participant was given a standardised request: "This study will be assisted by you telling me about your life and your experiences of becoming addicted, of being addicted, and your thoughts on resolving your addiction." At the conclusion of the interview, participants were asked to confirm that they were not distressed by the experience of telling their stories. Participants were asked if they had any questions or had anything that they wished to add to their narrative. Participants were advised the approximate date that their transcripts would be available, should they wish to receive a copy, and invited to read the final report on the research.

4.4 **Data Analysis**

4.4.1 **Thematic Analysis**

This research did not seek to generate theory but acknowledged that the analytic processes of grounded theory provide the theoretical framework for thematic analysis (Liamputtong & Ezzy, 2005), with the active use of theoretical sampling, in grounded theory, being the major point of differentiation.

Thematic analysis, in accordance with Chamaz's (2005, 2006) social constructivist outline, is considered appropriate to the study of how narratives incorporate and relate to the major models of addiction which implicitly attribute responsibilities for the development and alleviation of problematic behaviours. According to Creswell (2007, p. 65), Chamaz's (2005, 2006) methods are not confined to a "... single process or core category ..." but emphasise "... diverse local worlds, multiple realities, and the complexities of particular worlds, views, and actions." Research methods and process remain flexible throughout the data gathering with the researcher modifying coding categories and actively participating in an interpretive

approach to the “... views, values, beliefs, feelings, assumptions, and ideologies of individuals ...” (Creswell, 2007, pp. 65-66).

This research did expect the data gathering to generate analysis and discussion that reflects my prior views and learning experiences in exploring the cultural and social worlds of clients and their relationships within those worlds. However, in accordance with Anderson’s (2011, p.11) description of a postmodernist perspective, I endeavoured to maintain a “... critical reflection of foundational knowledge and privileging discourses ... “ and be open to alternative explanations and interpretations. Accordingly, and consistent with Finlay’s (2008) observations on reflexivity, the data analysis involved constant reflection on addiction theory as participants interpreted their experiences of addiction.

4.4.2 **Lower order coding**

Transcripts were analysed line by line using descriptive codings to ascertain relevance of individual statements to the episode (life event or observation). Descriptive codes were refined by constant comparison (both within and between subjects) allowing for the development of topic categories and interpretative themes.

Questions guiding ‘within subject’ narrative structure consideration included:

How was the narrative structured (e.g. chronological, episodic etc.)?

Was the narrative continuous or disjointed?

How were episodes of trauma or distress addressed in the narrative?

What did the narrative structure say about the development and alleviation of addictive behaviours?

Questions guiding ‘within and between subject’ theme development included:

What insights were gained by a narrative approach that might not have been readily achieved in another (e.g., clinical assessment) mode of enquiry?

How might such insights have contributed to alternative approaches to treatment?

How was the ‘addiction’ construct influenced by personal experience, interpersonal and social interactions or cultural (e.g., media influences).

4.4.3 **Analytical coding**

Questions guiding the analytical coding were:

What attributions were made regarding predispositional influences in addictive behaviour?

What attributions were made regarding recovery from addictive behaviour?

How was the concept of recovery defined?

How did the subjective experience of addiction relate to prevailing models of addiction?

4.4.4 **Reliability and Validity**

Reliability and validity issues were addressed through a number of processes during data collection and data analysis. Constant comparison processes assisted in the identification and refinement of descriptive and interpretative categories and themes as well as contributing to synchronic reliability. Diachronic reliability was addressed by the descriptive and interpretative categories being constantly reviewed throughout the research process.

Peer review of the research design, procedures and findings contributed to internal validity as did constant comparison of data between subjects and against prevailing theoretical models.

Chapter Five Results and Discussion

5.0 Presentation of Data

It is in the intrapsychic worlds of the participants, and the synthesis of their vastly divergent developmental pathways with the societal and cultural influences that they encountered, that addictive behaviours were developed and experienced. Social learning processes, novelty-seeking behaviours, peer group influences, and attempted alleviation of emotional distress, were evident among participants' etiological accounts as the development of addictive behaviours reflected participants' responses to compelling influences within their worlds. Their narratives were permeated with interpretations of these behaviours and reflected idealised social constructions of citizenship, with expectations of what should be valued in terms of family, employment, and community involvement, as well as constructions derived from their proximal social circles where companionship (or lack of), and the daily regulation of emotional state were paramount.

All of the participants had past, and recent, experience of addiction treatment. Some had attended residential treatment programmes and all had at least some experience of community-based self-help programmes based on the 12-step model. By virtue of the recruitment strategy deployed in this research, all of the participants had most recently attended an outpatient treatment programme that espoused a 'harm-reduction' philosophy. Exposure to these various treatment modalities inevitably impacts an individual's conceptualisation of the addictive process and its relevance to their particular circumstances and interpretations of its impact on their life course.

With the power of hindsight, albeit recent, and some alleviation of the distresses of their addictions, some participants described biologically-explained mechanisms, indicative of a capitulation of the brain's reward pathway or a genetic predisposition, as if these were universal. Cultural and societal influences were expressed in terms of availability and encouragement of consumption, as well as the role of the substance or behaviour in terms of self or social identity.

In accordance with the methodology espoused by Chamaz (2005, 2006, cited in Creswell, 2007) my analysis differs according to the style, structure and content of the individual narratives. Whereas Leonard's narrative was a flowing account of a life, rich in imagery, and ordered in its presentation, Christine and Darren's stories challenged my attempts at understanding. I became aware of my own propensity, conditioned by formal assessment processes, to seek order in the narrative, to understand context for seemingly unrelated episodic accounts, to find solace in 'preunderstandings'. Frank's (1995) tome, "the Wounded Storyteller" provided some insights and edification.

Additionally, Natalie did not have the opportunity to view the written transcript of her audio-taped narrative as per her expressed wish at the time of signing her consent; accordingly, and with Natalie's consent, I decided that an abbreviated summation of her story, and brief thematic analysis including her attributions of aetiology and constructions of addiction and recovery, devoid of quotations which had not been checked by the participant, was ethically appropriate.

5.1 The Stories

Natalie's Story

Natalie described an upbringing within a loving and supportive family. While not wealthy, her parents provided a secure and nurturing environment where the children were well fed, clothed, and did not lack for encouragement. Her brothers and sisters were protective of their 'little' sister.

Natalie did not elaborate on any medical reasons for a physical disability but instead focussed on the implications of 'being different' to her school mates and, particularly, the taunts that children can unthinkingly inflict upon an easy victim. She earned a nickname (not recorded for confidentiality reasons) related to this disability that, while possibly derogatory in intent, was later to become a term of affection within the various groups of 'social outsiders' with whom she would find solace.

The 'punk rock' movement was to provide Natalie with her first experience of people who aspired to 'be different' and she instantly felt an affiliation to this group of people who followed their own imperatives in a social environment that honoured conformity. The music, the clothes, the haircuts, and the body piercings marked her new friends as being outside of the social mainstream and they revelled in their marginalisation. She readily accepted their heavy use of alcohol, cannabis and other illicit substances as further evidence of their status while their unconditional acceptance of her into their ranks normalised her own use. Her progression to intravenous opiate use, however, was not as 'a follower' because the 'initiation' was an experience that she shared with her group and she quickly developed a reputation as one of the most regular users.

Following three years of increasing opiate use, the 'group' had diminished as various members entered 'mainstream' life, secured employment, and maintained only cursory contact with their former associates. Natalie remained a mainstay of the remaining 'core' of the group until their collective financial ability to sustain their opiate use compelled her to seek treatment. Along with one of her friends she entered treatment which included detoxification and a residential rehabilitation programme. Unlike her associate she completed the three-month residential component but without feeling any affinity to most of those with whom she shared the experience. To her, their use of alcohol and cannabis, and even some illicit drugs, constituted social use within a 'mainstream' context; they weren't living on the edge. Upon completion of the programme she did not accept offered accommodation with her siblings – she loved them but they lived in a different world. She returned to the two remaining members of the group and within a few days had succumbed to the allure of opiate use.

Within ten months she had repeated the detoxification/residential programme regime and been accepted onto a methadone maintenance programme which would enable her to recover physically (except for her Hepatitis C infection) and psychologically. However, over the next two years, Natalie endured a difficult relationship with clinic staff, whom she deemed overly 'controlling' due to their (correct) belief that she was continuing to use other illicit substances (as well as excessive alcohol and cannabis) and maintaining contact with her (still) opiate-

using associates. Accordingly, she undertook a withdrawal regime from methadone, over several months, and went back to her old world.

She was ‘taken back’ onto the methadone programme approximately eighteen months later having been unable to manage her continuing opiate use. Once again, she struggled with the compliance requirements of the programme while maintaining her peer group associations. This time, she actively participated in managing her own withdrawal, following three years of opiate substitution treatment, and finally rid herself of dependence upon opiates.

However, Natalie ‘related’ to her old associates and immediately gravitated back to the remnants of her old peer group. Alcohol and cannabis became her substances of choice (again) and her dependency on both substances matched her reliance upon the group for psychological support and sense of identity. Over the ensuing years, Natalie was referred to outpatient treatment services on two occasions following drink-driving convictions. Each of these interventions resulted in temporary cessation of alcohol use, and reduction in cannabis use, but ended prematurely as Natalie felt ‘the pull’ of those people who understood and supported her.

.

Leonard’s Story

Leonard’s narrative contained discourse that exemplified particular themes and interpretations, that defied paraphrasing: His story, particularly, represented an ordered and integrated narrative and numerous direct quotations are included in order to demonstrate an eloquence and succinctness that had not often been evident during treatment. His narrative embodied a practical and resourceful integration of a range of experiences while his interpretations of cultural and societal influences on alcohol use exemplify provincial New Zealand life from the mid 1970’s. The progression of addictive behaviours was also voiced as a response to frustration and dissonance between perceived societal expectations and measures of ‘a good life’ and the (then) current expression of values at an individual level. For these reasons, Leonard’s narrative is accorded considerable attention and space; his words speak for themselves.

Leonard adopted a chronological narrative approach explaining that “it explains who I am and what I am”. He revelled in the recollections, both good and bad, and readily applied interpretations of events and behaviours in terms of societal and cultural norms. Such observations were not presented as excusing behaviour, merely explaining context. The narrative was thoughtful, without indications of preconceived content or style, and reflective. Leonard was a natural storyteller and the transcript contains few prompts or requests for clarification.

Part One

His earliest recollections were of an unhappy early childhood and the fear and intimidation that his father’s alcohol use and abuse inflicted upon the family. The departure of his father, when he was five years of age, was described as the beginnings of a happier chapter in his life despite his mother “letting her hair down for a few years”.

“It was just a safe party house where I saw a lot of adults singing and laughing ... having a good time ... and yeah ... that’s where I wanted to be.” Despite his mother’s protestations and admonitions her guests would often provide the young Leonard with alcohol. I would get violently ill ... but the next night I would try it again.”

More than forty years later, and despite having a vastly different attitude to the provision of alcohol to children, Leonard still regarded his mother’s friends with affection. They had provided his mother with companionship and, for that alone, he remained grateful. He saw alcohol use in terms of a cultural norm that was integral to any social occasion.

“I saw a lot of adults that didn’t abuse Mum that would drink; drinking was what a small town did. That was the activity; people didn’t travel in the 60’s. That was the main activity ... it was more popular with BBQ’s ... people didn’t have BBQ’s ... they had a guitar and a few crates.”

His mother's remarriage brought stability to the home environment and an end to the parties and easy access to alcohol. Rather than spending his days in the company of adults Leonard developed some friendships which have endured more than forty years. His narrative was of four "ratbags" who become known for mischief and testing the boundaries of parental and police patience.

At ten years of age the four were before the Children's Court for a burglary that involved "the removal" of alcohol from a neighbour's basement. While the Court's sanctions were light Leonard described the distress caused to the boys' parents, and the dismay of a community that condoned alcohol use, even by minors, but did not tolerate theft. He was placed on 'a good behaviour bond' just to retain his milk-run job and, for a time, was barred from the homes of his friends' 'well-off' parents. He suggested that cessation of alcohol use was never considered but that he, and his friends, learned that the community had its own set of rules and expectations that were not to be violated.

"Seems funny that we continued with this alcohol because of what it done but it was what everybody done. It was all we knew and saw parents, we saw older brothers, we saw communities. Not being idiots but that was what we did in our small town. It was not a crime, people weren't crashing their cars."

This theme of 'responsibilities' associated with alcohol use continued throughout his narrative; it was exemplified by his attitude towards his early experiences of employment, workmates, and obligations to his community.

"You never let your mates down. So I've never used the excuse 'piss-crook' ... even if you were violently ill you turned up and you filled the gap."

"If you were able to drink you had responsibilities ... you did behave whereas even though we got violently ill and drunk we behaved. We didn't break bottles ... we didn't vandalise ... we were responsible little drinkers. You weren't hurting no-one with your drinking."

‘Responsibilities’ did not, however, extend to moderating the use of alcohol. Leonard and his friends sought to emulate the behaviours and capacities for alcohol exhibited by their older peers. They modelled themselves on the town’s (late) teens and the self-images that they projected. These were years that were “footloose and fancy-free” and, like his peers, Leonard indulged himself in the freedom of surfing and attending concerts, but always with alcohol being a necessary and accepted adjunct. A two-year working holiday, despite exposure to the Australian drinking culture of the 1970’s, enabled Leonard to save a considerable sum of money and, briefly, leave behind some of the insecurities regarding his childhood.

“My family was poor. My three mates had happily-married parents ... so I was ... I grew up feeling lower than my three good mates in (terms of) living environment. So when I went to Ozzy and they were still stuck in New Zealand ... I felt I had achieved something ... but still continued the drinking.”

The drinking was to undo much of Leonard’s new-found sense of wealth and achievement, and fragile sense of identity. Yet the need for acceptance and inclusion was more important.

“Came back and basically blew it with the group of friends I knew ... on alcohol and whatever else was going. Sort of jumped back in to the same old pair of boots. I had gone to Australia ... I had proven to myself ... no one else ... that I was equal to people around me ... and I came back and within 2 months I sort of wrote off this car drunk on tequila. And I basically shouted all my mates with the last two years of my savings. There was a bitter taste to that drinking ... when it was over I didn’t see any of them. But that was when I met my darling wife.”

Part two – Integration and Dislocation

“Well ... she had just got out of a bad marriage so she was similar to Mum ... she wanted a good time. We drank sensibly even though it was ... well we drank to get intoxicated.

Nobody in all this story just drank socially. You drank until you were drunk. We had basically seven years of happiness until the road became a bit rocky. It had a lot to do with alcohol and the functions.”

Leonard’s insecurities had again manifested themselves. He believed that he was ‘a lesser person’, due to his upbringing, and ‘acceptance’ by others only provided temporary relief for his fragile self-esteem.

“It made me feel very good to have a partner. But I did not feel comfortable with her because I still felt that everyone else had more to offer than me.”

His (now) ex-wife’s pregnancy was to dispel her thoughts of a separation. The birth of their first daughter, and a second some fourteen months later, also encouraged Leonard to reduce his alcohol use and, along with his wife, temporarily cease smoking tobacco.

“We didn’t want no more ... we would raise these two little angels and we wouldn’t endanger them in any way. I’m very proud of my ex-wife – she did a marvellous job ... our kids had three meals a day. They were well looked after ... we did not fight in front of them. I pulled my socks up and slowed my drinking down. When we did holiday we would go with the four of us even though the kids were very young. We gave up our social circle”.

Leonard’s work ethic now had a focus and he worked long hours in their small contracting business. He regularly worked twelve to fourteen hour days, along with their one employee, returning home mid-evening.

“My worker was also stuck in the old system ... didn’t think it was a crime but we would buy a dozen beer because we were in a small town and most of the jobs were an hour travelling. I’d buy a dozen cans from the closest pub and we would drink half a dozen cans on the way home even though today that would be seen as very irresponsible. We

did that every day so I would have half a dozen cans usually before I got home. I thought that was ok because I worked.”

“But alcohol was stuffing lots of marriages in the town and it started to stuff up mine. If maybe I hadn’t been so used to drinking every day I probably would have sorted out some problems a little bit different ... There was always food come first ... but alcohol was a close second.”

Both he and his wife were regular users of marijuana and grew “... a few plants ...” nearby on their farm cottage. Like alcohol, cannabis was widely used in his community and regarded as ‘normal’.

“I had sort of started to get used to smoking pot as well as drinking. The two seemed to combine very well. I also used alcohol and marijuana as just a way of chilling out from your day in society because a lot of people don’t realise in an organised society how much stress they put on people. Its very hard to raise a family, buy a house, keep a job without having that break at the end of the day. So it was usually a joint or a nice bourbon or a beer and that was your unwind like that.”

With the ending of the marriage Leonard’s past alcohol use was to impact upon every life role. He had a profound sense of failure and ‘dislocation’ from the roles that defined his self-identity.

“I admit I did abuse alcohol and the only way I abused her was that I used that to be happy. But yeah it got worse when I separated. Because it was such a long marriage I didn’t know anyone else. I didn’t know anything else but my two children and my wife. Basically 90% of my wages started to go on alcohol instead of the 10% through the marriage. So I didn’t have many goals. I thought my life had basically run its course. If I didn’t drink until I dropped I couldn’t sleep. I should have looked for help then but I didn’t. So yeah I filled the fridge. I emptied the fridge regularly.”

Leonard's work ethic, however, remained intact until his remaining "rock" left him.

"I still turned up for work ... that was an old habit of mine that you didn't use alcohol as an excuse. I was still smoking marijuana. I was still drinking. I wasn't bludging from the system. I was working. I was working hard for my employer."

"Then sadly Mum passed away. She was my rock, she was my person who loved little old me no matter what I did and things went pear for about 3 years. I went into harder drugs. I didn't really want to live. The cracks were starting to show with my employer ... he was very disappointed after helping me with Mum's funeral and helping me get over my separation. I was turning into a very unsafe, unreliable worker. I was using morphine which a person would break (it) down. Ritalin was the main one ... and poppy beige. I didn't want to commit suicide ... I just thought I've done my dash. I've done the best I could and that was it and go out like a good All Black while they are on top. No point in hanging around and just being the orange boy."

He did not want to be like his opiate-using 'acquaintances', and though they were his regular companions during his time of distress, he could never regard them as supportive or likely to act in his interests.

"Stuff that I swore all my life that ... we grew up in a small town ... so you never trust a junkie and all this sort of stuff."

It was his much-loved daughters who, having realised the extent of his predicament, threatened to expose his drug-using behaviours to his siblings. Though only in their late teens, they assumed the parent role and 'shamed' Leonard into action. They found him a "... seven day a week ..." job on a large contracting site in an isolated area. The change in environment, estrangement from his "junkie acquaintances", the loving support of his daughters, and an appeal to the work ethic that had dominated his life, enabled Leonard to cease his use of "... hard drugs ...". However the hard working, hard drinking environment ("there were forty to fifty contactors on big money spending up large") that he moved to encouraged an escalation

of alcohol use. Over the next two years Leonard earned high wages and spent most of it enjoying, and paying for, the companionship of his fellow drinkers (“it was normal to drink until you drop”). However, heavily under the influence of alcohol, Leonard crashed his new and highly leveraged car. The accident threatened his employment and finally challenged an entrenched disregard for drink-driving behaviour.

“I could drive a vehicle sensibly and get home. I’d always got home until this situation. If it hurts someone it ain’t so funny anymore. ”.

No one, other than Leonard, was physically harmed in that accident but Leonard felt the disappointment of people who loved him and respected him. Those people became further concerned over the next six months as the jovial Leonard became an unhappy drinker, who would be seen alone at the bar, at the end of the evening, miserably holding his head in his hands.

His employment ended and Leonard briefly pursued a new relationship in a nearby town. A medical check at the behest of his new partner revealed Hepatitis C (a legacy of his intravenous drug-using episode) and emphysema. The relationship ended and Leonard “... hit rock bottom ...”

The ensuing months included attendance at AA during which Leonard continued to use alcohol heavily. Brief counselling led to Leonard’s referral to a psychiatric emergency team, and the Alcohol and Other Drug team in which I am employed.

Leonard’s Story – the epilogue

“The alcohol couldn’t even hide my fuckups. I took responsibility.”

Leonard still uses alcohol at (work-related) social events and has, too date, maintained low-level use. He is working and chosen not to take legal refuge from the significant debts

resulting from his car accident. He enjoys a close relationship with his daughters. His Hepatitis C infection has been successfully treated.

“To cut a long story short I feel good about myself. My goals? To love my darling daughters and show them what I can do. I want to be happy. I want to feel equal. I want to feel part of the community. I’d just like to feel equal in this world, this living life I am in.”

Leonard’s narrative might have been two, or more, stories. Burr’s (1995) social constructionist perspective suggests that people utilise multiple discourses to interpret and describe their unique version of events. The narrative represented a constant interplay of self and social interpretations of behaviour, between descriptions of behaviours that were those of a flawed self and those that a society sometimes condoned and sometimes denigrated. His narrative was, at times, seemingly continuous, uninterrupted, and articulate while at other times delayed and thoughtful as he negotiated (on his own instigation) alternative social explanations.

Darren’s Story

Darren, having recently experienced a resumption of use (albeit at relatively low level) of cannabis, presented both a unique perspective of addictive behaviour and a narrative structure quite different to that of the other participants. His narrative was disjointed and seemingly without any discernible arrangement. His discourse was tangential with episodes, or stories, being left incomplete as he moved to new imperatives in the dialogue. Nevertheless, Darren’s narrative still revealed interpretations relating to the construct of recovery as formulated over a long association with disease-oriented 12-step treatment modalities. His narrative has been translated into a chronological ‘summary’ but I was concerned that the brevity of the final format belies the intensity of the subjective experiences which Darren sought to portray. It was in Frank’s (1995) book “The Wounded Storyteller” that I found some resolution of this dilemma. Relevant comments from Frank’s work are interspersed in Darren’s narrative.

Darren's narrative began with a lengthy and sometimes emotive telling of his recent experience of job loss (a contested redundancy) which was proffered as one of several (but secondary) attributions for his current difficulties.

Ricoeur describes how the self only comes to be in the process of life story being told: the subject is never given at the beginning of a narrative (Frank, 1995, p.61)

Darren, by virtue of a seriously-ill alcoholic father, extensive involvement with local 12-step programmes, and several residential programme placements, was fully conversant with the 'disease model' and had, throughout much of his adulthood, readily accepted his self-proclaimed labels of 'alcoholic', 'drug addict', 'sex addict' and 'gambling addict'. His notion of disease had demanded that abstinence from alcohol and cannabis, his two substance-based 'addictions', was crucial to his well-being.

... he was in remission, but it was the contingency of that remission, remission being defined as contingent, that drove him crazy (Frank., 1995, p.47)

Conversely, Darren expressed hope that his two behavioural 'addictions' would be amenable to harm-reduction strategies. As a young man in his late thirties, and with a new young family, Darren had associated his self-proclaimed sex addiction with two episodes of infidelity, one each during his current and a past relationship, and regular but not overwhelming thoughts of a sexual nature. With some encouragement by his sponsor, Darren had been able to transfer his disease analogy to these indiscretions as well as to his very occasional past propensity to gamble on slot ("pokie") machines when such expenditure was undoubtedly better allocated on behalf of a family with considerable financial difficulties. Both behavioural 'addictions' had been manifested during times of intense emotional distress precipitated by relationship difficulties and temporary estrangement from his partner. That such difficulty had, in turn, occurred in the context of low level use of cannabis or alcohol enabled and reinforced his causal attributions to a disease state.

The voice of the teller has been lost as a result of the chaos, and this loss then perpetuates that chaos (Frank, 1995, p. 6)

However, his regular narratives of such historical indiscretions to his (Christchurch) AA fellowship had not always met with, to Darren, due deference to the antecedent events that he considered important and predisposing in the development of his multiple addictions. Also, although encouraging a ‘disease’ conceptualisation of his perceived behavioural ‘addictions’ members of the fellowship were less supportive of his regular willingness to regale them with such stories. He perceived derogatory comments and gestures as a lack of support inconsistent with his often emotional discourses, and his perceptions of the fellowship’s duty towards him.

... the “sick role” describes behaviour the sick person expects from others and what they expect from him.... and they are internalized, meaning that individuals regard their expectations around sickness as normal and natural. (Frank, 1995, p.81)

Accordingly, he frequently disengaged from his previously strict regimen of ‘meetings’. The support of his siblings, which had been significant during difficulties in Darren’s late teens, had become conditional upon abstinence from alcohol and cannabis and commitment to the 12-step model by way of continued attendance at meetings. This support had dissipated over recent years as Darren regularly yielded to episodes of hopelessness and helplessness.

During more recent outpatient treatment (for his alcohol and cannabis use) Darren had begun to interpret some of his own behaviours as ‘immoral’ (extramarital indiscretions) or maladaptive (gambling as an escape from emotional distress) rather than disease symptoms. On occasions he had even subscribed to behavioural strategies targeted at reduction of substance use without resort to (to him) a demonising demand for abstinence with associated admissions of relapse and failure. However, he had continued to attribute his emotional distress, and the precipitating interpersonal crises, difficulties in the performance of life roles, and issues of self and social identity, to the automatic and inevitable consequence of low-level alcohol and cannabis use.

Despite the lack of continuity, Darren's narrative suggested a developing (albeit grudging) willingness to 'consider' alternative explanations for events in his life that had long been attributed to progressive disease conditions. During two periods of employment Darren had succeeded in developing a new self-identity which he identified in terms of being a reliable employee and, very importantly, as a provider for his partner and children. Along with a diminished focus on his 'diseases', and expectations of a life struggling against the relapses which are the lot of the 'addict', he ruminated less about the lack of support from his alcohol-dependent father and estranged siblings.

Darren's story represented a lack of coherence. While traumatic events in his life were well articulated these 'part-narratives' or 'episode stories' bore little relationship to preceding and ensuing elements of his narrative. Goncalves, Korman and Angus (2000) posit the term 'micronarrative' to describe 'episode stories', a lucid account of an event that constitutes a story in its own right. However, the narrative was without order.

Events are not told chronologically in these memoirs, nor is a life rehearsed in detail. Rather, present circumstances become occasions for the recollection of certain past events. The illness constantly interrupts the telling of the past life, although alternately, memories of the past life interrupt the present illness. Frank (1995. P. 120)

Jeanette's story

Jeanette's narrative exemplified the quest metaphor for a narrative in which the teller is seeking answers rather than wishing to tell a story. Yet her focus on the Maori adoption practice of whangai, her privileged childhood (compared to the siblings who remained with her birth parents), and her life before the overt appearance of addictive behaviours, suggested a need to focus on episodes and life stages that she understood rather than the more chaotic times which had ensued.

Jeanette had never assumed an addict identity though had engaged enthusiastically in therapeutic initiatives for both gambling (mandated following related fraud convictions) and alcohol use (by referral from her GP). Her narrative was devoid of disease connotations but permeated with quest metaphors, a need to understand the aetiology of maladaptive behaviours, and a resolution of what she termed as an identity crisis. Her social networks had been constricted, her very sense of citizenship compromised, and her performance of her 'traditional' roles subjected to scrutiny and criticism.

Her gambling behaviours had been addressed by appropriate (outpatient) services and she professed an understanding of the mechanisms by which her escalating involvement with pokie machines had provided 'an escape' from her emotional distress. She depicted the development of her problematic gambling behaviours as a transition from long-term occasional use during socialising at local hotels to a regular, almost daily, ritual as she struggled with disputes over remuneration with a part-time employer, and major behavioural issues with her children that compromised her marital relationship. She described all of these stressors as challenging her self and social identities, her perceptions of herself as a wife, mother, employee, and member of a small and insular community.

Her narrative included frequent references to immorality. At a community level, Jeanette was aware that her behaviours would not be forgiven within certain sectors of the community who would struggle to forgive the breach of trust that she had committed against more than one community organisation. She expressed remorse at such behaviours interspersed with incredulity that she could ever have resorted to the fraudulent removal of funds from organisations that held her in high esteem and had entrusted her with their financial affairs.

Jeanette's narrative revolved around family. She reflected at length on the legacy of values that she had been given by her adopting parents, the love and pride that they constantly imbued, and an upbringing vastly different from that experienced by the siblings still in the care of her birth parents. Her description of occasional childhood visits to the latter reflected shame and fear as she witnessed alcohol and drug-fuelled violence and childcare practices

vastly different to those that her ‘real’ parents exhibited. Similarly, visits to her adopting mother’s family demonstrated an environment much divorced from that which she experienced on a daily basis. Conversely, she had been able to see her father’s upbringing emulated in how she and her adoptive siblings were being raised.

Her early adulthood had included an abusive partner, the father of her two oldest children, and direct exposure to the alcohol and drug-fuelled violence she had been spared in childhood by her adoption.

“There were days when I thought “I’m going to die today God I wish the neighbours could hear me screaming ... and nobody would come”

She had eventually left this relationship, for the sake of her children, and moved to the South Island where her parents were then residing. Marriage, the birth of two further children, the close and loving support of her parents, and extensive engagement with community organisations suggested a geographical and psychological detachment from the violence and dysfunctional family dynamics of her earlier relationship, her mother’s family, and that of her birth family.

The death of her parents, however, was described in terms of ‘bringing to the surface’ or ‘exposing’ supposed predispositions or risk factors as well as questions as to her self-identity. The death of her mother had brought her adopting aunts to town.

“... and I know that side of the family go and take bodies from a bloody funeral for goodness sakes because that is not where they should be and they should be at this other marae and I thought ‘Oh My God ... ok ... right ... they are coming.’”

Jeanette’s narrative did not express disapproval at such practices but rather her own inadequacy of understandings of Maori protocols; she attributed resolution of the dilemma, and the decision for her mother to be buried locally, to the intervention of other members of her mother’s family.

Her father's death had an even more profound impact on her sense of identity. In the years following her mother's death, Jeanette's father experienced a rapid decline in health accompanied by atypical alcohol use that belied the 'moderation in all things' philosophy that he had espoused throughout his life.

"He really missed her and he probably did ... like a lot of drinking after she passed away. We were getting a bit concerned ... other people were getting concerned about his drinking. He'd be doing things at the pub that he wouldn't normally do, you know a lot of things were out of character. So, quite often I would have to sit him down and say to him 'You did this and did that and people aren't very happy about that. So he would be back out there apologising to people.'"

Jeanette's narrative reflected surprise at how the parent-child roles had so quickly become compromised, or reversed. The person who best represented the separation of her life from that of her birth family, and the gulf that existed between the different lifestyles and values that she had witnessed, was no longer a source of stability, strength, and support. Yet, even more significantly, her ailing Maori adoptive father began to speak Te Reo; Jeanette could not remember her father ever having previously used his first language and he had never demonstrated more than a cursory interest in Tikanga. Yet, as his death neared, he spoke to Jeanette of how his "Pakeha life" had ignored his cultural heritage and how he wished to 'reconcile' with it. He identified his recent 'late onset' abuse of alcohol as masking his concerns. Jeanette did not understand what he meant by this, or how she could assist him to achieve it. His funeral was, therefore, more representative of his "Pakeha life".

Jeanette's described her subsequent life as a wife, mother, employee, and active participant in the community, as being fraught with self-doubts and "an identity crisis". She tried to establish links with her birth family but she described such efforts as having been met with indifference. Attendance at a birth parent's tangi did not provide the sense of inclusion that she had anticipated.

Meanwhile, her own family life was deteriorating. Her two oldest sons were increasingly arguing with their stepfather and demanding that Jeanette take them away from her once happy home. The boys' school life deteriorated, and their late teens were notable for alcohol and drug-fuelled crime that infuriated members of their small community. Jeanette's alcohol use escalated ostensibly due to much needed stress relief in the company of socialising work mates and sporting associates. Nightly 'after-work' drinks were accompanied by a "relaxing couple of hours" on the hotel slot machines. She often dreaded going home to the inevitable arguments. She expressed despair at how her much-loved mother and father would have regarded her gambling behaviours and the betrayal of trust she had inflicted upon employers and trusting community organisations.

Despite her adopting family paying little homage to their (Maori) cultural roots, and Jeanette having little exposure to Maori tikanga, she instinctively located her narrative in terms of her family of origin. As Neimeyer (2006) observes, it is frequently observed that life stories must be 'situated' within indigenous cultural contexts. While Jeanette had ignored, rather than denied, her Maori heritage throughout most of her life, her father's 'reconciliation' with his first language, shortly before his death, had had a profound impact upon her.

Christine's Story

The memoir is the gentlest style of quest story. Trials are minimised, but they are told stoically, without flourish. No special insight is claimed at the end, the insight is rather the incorporation ... of illness into the writer's life. Frank (1995, p. 120)

The consistent theme throughout Christine's narrative was one of "blocking it off", her description of cognitive and behavioural processes by which she attempted to distance herself from real and potential sources of emotional distress. She spoke of childhood physical and sexual abuse, by a relative, that she attributes for a lifelong distrust of males other than her father.

“For years I couldn’t walk down the street if a man was coming along. I would turn, like this, (twisting in her chair) and I didn’t even know the person, you know what I mean? They just scared me and I would go like that”

Christine’s story portrayed a close relationship with her father: “He was the only man I have ever loved”. Conversely, she expressed resentment towards her mother whose behaviours were described in terms of dysfunction and as a regular and unwelcome intrusion into a (potentially) happy family dynamic.

“I wanted Dad to hit her and shut her up. Then there was Mum’s drinking ... she was bad ... it was every weekend and we knew what would happen when they’d come home ... she would ...she was the one who was abusive to my father“.

Though her father consumed alcohol, he did not exhibit signs of intoxication in front of Christine or her sister. She recalled her childhood reasoning that “Dad’s can drink but Mum’s can’t”. And she did not begin to use alcohol until around 30 years of age. Christine attributed her own ‘late-onset’ use of alcohol to “blocking out” the anxieties of being in threatening social situations.

“It was the alcohol but I never used to like it ... but I used to be scared of people who were drunk so I would get drunk too so I wouldn’t be scared. There used to be a lot of alcohol at home”.

She had felt powerless to influence her home environment until learning of the suffering that her own children were experiencing. Christine described a devastating sense of betrayal by her husband but that paled in comparison to the overwhelming guilt that she experienced at having failed in her duty as a mother.

“That was the worst place ... The worst place I was in was when I was married to a guy and he was abusing my children. That was before it was fashionable and then it is all in the papers and he was a” (profession deleted to maintain confidentiality).

Christine's gambling began after the breakup of her marriage. Her small social circle diminished further as she avoided those acquaintances who were privy to the shame of her ex-husband's behaviours and her own failure as to protect her children. With her innate mistrust of strangers Christine cherished and nurtured a friendship with someone who was also "damaged".

"I had this older friend that used to like going to the casino and she had agoraphobia so she wanted me to go with her ... and I would just sit there and she would play this certain machine all the time and it bloody bored me. I'd sit right by her side ... she would say "Go and look at the other machines" ... you know ... and that's how it started and I found this machine and I played it and it was one of those machines that had music and bright colours and that's where it started".

As a solo mother, Christine's financial pressures mounted and her gambling and alcohol use were, necessarily, restricted. However, despite her innate fear of strangers, she "... drifted into prostitution ...".

"Yes well ... I was a solo mother and I had a wee part-time job in a hotel and it was a restaurant type and it closed down and I saw an ad for a receptionist and I was a receptionist but then ... you know ... "Come on down the side and so I did."

Christine directly attributed the escalation of her gambling behaviours to the humiliations that she experienced as a prostitute. While her need to provide for her children was paramount, and she would have done anything to achieve that end, she could not reconcile that cause with the shame and indignities that she experienced.

"Yeah ... it was always going into work. I was always worried about family finding out and stuff. I was so ashamed. I was a prostitute and that's when my gambling really started bad. Yeah ... I don't know why ... and my drinking got worse too. And when I used to start going to hotels I drank before I went so I could walk in. "

Christine associated the casino with a place of refuge from the men that she feared and a sanctuary from her anxieties and shame. She found solace in the anonymity of a venue which, by virtue of its crowded and noisy atmosphere, also provided safety.

“And ... yeah ... I don’t know ... and the casino was a place you could go ... not like a hotel where a woman walks in you know ... or yeah right ... she is there to pick up a man or whatever. It was a place where you could go and be anonymous and people didn’t know you weren’t there with someone else ... and you could just get lost in your own little world”.

But Christine also described another motivation for her developing gambling addiction. While her remuneration from prostitution enabled her to feed, clothe and house her children, and provide them with the luxuries that had been denied them in recent years, she could not enjoy, or even keep, the significant residual ‘earnings’.

“I think it was the lifestyle. It’s a case of ... you don’t deserve this money so I would get rid of it. Apart from the machines ... I used to buy people drinks ... I used to buy people stuff. This went on for three or four years. It got to the stage where I couldn’t stand the smell of a man “

But Christine’s exit from prostitution did not portend an end to her gambling. Despite vastly reduced finances she continued to attend the casino on a regular basis. Whereas she had previously used “the machines” as a distraction from the distress and shame of her prostitution, and a means of disposing of money that she considered ‘dirty’, the casino became a diversion from a life that was distressing and a perceived “way out” of her difficulties.

“It was just the things that moved and the excitement of getting the free games which is really wrong because the free games aren’t free at all are they?

Other “blocking out” behaviours that she had developed during her career as a prostitute escalated. Whereas, most of her co-workers engaged in drug-taking, Christine had begun self-harming ... many years later she was to be diagnosed with a mental health disorder and prescribed medications.

“All they wanted to do was prescribe me bloody pills ... whenever I went to mental health ... all they would ask about were the pills ... it was the only time they would actually listen to me. Then they decided my drinking was a problem and guess what ... they wanted me to take another bloody pill to stop me doing that. Makes you sick when you drink.”

The ensuing years as a solo mother on welfare benefits were incredibly difficult and exacerbated by her new ‘identity’ as a mental health patient. She now considered that her life was under the control of others who were making moral judgements under the guise of supposed medical imperatives. She baulked at the notion of being included on ‘a caseload’.

“... no ... we are clients now aren’t we. Some of those times were tough ... I only drank when I could afford it ... sometimes when I couldn’t. Same with the gambling ... but I could forget things for a while. But no one could understand that ... like the cutting”

Several years of married life have brought some relief from all of these behaviours. She spoke kindly of her husband but in terms that might be described as ‘a rescuer’. At times she has resented his ‘advice’.

“I’m not alone anymore. Kevin (name changed) tries to understand me ... he keeps me on track. But I still get angry sometimes and it scares me. Life’s not as bad as it was ... noand I’ve got a good friend who I can talk to ... she understands me. Sometimes we have a drink and sometimes we play the pokies ... but it’s not like it was.”

Christine had indicated her intention to adopt a chronological approach to her story and suggested that such an approach was essential to portray the antecedents of her addictive

behaviours. However, unlike Leonard's narrative which was consistent in terms of attention to time spans and developmental stages, Christine's narrative was fragmented with particularly traumatic periods of her life being either 'glossed over' or noticeable by a disintegration of the narrative. Christine's narrative alluded to these events, and she purposefully ensured that their relevance to her circumstances were understood, but in so doing her story lost its intended chronological structure. Remarkably, considering some of the events described, any elaboration that Christine proffered was noticeably devoid of emotional intensity in the telling.

Ellen's story

Much of Ellen's narrative was focussed on a childhood home environment in which her mother, grandmother and aunty determined and limited socialisation opportunities, educational and recreational pursuits, and vocational choice. Church attendance was deemed to be a suitable, and the primary, means of social interaction for "a young lady". Ellen's friendships were closely scrutinised and seldom encouraged. Infrequent visitors to the home were invariably adults and a level of decorum was expected even from the young Ellen.

"I never came into it. No one ever said 'well what do you want? What do you think?'"

She described her father as having psychological impairment from wartime experiences but, by virtue of heavy medication and "... social use of alcohol ...", as being able to maintain the required façade of normality. However, his role in the family was perfunctory in a strongly matriarchal environment. Alcohol was ever-present in the home, and imbibed on a daily basis, though consumption was regarded as appropriate and "proper" given the family's perceived social standing.

Accordingly, Ellen regarded her university experience, and subsequent attendance at an "appropriate" training institution as being epitomised by social awkwardness and complemented by resentment that she was vicariously fulfilling the frustrated career aspirations of the family matriarchs.

“But ... anyway ... profession and study ... yeah I resented it. I didn’t want to do what I did and it was always for the parents and everything was for somebody else.”

She began to use alcohol extensively in an effort to ‘relate’ to her peers and quickly developed a propensity for binge-type use. Though her alcohol use did not prevent her from completing her studies its increasingly problematic use manifested in a conviction for driving under its influence. Her family responded to this blight on its reputation by enrolling Ellen into a residential treatment programme, arranged by courtesy of the family’s General Practitioner, thus beginning her long association with AA.

“I heard the doctor say ‘I wouldn’t like to go into a room full of strangers and tell them my deepest darkest stuff, you know my personal things’. And he is right ... but you did and I didn’t have a one-on-one counsellor then and it was quite bizarre. I just existed, did what I was told to do and that was cool. But the people that were in there ... of conniving, manipulating, playing games because we had nothing better to do. Judgemental ... you’re this and you’re that ... and I remember one of them saying ‘you’re going to have a lonely life.’ God ... All these sickos and then I came out of there and kind of dabbled with AA and ... kind of kept it ... because I did my ninety meetings in ninety days and then got out of the programme and kept it going and got back into my profession.”

“But the programme itself ... to me ... I learnt more about drugs and addiction met some amazing characters. I certainly saw a side of life that wasn’t my life. Then all the clichés ... I mean ... I have still got some of them and I still use some of them and say some of them. The words are stuck and I hate using them. It was like ... read this book and then you will this and that and this and that and it was the same dictatorial crap that I had had all my life ... and who are they to tell me ... friggin bloody drunks out of the gutter ... what?”

Ellen's marriage in her late twenties did not assuage her use of alcohol or dissatisfaction with her professional or social lives. Her husband became a new, albeit more moderate (than her parents), authority figure. Like her parents, he could not easily acknowledge Ellen's accomplishments. And Ellen believed that her inability to have children cast a dark shadow over the marriage. She believed that, like her family, he did not understand endometriosis or the pain that she had experienced.

“That was another thing that we didn't pick up until I was 32 so that had huge implications because through my teens they took collagens and all this stuff where really I was just in pain and alcohol was a great pain relief, especially on a Friday night when you have been working all week and ... oh ... tell me about it.”

Her husband struggled with her 'before, during, and after' dinner wines and frequently 'encouraged' her return to AA. But, she continued to struggle with the “public disclosure” demanded by the fellowship, the perceived judgemental attitudes, and her inability to relate to members.

“... and you're trying to help these people ... picking them up, taking them out ... and they dick you around. But putting it out there, putting out your private business to these people. Just ... no. Not the way I was brought up. It wasn't all bad ... I did learn some things.”

But she resented having to attend meetings at the behest of others. The occasional social acquaintances that visited her home invariably sided with her husband who would warn them of Ellen's 'problem' and she would react accordingly.

“No matter how tough a day I had had ... I would go out on a Friday night and go to the deli and cook a nice dinner for us all. I know I would have a couple of glasses of wine before dinner and a couple of glasses after and then fall asleep on the couch. Oh my God ... she has drunk the whole bottle. Oh my God ... that was just a tragedy that was terrible. Huh ... have one with me ... you need it ... cheer up”.

Ellen has had a GP referral, and a subsequent self-referral, to the outpatient alcohol and other drug service at which I am employed. She has seen two clinicians and pursued a ‘controlled-use’ strategy that, to date, is working well for her. But most of, she describes her life as ‘happy’.

Ellen, perhaps reflecting her academic training and her love of reading, sought to impose order on her narrative. She had devised ‘chapter headings’ that corresponded to significant developmental life stages but which were also rich in metaphor. Within these largely chronologically-ordered episodes were thematic story-lines and it was in these that I began to identify the meta-theme “dissonance” which is elaborated on in the analysis.

5.2 Attributions of Aetiology

Several of the participants described family histories which might be suggestive of a genetic predisposition to addiction. The stories of Darren, Leonard, and Jeanette included reference to heavy drinking fathers and pervasive use of alcohol by other family members. Christine’s and Ellen’s narratives suggested social learning processes during their formative years.

It would be reasonable to suggest that any alcohol and other drug assessment would give considerable credence to such variables in a formulation of causative factors. Indeed, a number of participants described family history of alcohol use as having been treated as a revelation by assessors with subsequent family disruption being recorded as a consequence of the parent’(s) addiction. But, while such dysfunction in family life was purported to have contributed to possible developmental issues, participants’ addictive behaviours were, frequently, reported as having been associated with genetic predisposition. Such attributions were not confined to 12-step engagements but also described as having occurred, along with various social learning processes, in the formulations of outpatient alcohol and other drug treatment providers.

Natalie's narrative was atypical in that she specifically denied familial or heritable influences in the development of her addictive behaviours. Indeed, she protested that her family origins, and siblings, were so "normal" that she was to assume a "black sheep of the family" persona. This 'sense of self' as 'different' initially occurred as the result of her physical disability that meant that, while she was doted on by her older siblings, she was bullied during her early schooling. Even then, she sought out the company of schoolmates who were outside of the 'mainstream'.

The punk rock movement provided Natalie with her much-needed 'social identity'. 'Difference' was celebrated and demonstrated in the extensive use of illicit substances as well as alcohol and cannabis. She did not feel compelled to use, it was just 'what they did'. Escalating use of opiates further marginalised the group and, in response to the stigmatisation, the bonds between them tightened and they withdrew into their own 'community'.

+ + +

When initially referred to specialist mental health and addiction services, the primary health referral had recorded Leonard's attestation that his use of alcohol, throughout his 22 year marriage, had been deemed as a means of "stress reduction and winding down ..." at the end of the working day. By the time of his presentation to outpatient treatment services, his diagnosis of depression was accompanied by alcohol usage that suggested, and was also described by him, as a self-medicating behaviour. His father's use of alcohol was accentuated as affirming the proffered diagnosis of alcohol dependence which accompanied diagnoses of emphysema and active hepatitis C.

Leonard's narrative confirmed circumstances that had been determined, during comprehensive assessment, as possible predispositions for addictive behaviours. His description of his father's alcohol issues had suggested possible heritability for an alcohol or other drug disorder. Similarly, social learning processes, occasioned by the frequent parties hosted by his mother, were deemed likely to have impacted during early and impressionable developmental stages.

His narrative, however, provided powerful elucidations of a need for social acceptance as well as companionship. In particular, he described the childhood friends, with whom he had maintained contact over many years, and his awareness of a 'social divide' constituted by his modest family circumstances. The alcohol-fuelled indiscretions of the young group had led to his temporary banishment from the more affluent homes of his friends with a perceived implicit attribution that he, by virtue of his upbringing, was having an undue and negative influence upon his young peers. While Leonard protested that he was not the 'ringleader', and considered himself privileged to even be included within this reference group, the community was adjudged to have attributed responsibility to him. When the group was permitted to reunite, and in the years that followed, alcohol-use was a constant and 'necessary' obligation of membership. While Leonard described the joys of these teenage years, his insecurities regarding continued inclusion and acceptance were clearly evident. Even his description of his triumphant return from a working holiday in Australia, having accumulated significant savings despite continued heavy alcohol use, was couched in terms of earning the respect and acknowledgement of his peers. As such his narrative exemplified the self and social identity vulnerabilities that Walters (1996) identifies as significant precursors to addictive behaviour. That the small town to which he returned, and much of provincial New Zealand, continued to embrace a 'culture' of heavy alcohol use provided a societal norm that, to Leonard, was inescapable.

+ + +

Darren's attributions regarding the aetiology of his addictive behaviours were not rooted in societal or cultural influences but imbued with causal implications at familial and interpersonal levels but still, overwhelmingly, a disease process. His formative years were described in terms of the pervasive influence of his father's alcohol use which impacted all aspects of family life. Darren told of his trepidation about inviting childhood friends to his home and the possible embarrassment at his father's behaviours. Following the departure of his mother, for another relationship, the deterioration in the home environment seemed to correspond to his father's escalating alcohol use and declining health. Darren interpreted the progressive departure of his older siblings from the family home as a further sense of abandonment on top

of his mother's perceived indifference to the welfare of her younger son. Darren remained in the 'care' of his father, a man who demonstrated increasingly bigoted responses to those, including his ex-employer and ex-wife, who criticised his alcohol use and who found little joy except in the company of his few remaining (heavy-drinking) friends. Medical issues, possibly linked to his alcohol use, added to the misery of his father's existence. Darren knew his father as "an alcoholic" and a man who responded very negatively to suggestions that he should seek help.

As Darren's experiences of binge-type alcohol use, in his late teens, increasingly ended with alienation from his 'new' friends, and emotional distress, he readily adopted the "alcoholic" label which was endorsed by the AA group to whom he went for assistance. Darren considered his affiliation with AA to be the important differentiation between himself and his father, the source of his (to Darren) undoubted genetic predisposition to alcohol and the other addictive behaviours to which he would "progress".

Darren's narrative, however, offered multiple alternative explanations. His emotional discourse of difficulties in relationships involving partners, siblings and (more latterly), employers indicated that such breakdown of interpersonal relationships often occurred prior to lapses into substance use or other addictive behaviours rather than as a consequence. The sense of anxiety that pervaded his childhood friendships was evident in his stories of interpersonal, vocational and recreational difficulties. At times of intense emotional distress Darren would present to mental health and addiction services citing the pervasive effects of substance dependency on his sense of wellbeing. Perhaps, as Davies (1992, cited in Bailey, 2005) contends, it can be functional for persons to conceptualise their addiction as 'learned helplessness' rather than suffer moral condemnation or concede alternative reasons for relationship problems.

+ + +

The prevailing theme in Jeanette's narrative was "being lost". In spite of her role as a wife and mother (albeit of offspring who seemingly took turns at "going off the rails") she described the

passing of her adopting parents as “losing her anchor”. Despite having been raised in a secure and nurturing home Jeanette’s knowledge of her birth family, and the way that they lived their lives, remained imprinted on her sense of identity.

She had left a relationship with the father of her two oldest sons for fear of the boys being scarred by the frequent alcohol-fuelled violence that they were witnessing. Yet her own use of alcohol escalated some years later in the context of work relationships (regular after-work socialising), sporting and social events based around a local hostelry, while family interrelationships dissolved into acrimony.

All of these ‘community’ activities enabled access to slot machines with “the occasional flutter” developing into two or three hour long “full-on sessions”. She described not wanting to go home to inevitable arguments and recriminations. She often thought of abandoning the family and moving away “to find myself again”. This ‘detachment from responsibilities’ extended to employment roles where, to satisfy the increasing financial costs of her “need” to gamble, she began to engage in fraudulent accounting practices.

Jeanette described the absence of a discernible self-identity and social identities complicated by community attitudes regarding the petty crime of her children; she was revered by some for her community involvement and shunned by others as an ‘obviously’ poor mother. Having been raised to be an obedient and well-behaved teenager, she heard her own parenting skills being described in terms that were comparable with those of her birth parents and she wondered whether she had somehow ‘inherited’ these; she did not regard alcohol use and gambling as heritable, or even addictive. Her roles as a wife and mother were compromised and her self-esteem was inextricably tied to them. Alcohol and gambling were an escape from responsibilities that she could no longer uphold.

+ + +

Christine identified her addictive behaviours as being a response to emotional stressors in the same manner in which self-harming (“cutting”) was later perceived to alleviate emotional

pain. Childhood sexual abuse denied her the trust and safety that the family home should have provided and left Christine with a profound mistrust of all males other than her father. Meanwhile her mother's drinking behaviours brought dysfunction upon all familial interrelationships. She adapted by avoiding such confrontations and found sanctuary in her own company.

Alcohol was a means of allaying her own fears and anxieties of being around intoxicated people; her increasing use corresponded to her exposure to threatening social situations. The "betrayal" by her husband exacerbated her mistrust of others and caused her to further rely upon her own counsel. Problematic gambling behaviours developed as Christine found a refuge from the psychological "hell" of her life as a prostitute.

+ + +

Ellen's aetiological attributions were clearly embedded in a lack of socialisation and a fragile self-esteem. The virtual exclusion of childhood friends from her home had inevitable consequences in her school life where, despite the similarly affluent families of her fellow pupils, she was regarded as 'different'. At home she was denied encouragement or acknowledgement of her academic or sporting accomplishments – success was expected. Perhaps inevitably, her endeavours in both of these domains were increasingly in solo pursuits rather than team environments.

During her university studies alcohol was a means of 'bridging the gap' between herself and the students who so easily 'fitted in'. The pain of her (undiagnosed) medical condition encouraged her to seek 'relief' in alcohol much in the manner that she had seen her father do throughout her childhood.

5.3 Participants' Constructions of Addiction

Participant constructions covered the spectrum of theoretical perspectives of addictive behaviours and were expressed as immoral behaviour, maladaptive behaviour, and a disease state.

The latter, exemplified by the medical model, suggested to participants an unremitting progression without 'expert' or 'fellowship-type' intervention, and imposition of a diagnostic label or lifetime adherence to an 'alcoholic' or addict identity, with associated admission of powerlessness over the substance or behaviour.

All participants had some experience of 12 step philosophies, however, attendance at community-based (AA/NA/GA) self-help groups had often been conceived of as a self-instigated initiative where the level of engagement was under the control of the participant. Despite such attendance sometimes having been coerced by employers, GP's or significant others, several participants suggested that joining AA was on a continuum of initiatives by which they were "taking control". Reasons given for engagement with 12-step residential programmes varied from an unnecessary and premature response by family to a legal indiscretion in the form of a first drink-driving offence (Ellen) to a very necessary intervention at a time of severe emotional distress associated with substance misuse (Darren). During intervening years Ellen, who had subsequently attended several residential programmes during her early to mid-adulthood, had defied the 'alcoholic' label and thus had experienced numerous turbulent engagements with the AA fellowship over a 24-year period.

A consistent theme in withdrawing from such engagement was a dissonance between an initiative associated with self-empowerment and a philosophical insistence on an admission of powerlessness. Similarly, adoption of an 'alcoholic' or 'addict' label was an anathema to several while one participant spoke of vehement accusations of 'denial' being directed towards her when her 'story' failed to express having 'surrendered' to the effects of alcohol.

Attendance at an outpatient treatment programme, the association with which had led to recruitment in the study, was often regarded as being towards the end of the continuum of self-help initiatives and was associated with a resignation that alleviation of distress might no longer be self-determined. Indeed, Gossop, Eiser and Ward (1982, p. 193) suggest that clients presenting at outpatient services are more typically resistant having “... tried and failed to give up...” and were more likely to deny the likelihood of successful treatment. For several participants, such attendance had been under referral from a General Practitioner, or other primary health professional, with diagnoses of substance dependence already proffered.

Natalie, having experienced numerous treatments including detoxifications, residential programmes, and two episodes of methadone maintenance, had had considerable exposure to the discourses associated with medical and disease models of addiction. However, she had “... never really ...” engaged with 12-step philosophies and not attended community ‘self-help’ meetings unless mandated by a residential programme provider.

Despite the protestations of caseworkers from the methadone maintenance programme, Natalie had never considered her alcohol and cannabis use as unduly problematic and certainly not ‘a disease’; her level of use was typical within her peer group and, despite developing health issues in later years, she could not imagine her life without either substance. Such use remained integral to the ‘group’, it identified their marginalisation within society in the same manner that opiate use once had.

Natalie’s opiate use, which had been acknowledged as having been beyond her (then) control to moderate or cease, was also not considered as ‘a disease’. It was, in Natalie’s view, undoubtedly an addiction but she used the medical model’s own conceptualisation to belie its disease status; she no longer used (or even thought about using) opiates and, therefore, it could not have been ‘progressive’ or ‘chronic’. Opiate use was no longer an issue for her but she conceded that for others the disease model might have utility; that is, for those who didn’t want to take responsibility or for those who couldn’t ‘leave it behind’.

Thus, the disease concept was considered ‘an end state’. Leonard had tried to reconcile his referrals to MH and outpatient AOD services, and his expectation that his alcohol issues would be ‘medicalised’, in the same way he interpreted his recent diagnoses of emphysema and hepatitis C. However, despite his ready acceptance of a disease state for his lung and liver conditions, and acceptance that both disorders had emanated from substance use, he directly attributed his emotional distress and alcohol-related issues to developmental origins, socially-acceptable learned behaviours, and maladaptive responses to interpersonal and societal stressors.

Leonard’s conceptualisation of his long-standing (almost lifelong) alcohol use, and his briefer but intensive and devastating foray into intravenous opiate, was expressed in the context of his significant relationship’s; with his mother and those who attended her ‘party-house’, with the friends who were his constant companions throughout his childhood and adolescence, with his ex-wife, with his opiate-using acquaintances, with his work-mates on the contracting site, and finally, his daughters. These relationships were described as flourishing and waning according to a multiplicity of psychosocial stressors and a cultural environment that condoned heavy alcohol use but denigrated illicit drug use. His use of opiates represented a period of self-loathing, in accordance with his view of societal attitudes, during which he was estranged from those he loved and who, despite his estrangement from them, still loved him. The ‘acquaintances’ who initiated him into intravenous use provided companionship (albeit self-serving) when he needed it. His subsequent alcohol-fuelled excesses on the isolated contracting site were described in terms of his search for ‘acceptance’ with workmates who were engaging in alcohol consumption that was condoned and expected in such an environment

These conceptualisations of addictive behaviour, typical among participants who resisted the connotations of the disease model, challenge supposedly ‘expert’ discourses of dysfunction. Substance use and gambling were contextualised as ‘functional’ in coping with the demands of dysfunctional relationships in various life domains, as well as pre-existing or developing psychological distress. Despite increasingly distressing consequences, engagement in addictive

behaviours still represented the ‘known’, a life generally regarded as more tolerable than the ‘unknown’, a life divorced from the perceived comfort of the substance or behaviour. The addictive behaviour represented an adaptation, a means of coping with dynamic relationships within social worlds, as well as deterioration in the conceptualisation of self as social interrelationships failed to provide succour.

+ + +

As Burrell and Jaffe (1999, p. 43) suggest, having cultivated and ‘lived’ an addict identity for many years, many people have limited ability “... to reconstrue the self in other terms ...”.

Darren’s narrative exemplified the disease conceptualisation of addictive behaviour; it was described in terms of having permeated every aspect of his life for several years, impacted his current enjoyment of life, and had the likelihood of being the primary, if not sole, determinant of his future wellbeing. His account was, at least initially, dismissive of alternative explanations for difficulties in financial circumstances, severely strained relationships, and an erratic engagement in employment. In the same way that Darren had been able to maintain affection for his father, by attributing all of his unpleasant and demeaning attitudes and behaviours to the demon of his alcoholism, he could blame all of his own behaviours on addictive behaviours.

Darren seemed to take some comfort from his attributions. Episodes of lowered mood and anxiety had typically been explained within a context of addiction rather than the life events that had often precipitated episodes of extreme emotional distress.

His impassioned account was almost devoid of expressions of self-efficacious capability. Whereas he had previously placed total reliance on, and confidence in, his adherence to the 12 steps, his current (and intermittent) estrangement from the fellowship, and regular (albeit minor) lapses into his addictive behaviours, had translated an acknowledgement of powerlessness into a profound sense of helplessness. Alleviation of distress was conditional upon abstinence from alcohol and cannabis use, if not other addictive behaviours, and

Darren's prognosis was constituted by his understanding, heavily influenced by the experiences with his father, of addiction as progressive and chronic.

Darren's disease connotations for his addictive behaviours appeared to have shielded him from, at least acknowledging, more painful self-concepts.

Frances (2010, p.3) contends that adoption of an "addict identity" may be associated with the following connotations:

1. *The substance has already gained a central and difficult to end role in the person's life*
2. *It will be terribly difficult to give up because of psychological and/or physical dependence and painful withdrawal symptoms*
3. *All this is somehow biological, fated in the genes, and outside his control or ability to change*
4. *The individual has reduced personal responsibility for substance use and its consequences. Being "addicted" can become a self-fulfilling prophecy and a great excuse for not meeting responsibilities to self, family, school, and the legal system*

From the constructivist perspective Johnson, Pfenninger and Klion (2000) posit that threats to the client's conceptualisation of the 'disorder', if it has become part of the sense of self (e.g., "I am an alcoholic"), may result in "dissolution of the core role or self". The disease model was useful so long as he was abstinent and supported by the fellowship but his unwillingness to re-engage with AA demanded alternative explanations.

+ + +

Jeanette did concede a 'progressive' escalation of her addictive behaviours (gambling and alcohol use) but could not accept a 'disease' state; the escalation corresponded to the intensification of emotional distress and sense of 'a loss of identity' rather than any 'physiological' process. Inherent in such conceptualisation was an expectation that alleviation of stressors would 'automatically' result in a commensurate reduction in 'escape' behaviours.

However, Jeanette had begun to question her ‘sense of self’ and her ‘dislocation’ from her family of origin. While denying “genetic stuff” she wondered how she had adopted similar behaviours to her birth parents, and many of her siblings, when such behaviours had, for the most part, been absent in those who had raised her. Similarly, she deliberated on her own (frustrated) sense of responsibilities as a wife, mother, and member of the community when such roles, seemingly, were not highly regarded by her family of birth.

The deaths of her adopting parents had exposed Jeanette’s underlying ‘crisis’ of identity; with her overtures to her family of birth having been rejected, and her family embroiled in dysfunctional interrelationships, she was ‘lost’ and the local hotel, with its “pokies”, was somewhere that she did not have to face her dilemmas.

+ + +

Similarly, Christine rejected any notion of having experienced a developing physiological tolerance to alcohol but described escalation of use as an inappropriate, and eventually ineffectual, response to psychological stressors. She deemed alcohol use as having been the most ‘practical’ and ‘available’ panacea for a debilitating social anxiety and (to her) a reasonable and rational fear of intoxicated people. It allowed her to engage in social settings that she believed would otherwise have been inaccessible to her.

She was offered alternatives by medical practitioners but rejected the proffered sedative ‘solutions’. After all, alcohol was acceptable ... everybody used it ... whereas pills implied disorder, difference, and deficit. Alcohol made her ‘equal’. Her rejection of medications (prescribed or illicit) was reinforced by her experiences in the sex trade as she observed her colleagues’ ever-increasing use of sedatives, opiates, and “whatever they could get their hands on”.

“Pills mean you’re different.”

Nightly visits to the casino represented a disengagement from a lifestyle that belied her values and her perceptions of her role as a mother and nurturer. She could become absorbed by the slot machines and forget the identity dilemmas that plagued her. Losses didn't matter ... it was 'dirty money' that she was giving to the machines anyway. It was not an addiction so much as an increasingly needed psychological detachment. She enjoyed the anonymity ... the lack of judgement. Yet she watched others in the casino ... and she could see the differing needs of others at nearby machines; in some of those she recognised as 'regulars' she saw the same need for 'escape'.

+ + +

While Ellen's career was deemed, by her AA fellowship, to have succumbed to the 'disease of alcohol addiction', Ellen regarded such a 'cause and effect' attribution as simplistic and dismissive of the power imbalances that had pervaded her professional environment. She realised that she had transferred the submissive persona, that had served her well and was appropriate during her highly controlled and structured childhood, into the workplace and that it had been cruelly exposed in an environment that she believed encouraged self-promotion rather than competence. The 'acceptable' late afternoon imbibing, into which she had been socialised in the family home, became increasingly problematic as alcohol was consumed in the context of the daily irritations and frustrations of her career.

Marriage had provided a stability and alternative focus to her life though her husband's "simple approach" to life failed to satisfy her want for intellectual stimulation and her need for a close confidante. Though Ellen had a longstanding recreational pursuit, that she had once longed to pursue as a career, she could not translate the 'acquaintances' that she made into close friendships. Her reserved demeanour in social situations, when sober, continued the socialisation dilemmas of her childhood. This sense of 'being different' had been exacerbated by a sense of incompleteness engendered by her inability to conceive due to endometriosis. Her narrative suggested that she struggled to cope with, and began to avoid, social situations where motherhood and children comprised the default topics of discourse. "A couple of drinks at home" were eminently more comfortable.

However, the endometriosis was an undiagnosed condition for a number of years and was the source of considerable pain that was neither alleviated by prescribed pain medications nor understood by a sceptical family. Ellen admitted that alcohol use provided a means of ‘escape’ from both the physical and psychological pain of her “silent illness” much in the manner of the Khantzian and Albanese’s (2008) self-medication hypothesis (SMH).

The resentment engendered by her enforced removal from professional life, following another drink-driving infringement, was accompanied by umbrage that her binge-type use of alcohol received stereotyped attributions of causality and perpetuation. Her alcohol use was a real problem and she longed to explain what it meant to her. Her ‘audience’ had always been the AA fellowship and the medical services to which she would go when “the shit hit”, and both had similar and entrenched explanations proffered under the guise of ‘expert’ discourse.

These explanations offered little in terms of solace and alcohol use usually followed closely behind attendance at either form of meeting. As Hammersley, Jenkins and Reid (2001, p. 147) suggest “There are limits to anyone’s capacity to affect, or refuse to accept, how they are categorised by others; the line of least resistance may be a return to use.”

Ellen’s conceptualisation of addiction included themes of ‘learned behaviour’ and self-medication for both psychological (anxiety in social and professional settings) and physical (endometriosis) conditions. Despite such varied attributions, Ellen described the addictive behaviours as if they should be entirely understandable and acceptable in the context of her life circumstances; the development of those behaviours were as little ‘her fault’ as if they had been iatrogenic in origin.

+ + +

Participant narratives conceptualised addiction in terms of a repertoire of behaviours that had, at varying times, served some purpose or function in their lives but which had increasingly been deemed problematic, distressing or dysfunctional in terms of their current and future

sense of wellbeing. The range and extent of disruption to specific life domains or roles varied between accounts, however, according to the magnitude of the ‘relationship’ that each participant had with the addictive behaviour.

Most of the participants described the substance(s) or behaviour in a manner akin to that which might be accorded an old friend ... frequently thought about, sometimes missed, sometimes derided over past incidents or indiscretions on the friend’s part, but still regarded as having been a past accomplice or intimate. .

One participant described alcohol as being like his mother-in-law ...in the early days she had been wonderful, good humoured, and trustworthy. Encouraged to develop the metaphor, he related how he had enjoyed her company and could not believe how lucky he was ... “she helped me out a lot”.

However, as time went on, she (alcohol) frequently assumed a privileged position demanding that her role be considered (and her voice heard) in the marital, or any other, relationship that the participant engaged in. She had an opinion on everything and increasingly began to undermine him. He suggested that she (alcohol) was chipping away at his self-respect behind his back and bad-mouthing him to his family, friends, employer, and anyone who would listen. To his face she was amicable, complimentary, and extolled his virtues. Behind his back she would tell everyone, and particularly his wife, how he could do nothing right. When he eventually realised what she was up to, he vowed and declared (to the fellowship) that he would have nothing further to do with her ... that she would be banned from his home and he would never acknowledge her in public again. But as much as he wanted to disown her, and never hear her name again, she was well known in the community ... and she was liked. Only a relatively few people knew her as he did ... as ‘two-faced’. He decided that he could maintain a respectful but guarded relationship with her ... but he would always be careful and would never trust her again.

Perhaps surprisingly, the relationship with the substance or behaviour was seldom expressed in negative terms. However, when the participant (Darren) subscribed to a disease

conceptualisation, the substance or addictive behaviour was given human characteristics and described as “insidious”, “cunning”, and “patient”. While both substance use and gambling were styled as adaptive behaviours, the latter was, undoubtedly ascribed with connotations of immorality whereas substance use was regarded as maladaptive.

5.4 Participants’ Constructions of Recovery

All of the participants, with the exception of Darren, indicated conceptualisations of ‘recovery’ that encompassed alternative domains of wellbeing rather than a narrow focus on the alleviation of addictive behaviours. ‘Recovery’ for these participants was expressed in terms of self-determination, redemption, alleviation of emotional distress, and psychosocial integration.

Natalie struggled with the concept of ‘recovery’. To her ‘recovery’ meant abstinence from alcohol and cannabis and attendance at AA. However, she was able to articulate ‘wellbeing’ which, for her, was constituted by companionship. Natalie’s ex ‘punk’ associates have largely moved on with their lives and, for those that remain, ‘dislocation’ is now a reality that is no longer voluntary. Illness and stigmatisation (resulting from the addictive behaviours rather than the other ‘alternative’ choices of years ago) have forced most of her past associates into lives of isolation.

For Natalie, ‘recovery’ therefore had connotations of alleviation of clinically-determined symptoms of pathology. ‘Wellbeing’, however, represented a renewed sense of self which was associated with meaningful relationships that could emulate the ‘love’ and the ‘trust’ that she experienced as part of a tight-knit group living ‘on the edge’ of society. Natalie expressed her hope that a ‘permanent’ romantic attachment has not eluded her and that she would “quit” alcohol and cannabis use if she met her “soul-mate”.

Leonard, by virtue of the hepatitis C infection that had been addressed, and the emphysema which he was still coming to terms with, offered a unique perspective of diversity in notions of recovery. The achievement of recovery, in terms of his hepatitis C, was expressed as being contingent upon continued remission from the infection. Similarly, Leonard considered any resumption of opiate use as an anathema in his multifaceted conceptualisation of recovery and at variance with his vision of psychosocial reintegration. However, he was progressively assimilating a notion of ‘incompleteness’ and compromise in terms of his emphysema that was not based upon his continuing struggle to cease tobacco use; rather he was integrating the debilitating and varying impacts of the disease into the vocational and recreational domains of his future goals.

Likewise, but with ambivalence about ‘disease’ connotations, Leonard had incorporated moderated use of alcohol into his model of future wellbeing. Whereas an initial and significant reduction in the quantity of use had been assisted by his reduced circumstances Leonard had succeeded in virtually eliminating solitary drinking behaviours and deploying effective ‘controlled use’ strategies in social settings. While such efforts, and his ambivalence towards a commitment to abstinence, had failed to impress his AA fellowship, his determination to make positive change was encouraged within a treatment facility accepting of ‘harm reduction’ models. Strategies were developed to encourage social ‘reintegration’ and vocational rehabilitation while he underwent the physically and emotionally demanding treatment of his hepatitis C infection and began to accept the certainty of permanently compromised lung functioning. With reduced alcohol use his ‘dysthymic’ mood was able to be assessed and treated.

However, these rehabilitative processes did not constitute ‘recovery’ for Leonard. For him, ‘recovery’ was encapsulated by terms such as “acceptance”, “equality”, “participation” and “giving back”. In short, Leonard sought the companionship and societal inclusion that he had long considered contingent upon the use of substances to enable social interaction. He craved the parent role that substance use had compromised for many years and the opportunity to demonstrate his love of his daughters. He sought recognition as a contributing member of the community and society that had assisted him when he had reached his “rock bottom”. He

would not deny the profoundly negative impacts that alcohol, and opiates, had inflicted upon every one of his life roles ... he just had no need of “alcoholic” or “addict” labels in his pursuit of “equality”

+ + +

Conversely, Darren described ‘recovery’ first and foremost in terms of an alleviation of his addictive behaviours. While his narrative was beset with examples of interpersonal difficulties and a lack of sustained and meaningful participation in life roles, his purported focus in recent years had been primarily on cessation of alcohol and or cannabis use. His narrative identified that presentations to mental health or addiction services, in recent years, had followed some form of dislocation most typically within the domains of interpersonal relationships or vocational pursuits. Presentations following relationship difficulties usually constituted a ‘negotiated attendance’ by which he had agreed to attend specialist services following his attribution of the current difficulties to substance use.

Though conditioned to disease/medical model connotations of a progressive and chronic condition, Darren’s descriptions of presentations were portrayed as ones of emotional distress in which alleviation of symptoms were often not addressed with the immediacy that he had believed had been warranted. However, his narrative recorded that ‘satisfactory’ outcomes from such attendance had been development of a comprehensive treatment plan, which acknowledged the primacy of addictive behaviour in his distress, and, ideally, included referral to a residential programme.

Darren’s conceptualisation of recovery, despite his narrative suggesting some concessions to a previously entrenched belief in ‘disease’ connotations of addictive behaviours, remained overwhelmingly constituted in control over the substances that had ‘beset’ him. Consequently, proffered opportunities to pursue relationship counselling or vocational training had been, politely, deferred until the imperative of abstinence from substance use had been addressed.

+ + +

Jeanette struggled with the notion of ‘recovery’ due to its association, in her own community, with her cessation of gambling. She aspires to ‘reintegration’ into her local community and that process involves redemption (by way of restitution) and forgiveness. She is aware that while her alcohol use may have been regarded as ‘maladaptive’ but tolerable, by a community that accepts heavy alcohol use, her gambling was assuredly ‘immoral’ because the victims of the resultant fraudulent behaviours were community-based organisations.

She regards neither of these addictive behaviours as still being problematic for her, in the sense of them being beyond her control, but struggles with the continuing community disapproval of her attempts to engage in social activities. Only with ‘reintegration’ will she achieve ‘recovery’.

+ + +

Christine still gambles on slot machines “occasionally” but no longer seeks out the casino as a place of refuge. While she still feels ‘shame’ at her past participation in the sex industry she no longer needs to ‘escape’ as she did when actively involved. Slot machines no longer provide, or are needed to provide, the total sense of dissociation that she had needed during those difficult times. The slot machines, simply, have lost their allure and she can walk away after “throwing away a few coins”.

Likewise, alcohol is “... no longer an issue”; she drinks occasionally but does so in the company of her moderate-drinking partner of several years. She does not frequent the places that provoked such fear or associate with heavy drinkers.

But while gambling and alcohol use are no longer problematic for her, or the source of emotional distress, Christine does not consider these outcomes constitute ‘recovery’... nor did she ever. The focus on her alcohol use and her gambling were necessary interventions, and she was grateful that ‘harm reduction’ outcomes were ‘negotiated’ with AOD and mental health services, but these were only ‘symptoms’ of her emotional distress and lack of integration

+ + +

Ellen stated “I didn’t want to be ‘in recovery’ – I didn’t need to recover from alcohol. I wanted to feel good about myself and get on with life”. Alcohol cessation, therefore, as demanded by her AA fellowship and recommended by her medical practitioner, contrasted with her sense of an unfulfilled need for ‘self-determination’. While medical issues had prevented her from becoming a mother, it was the familial and professional ‘controlling’ to which she believed she had succumbed as a person. Alcohol use, though serious and problematic, was peripheral and secondary to such dilemmas and engagement in ‘treatments’ that denied or minimised such factors were summarily terminated.

She described the current resolution of these dilemmas in terms of “lifting the lid off”, a metaphor for refusing to, any longer, suppress her own desires, expectations and aspirations. She had developed an assertiveness that extended across all life domains; she became more active in the completion of a prolonged house renovation project initiating employment of subcontractors for jobs that her husband had delayed for two years; she insisted that her medical practitioner address issues that had long been attributed to her alcohol use, and received appropriate and effective medication; she assumed responsibility for the healthcare of her, now, ailing mother and clearly addressed perceived deficits in her care; she nurtured a new friendship that provided her with, and facilitated, social interaction;

“I’ve got a very good friend who has shown me what my parents didn’t show me in socialisation and interaction with people and that has been amazing.”

Ellen adopted ‘controlled use’ strategies for alcohol and reduced her use without undue problems. Most of all, she no longer ruminated over her past career or familial resentments ... and she reported being happy.

5.5 Meta –themes

While each of the narratives was a unique and intimate exposition of participants' experiences of the initiation, development, and (at least partial) alleviation of addictive behaviours I became aware of four compelling and overlapping themes.

In the aetiology and experience of addictive behaviours, 'dislocation', 'adaptation' and 'dissonance' were predominant; two of these themes (adaptation and dislocation) have been well documented in the works of Alexander (2008) though his elaboration of 'dislocation' appears to be more embedded in cultural, societal, and global economic influences. Most of the participant narratives portrayed dislocation processes at more proximal interpersonal levels and experienced more in accordance with the explication of Adams (2008). Accordingly, the theme of 'dissonance' is afforded greater attention.

Dislocation

As social beings, each of the participants expressed either a failure to engage with desired social identities and relationships, or disengagement with relationships in the form of interpersonal romantic or familial connections, vocational pursuits, or wider cultural paradigms.

Natalie's narrative (regrettably abbreviated in this study due to afore-mentioned ethical considerations) provided an alternative, rather than contrasting, perspective in that she had consciously sought out a 'sub-culture'. Despite an upbringing in a loving and supportive family, in the punk music culture she had found solace in the company of people who revelled in being 'different'. Initiation into alcohol, cannabis, and eventually, opiate use had been peer-led and fuelled by a wish to belong. Despite having experienced the physical and emotional ravages of intravenous opiate use, and the intense commitment to achieve two voluntary withdrawals from opioid substitution programmes, Natalie gravitated back to the remnants of her chosen social group citing that sense of belonging. Though she had maintained (albeit sometimes strained) relationships with her frustrated, bewildered but supportive siblings, she

now resided amongst a group for whom heavy alcohol use and cannabis use was still the norm. The dynamics of the group were always changing, due to illness, imprisonment, or remission from addictive behaviours, but they were “her people”. They didn’t judge her, and they understood her. The process of dislocation had been self-initiated but was now considered irrevocable.

Christine, Darren and Ellen described dislocation processes, attributed to non-normative childhood processes of socialisation, which would portend difficulties in adult interpersonal relationships.

Jeanette enjoyed a happy and secure upbringing but experienced, during visits to her birth family, a sense of dislocation in that her siblings were enduring a far less privileged childhood. She witnessed the drug-fuelled violence that they were exposed to and wondered how and why only she had been spared. It was only upon the death of her adoptive father (her “anchor”), and his self-recriminations at denying his own cultural heritage, and the increasingly dysfunctional interrelationships among her own family, that she sensed a need to really engage with her birth family and find her cultural roots; these approaches were greeted with ambivalence by her siblings and rebuked by her own husband and children. Ironically, the pattern of dislocation would reach its zenith when her fraudulent activities were exposed and much of her own community would renounce her.

Adaptation

Darren’s narrative of a disrupted home life, throughout childhood and adolescence, was replete with themes of relationship difficulties. His father’s alcohol use dominated family dynamics making the family home a place of unpleasantness and uncertainty rather than security and comfort. It was place from which the young Darren, and his siblings, sought refuge in sporting or other community pursuits and from which his mother, and siblings, departed permanently during his formative years. Darren remained with his increasingly isolative father in a home which only his father’s “drinking mates” were welcomed.

Darren described difficulties in maintaining close friendships suggesting that his confident (“cocky”) demeanour masked anxieties, defensiveness and insecurities about “not being as good as other people”. Despite worrying incessantly that such use could emulate the destructive course that alcohol had for his father, Darren engaged in regular use of cannabis and alcohol throughout his later teenage years. His use of both substances, initially at least, facilitated admission to peer groups to which he had previously felt excluded though his binge-type use of alcohol soon caused frictions in interpersonal relations. While suggesting that cannabis allayed his anxieties, and alcohol alleviated his insecurities in social settings, he was conscious that his perceived reliance on both substances was actually exacerbating both conditions and diminishing his sense of self-worth. .

Christine’s adaptive behaviours developed in response to childhood abuse (physical and sexual) by a relative and the erratic behaviours of her heavy-drinking mother. Despite an innate fear of males, the betrayals of her husband and the need to provide for her children caused her to enter the sex industry where she continued to use alcohol to mask her fears. Gambling provided a psychological ‘escape’ from this lifestyle and the symptoms that would later be diagnosed as a mental illness.

Dissonance

Unexpectedly, I was compelled, by the narratives, to reflect upon the assumptions that have supported my therapeutic practise. Implicit in those assumptions was an expectation that addictive behaviours are supported by irrational and relatively entrenched belief systems which, in turn, explain maladaptive patterns of behaviour. My assumptions recognised the historical, cultural and societal contexts of such beliefs but still suggest that people seek meaning within the constraints imposed by relatively ingrained schemas and that these beliefs consistently permeate individuals’ interactions with their environment and their interpersonal relationships.

This particular cognitive orientation is consistent with ‘evidence-based’ practice which meets the criteria for ‘brief interventions’ advocated within specialist outpatient (and some

residential) treatment services in New Zealand. Despite an abiding interest in, and growing appreciation for narrative approaches, I have consistently reverted to such cognitive perspectives in order to facilitate treatment planning which meets service protocols. In so doing, I have assumed a privileged position in which I am the arbiter of client's belief systems and adopt an orientation of pathology, assumptions that certain beliefs are stable and maladaptive rather than adaptive and developing (Rothschild, 2010); time constraints dictate that behaviours be placed within such contexts and suggest that the client will benefit from the clinician's insights and exposure of a causal link between said behaviours and the belief systems that determine their use in response to environmental cues.

Early in the data gathering process, Participant interviews suggested that those belief systems, rather than being the fixed and established schemas which are assumed to exist and await 'identification' during brief assessment and treatment interventions, often represented potentially dynamic constructs which were constantly being challenged and questioned without 'clinician input'. The narratives of Leonard and Ellen, in particular, described a constant questioning of behaviours and their antecedent beliefs. Ellen suggested a 'faulty belief system' which had its origins in childhood and reinforcement throughout a long involvement in 12-step programmes; recurring and distressing behaviours were represented as a constant testing of an unsatisfying self-identity and expectations. As such, these behaviours did not represent 'adherence' with a maladaptive schema, but a conscious and repetitive challenging of 'beliefs' which were considered to be erroneous and not self-serving; the resultant behaviours, rather than disputing these beliefs, reinforced them and precluded development of new and more satisfying schemas.

Darren, engaged in cannabis and alcohol use despite having had intimate, familial experience of the disruptive influences of alcohol on relationships. His immediate needs, to allay anxiety and insecurity in his peer group associations, outweighed his more distal concerns regarding the impact of such use on his fragile self-identity.

At the heart of these narratives was a dissonance between the perceived ‘functional’ or even ‘protective’ qualities of the addictive behaviour and the increasingly disruptive and distressing impacts across life domains, and particularly, relationships. Such dilemmas were not assuaged by brief ‘decisional balancing’ exercises that generally replicated or ‘reframed’ cognitive appraisal processes that the client had self-instigated and sometimes engaged in over many years. As such, Motivational Interviewing (MI) techniques had not penetrated the deeper or core ‘constructs’ that underpinned engagement in addictive behaviours. Perhaps, as Bill Millar (cited in Ashton, 2005) suggests, these clients had not been ambivalent about change – they were ready for meaningful improvements in their life and it can sometimes be unhelpful to reassess that same dimension.

Underlying the distress so often manifested in self-destructive and threatened self-harming behaviours was a dissonance between a developing self-conceptualisation as damaged and unworthy *and a value system which was generally well-meaning and honourably-intentioned.*

It is posited that Alexander’s (2008) Dislocation Model of Addiction allows for an alternative conceptualisation of participant’s narratives that is at least as plausible as a formulation based upon a medical model. Given an opportunity to tell their own stories participant’s clearly identified developmental processes in which addictive behaviours served a purpose in ‘shielding’ them from emotional distress or a lack of psychosocial integration. Additionally, Alexander’s (2008) Dislocation Model is inclusive of the full spectrum of addictive behaviours and allows for the coherent incorporation of co-existing conditions in case conceptualisations and provides for integrated treatment plans.

Reintegration

For the participants, resort to ‘medical model’ or neurobiological ‘education’ had not tipped the balance into meaningful change. Sometimes, change had been demonstrated, such as by a reduction in intensity or frequency of engagement in the addictive behaviour, and constituted change that was ‘meaningful’ to the fellowship or the attending clinician. However,

‘meaningful change’ in the language and understanding of the participant constituted viable alternatives to their adaptive means of existence and paths to ‘reintegration’.

Frese, Stanley, Kress and Vogel-Scibilia (2001), usefully, delineate ‘clinical recovery’ and ‘personal recovery’ and how ‘expert’ discourses can assume priority over the aspirations of our clients. Clinical recovery is an objective, outcome-focussed perspective of recovery that is constituted by abatement of symptoms. Personal recovery, conversely, involves a renewed sense of self and engagement in a meaningful and fulfilling life, regardless of abatement of symptoms.

Accordingly, the medical model of addictive behaviours can define our clients in terms of perceived pathology and locate them as passive recipients of treatment isolated from all meaningful life contexts.

Epstein (1996) suggests that medical metaphors of disease applied to addictive behaviours denigrate the powers of resilience at an individual level and do not imbue hope. Such metaphors also contribute to powerful social constructions of drug use and behavioural phenomena such as gambling, and can actually increase, rather than diminish, considerations of morality. Likewise, ‘recovery’, due to its association with 12-step modalities, has an implicit meaning of abstinence.

However, Gossop (1996) argues that reductionist and narrow conceptualisations of client needs are not confined to the medical fraternity. In reviewing Rosenhan and Seligman’s (1995) edition of *Abnormal Psychology*, Gossop (1996) observes that the chapter on psychoactive substance use includes the statement “most alcoholics do not recover”, a pessimistic conclusion that is now contested by several research findings (Klingemann, Sobell & Sobell, 2009). Further, harm reduction philosophies are omitted completely, perhaps in deference to a predicted North American readership. Indeed, Prins’ (1995) study found significant occurrence of the “maturing out” process of natural recovery from drug use in a society which espouses harm reduction modalities. Similarly, in a large population survey,

Slutske, Piasecki, Blaszczynski and Martin (2010) established that almost all of the reported 'recovery' from pathological gambling was achieved without abstinence.

Larkin and Griffiths (2002) have argued that psychology must be more attentive to the subjective experience of addiction, and its role in the construction of self and identity, recognising that change may be contingent upon clients' opportunities to envisage a more purposeful and fulfilling future. "This will require that problem users receive psychological support as they re-imagine and re-write their self-narratives, during the process of recovery and change." (Larkin & Griffiths, 2002, p. 310).

Borg and Davidson (2008, p. 139) suggest that rehabilitation and treatment programs in the mental health sector " ... will do well to elicit, listen to, and appreciate both the dramas and trivialities of everyday life, as well as the individual's own expertise in managing these tasks." As Hammersley et al. (2001) argue, clients may strategically obscure or rebuff those characteristics of themselves that are fundamental to their self-concept.

Participants' narratives contained varying accounts of the development of their addictive behaviours and their conceptualisations of 'addiction' were, inextricably, linked to these respective etiological attributions. Furthermore, amelioration of these addictive behaviours was often associated with, if not a resolution or acceptance of these developmental issues and dilemmas, an appeal to 'an inner self', a self constituted by a value system that had been lost in the maelstrom of emotional distress and dysfunctional behaviours that accompanied development of the 'addiction'.

Treatment, therefore, had not been contingent upon the client being 'educated' in a particular disciplinary approach to addiction, nor a philosophical orientation shared between client and clinician. The various narratives contained not only descriptions of the processes by which addictive behaviours were addressed but suggestions that participants had, much earlier in the process towards wellbeing, identified those variables which could foreshadow amelioration of their behaviours. While reflective hindsight focussed on their experiences of escalating addictive behaviours and the achievement of resolution to them, the narratives included

descriptions of events and milestones that were imbued with imagery of emotional distress associated with dissonance between ‘present selves’ and idealised selves’.

This study suggests that a model of addiction should have resonance with the client’s worldview and ‘fit’ with the client’s own holistic conceptualisation of recovery. As McIntosh and McKeganey (2000) contend, concepts of ‘addiction’, ‘dependence’, and ‘recovery’ are open to multiple and conflicting interpretations.

From a practitioner’s perspective, such a model should, therefore, be inclusive rather than reductionist in order to have utility in treatment settings. Clients should have expectations that the practitioner is deploying an evidence-based framework while provider agencies will demand that treatment modalities are appropriate to a designated and sustainable model of care. Therein lies the challenge to the addiction treatment sector.

5.6 Narrative Expression versus Comprehensive Assessment (and implications for treatment)

Comprehensive assessments generally focus on the 5 P’s: namely, factors that are deemed ‘Predisposing’ and ‘Precipitating’ for the ‘Presenting’ condition as well as those that ‘Perpetuate’ the condition, or provide “Protective” influences on the person’s experience of that condition. Presentation to alcohol and other drug treatments services, or mental health facilities, is often precipitated by very adverse circumstances experienced as extremely distressing to the individual and their significant supports. Despite such emotional turmoil a functional enquiry can provide some evaluation of the condition, the level of distress associated with the experience of it, and a reasonable awareness of any events precipitating the individual’s entry into the service. Assessment should identify historical factors in the development of the condition by way of enquiries focussed on developmental issues, family history and dynamics, and psychosocial functioning. Protective factors which may contribute to the individual’s short to medium-term safety, and some alleviation of the distress, are a focus of such assessment.

If such assessment occurs in the context of a 'brief intervention' treatment modality, it is feasible that diagnosis and treatment determinations are based on formulations that emanate from a single assessment episode in which safety imperatives have prevailed. It is suggested that the assessment of predisposing and perpetuating influences may be perfunctory having focused, reasonably, on significant or traumatic developmental issues and historical antecedents. Necessarily, an orientation to a particular model of addiction would exacerbate reductionist or simplistic formulations given credence under the guise of an 'expert' case conceptualisation.

Leonard was well known to me having, some twelve months earlier, been referred for treatment for alcohol dependence. Accordingly, he had participated in a Comprehensive Assessment process upon which a brief treatment intervention was formulated. Aetiological factors in the development of both his addictive behaviours, and his depressive illness, had been assessed.

The narrative provided for this study included the alleviation of his addictive behaviours and the development of new goals and perspective on his future. However, his narrative also revealed insights that had not, and probably could not have, occurred in the context of a structured assessment process.

Leonard described a passage from a state of virtual self-loathing, impending homelessness, unemployment, and chronic illness to a life focussed on engagement with his daughters, and considering himself worthy of their love and restored respect. His narrative expressed a self-identity which had personified moral deficiency yet his successful adoption of controlled-use of alcohol coincided with efforts at financial restitution, to insurers of a vehicle destroyed some years previously, which severely strained his limited resources. While earning little more than a minimum unemployment benefit he committed to substantial repayments of a debt from which he could have easily have been excused through legal processes. He spoke of an underlying value system that precluded such mechanisms and compromised both his own enjoyment of his minimal income or any accumulation of assets for his own future security.

He reminisced over the wrongs done to an employer whose support (financial and emotional) had been sacrificed to a three year long experience with opiates many years previously; he revealed his wish to, one day, repay the kindnesses that he had received from that employer and managed to ‘forget’ in subsequent years of alcohol-fuelled excesses. He expressed gratitude for the health care that had addressed the Hepatitis C infection, but one of the costs of his past appetite for opiates, when others might have expected no less as of right. Most importantly, he had resolved his demons regarding his ‘addict identity’; his commitment to abstinence from opiates was definitive but acceptance that he had successfully adopted ‘moderate use’ of alcohol was crucial to an improved psychological state and pursuance of a life more consistent with his values.

As Johnson, Pfenninger and Klion (2005) observe, constructivist modes of assessment focus on overall ‘constructions of self’ including values and beliefs, and how the conceptualisation of the problem has been incorporated into a core role (e.g., I am an alcoholic). Such a mode of enquiry may differ considerably from the supposedly ‘biopsychosocial assessments often occurring within even specialist addiction and mental health services.

Notwithstanding that the references are to physiological disease processes being addressed in the primary health (family practice) environment, and in medical doctor–patient engagements, Bartz (1999), suggests succinctly that there are two discrete strategies for introducing biopsychosocial approaches to treatment. In an instrumental approach, understandings of illness are based upon the client’s acceptance of the clinician’s (biopsychosocial) perspective of the illness, and treatment processes; a dialogical approach requires that the clinician engage and interact with the client to understand the biopsychosocial issues and jointly formulate future care.

While committing to dialogical perspectives, Bartz’s (1999) approach is, understandably, constrained in that the practice of a family physician is more associated with accepted disease entities where biomedical treatments can be applicable and appropriate.

Tavakoli (2009, p. 28) contends that, in the wider mental health sector (including addiction services), “It is paramount ... that we get to know our patients, allow them to tell us their life stories, to guide them, and give them a chance to re-tell their histories in order to gain insight for a better future.” Such advice suggests not only a quantum shift in approaches to assessment but also a continuity of treatment beyond the ‘acute model of care’ that pervades and predominates the New Zealand addiction sector (MacEwan, 2011).

Narrative methodologies may have utility as both a form of enquiry for assessment and an efficacious therapeutic intervention. This study has revealed how client narratives, unencumbered by the (at least) semi-structured format of traditional assessment, can reveal information that may otherwise not have been divulged. Also, that discourse is, in itself, generative, allowing other possible meanings to be raised into consciousness and considered as alternative explanations. A client’s conceptualisation of the aetiology and course of their addictive behaviours are rooted in interpretations of experiences and life contexts; in this vein, it seems counter-productive to impose an alternative model of addiction, within a brief treatment modality, that is neither anchored in the clients own understandings or has immediate resonance with the client’s own place in the world and way of being in that world.

Goncalves, Korman, and Angus (2000) suggest that psychopathology can be revealed by disruption of narrative structure, process, or content. In the course of this study, two narratives, in particular, exemplified the ‘disrupted’ narrative. Darren’s narrative, despite him being well known to addiction services, suggested an underlying anxiety that had been masked by his insistence upon the primacy of substance use problems. Christine, conversely, divulged a ‘diagnosed’ (some years previously) mental health condition that she had chosen not to accept in terms of adherence to the prescribed medication regime or the proffered prognosis of lifelong illness. While she had exercised her prerogative to disengage with mental health services, due to their perceived unwillingness “... to hear ...” her, and their preoccupation with medication rather than talking therapies, her narrative suggested a sense of paralysis in life. She both attempted to deny the condition (to herself, loved ones and others) but awaited

the onset of the inevitable symptoms that she had been warned of. She had addressed her (adaptive) behaviours of alcohol use and gambling, which she reported as being the inevitable first topic of enquiry by mental health services, but sometimes wondered whether she had not been better off when she had been engaging in those behaviours. Her efforts had not alleviated the emotional pain of the experiences that had, in her interpretation, precipitated her resort to addictive behaviours. Her narrative was one of ‘parts’, a collection of often painful episodes that she struggled to understand or reconcile. Her abhorrence of medical model assessments was dissuasive of further attempts to obtain help with her dilemma.

Roesler (2006, p. 575) states “Identity is the construct which provides the person with a sense of continuity of being over time, which creates a sense of coherence so that the divergent experiences form an interconnected whole, and which gives meaning to one’s experiences and to life as a whole. All these aspects of identity: continuity, coherence and meaning, are created by putting one’s experiences into a life story, a narrative.” However, incoherent subplots provide an opportunity for ‘re-authoring’, a source of liberation from ‘problem-saturated’ storylines that impede visions of future wellbeing (White & Epston, 1990).

Darren’s insistence on “being heard” during presentations to treatment services was conditioned by his self-reported history of regaling his AA fellowship with ‘his story’, and the emotional distress engendered by precipitating difficulties in interpersonal relationships. With his wellbeing always described as being contingent upon the immediate alleviation of addictive behaviours, however, his pleas for treatment were usually seen as ‘demanding’ by attending clinicians. His narrative, however, exposed his conditioning to a disease conceptualisation of addiction that lent understanding to such insistence while also offering opportunities for adoption of alternative self-concepts.

However, “being heard” was described as crucial to therapeutic relationships that were deemed collaborative in terms of treatment planning. But most of all, participants suggested that treatments for addictive behaviours should incorporate the client’s conceptualisation of ‘recovery’ and that clinicians’, or service providers’, imperatives should not dominate, or limit, the therapeutic discourse to the ‘mere’ alleviation of those addictive behaviours.

Participants' expectations were encapsulated by Vromans and Schweitzer's (2011, p. 4) proposition that narrative therapy involves "... an equitable therapeutic relationship; eliciting of problem narratives; deconstruction of dominant problem stories; development and enrichment of preferred stories; and the living and witnessing of preferred stories."

However, such modes of enquiry and therapy will have inevitable tensions with assessment and treatment modalities that currently prevail in the New Zealand addiction treatment sector. As Freedman and Coombs (2000, p. 345) suggest, narrative therapy demands a worldview encompassing "... a way of living that supports collaboration, social justice and local, situated, context-specific knowledge rather than normative thinking, diagnostic labelling, and generalized (non-contextualized) 'expert' knowledge.

Diagnostic labelling is implicit within the medical model, a requisite of most specialist treatment providers, and involuntary within 12 step models; 'one cannot be partially an alcoholic'. However, as Drewery, Winslade and Monk (2000, p. 250) argue, "Authoritative diagnosis maintains expert power and thereby adds authority to the intervention that follows on the diagnosis." Thus a client-clinician relationship that is contingent upon a diagnosis has an implicit powerlessness-power component regardless of other efforts to establish a therapeutic relationship. Importantly, alternative constructions of the addictive behaviour may be denied.

To conclude, it is appropriate to briefly consider narrative modes of enquiry and therapy in relation to existing modalities deployed in addiction treatment. Motivational Interviewing continues to be widely used, and is well supported by research, but is generally deemed to be most effective when followed by another model of treatment. Accordingly, a typical brief treatment engagement might be expected to involve two sessions (assessment and motivational interviewing) followed by cognitive or behavioural interventions. Vromans and Schweitzer (2011) have addressed the dearth of empirical research and demonstrated the effectiveness of an eight-session manualised narrative therapy for depressive symptom and interpersonal relatedness. There was considerable evidence for the alleviation of acute symptoms related to subjective wellbeing while improvements in more chronic interpersonal relatedness were not

sustained. The authors concluded that entrenched interpersonal difficulties may require follow-up therapy much in the vein of MacEwan's (2011) contentions regarding the 'chronic' aspects of addictive behaviours, and the need for extended treatment interventions.

This study privileged participants' stories and knowledge, and suggested to me that the telling of those stories allowed participants to gain coherence and perspective regarding the role of addictive behaviours in their lives. The potential application of such modes of enquiry to clinical practice was inescapable. It is conjectured that the manualised narrative intervention, employed by Vromans and Schweitzer (2011, p. 7) may have utility in the assessment and alleviation of addictive behaviours; notwithstanding the focus on "... local and personal experience ..." rather than "... universal descriptions of disorder ...", the second phase of the intervention approximates with traditional 'assessment' while the third phase ('deconstruction') has similarities with MI's process of 'developing discrepancy'.

Vromans and Schweitzer's (2011) construct of 'interpersonal relatedness' is closely aligned to Alexander's (2008) notion of 'psychosocial integration' and recognises cultural influences in addictive behaviours. As Larkin, Wood, and Griffiths (2006, p. 213) observe "... it is culture which offers us meaningful opportunities for engagement with these activities and substances, and it is culture which furnishes us with both the motives for doing so, and the resources for making sense of our experiences when we do. 'Addiction' can only exist *in the relationship between* persons (bodies-minds), actions (activities-substances), and culture."

Chapter Six Conclusions

6.0 Summary

This study identified the meanings attributed to addictive behaviour by a number of participants who had recent experience of this phenomenon. During the course of those interviews I became aware that there were unknown ‘dimensions’ to clients whom he had previously ‘comprehensively’ assessed and engaged in treatments based upon those assessments. Necessarily, I was compelled to reflect upon the processes that had been employed and how the insights gained in these narratives might have led to alternative and more effective treatments.

It would be simplistic to suggest that comprehensive assessment, and resultant treatment planning, be deferred until after the client has established an appropriate level of rapport and engaged in a therapeutic relationship with the attending clinician. Indeed, Motivational Interviewing (MI), the evidence-based ‘early engagement’ model shown to demonstrate efficacy in instilling client motivation and facilitating retention in treatment, advocates that treatment planning begin immediately that ‘change talk’ is identified.

Further, as Miller and Rollnick (2002) state, one of the four fundamental principles of MI is ‘developing discrepancy’, which equates closely to the theme of ‘dissonance’ identified in client narratives. Additionally, Wagner and Sanchez (2002) suggest that MI can initiate definition of an ‘ideal self’ and the explication of the ‘values’ that I had considered to have eluded identification during comprehensive assessments associated with two of the study participants. Contrastingly, the afore-mentioned assessments had identified various ‘beliefs’ that had prompted cognitive-behavioural interventions targeted at what were, following the narratives provided by those two participants, deemed peripheral rather than core constructs.

It is posited that clients, as meaning-making beings, have expectations of their treatment provider, and the likely treatment modality that they will encounter, informed by social discourse and engagement in previous treatments regimes. In accordance with their own

imperatives it is reasonable that clients may divulge only such information as they consider relevant to their immediate needs, or they believe to be relevant given their own conceptualisations of the addictive process, or that corresponds to what they believe are the conceptualisations of the treatment provider.

As has been suggested, clinicians conducting comprehensive assessments have requisite outcomes from such activity in that a formulation of the client's presenting condition, supported by historical and contextual psychosocial and biomedical information, should inform a provisional diagnosis upon which treatment planning will be considered by their 'multidisciplinary team'. Inherent in such a formulation are obligatory and necessary considerations of the client's immediate safety and needs in terms of alleviation of medical or psychological distress. Time constraints dictate that a relatively structured question and answer format, compounded by the use of mandated screening tools to comply with CEP assessment protocols, is almost inevitable. These processes are not contested, as such, although such a format may not be conducive to initiating a therapeutic relationship, or encouraging client commitment to on-going treatment. Indeed, I, as a clinician, have experienced the sometimes conflicting imperatives of mandated information-gathering and the MI processes that are often deemed more appropriate.

However, even MI processes are, necessarily given the objectives of the treatment provider, oriented towards the current expression of addictive behaviours. Though conducted, hopefully, in synthesis with a 'comprehensive' biopsychosocial assessment, this study has indicated that deeper constructs pertinent to optimum treatment formulation may not be typically identified using such methods. With due regard to the client's apparent 'stage of change', any 'stabilisation imperatives' identified during initial presentation, and the assessment protocols of a treatment provider, this study suggests that narrative forms of enquiry may have significant utility in developing treatment relationships that enhance the effectiveness of the intervention.

1. The narrative reveals information considered relevant by the client and particularly with regard to sense of 'self' and 'social' identities. This 'locates' addictive behaviours within social

contexts in a manner that ‘traditional’ assessment may not permit. Arguably, increasing CEP prerogatives may be better served by narrative forms of enquiry in that clients can better explicate the aetiology of addictive behaviours in relation to (primary verses secondary) co-existing problems. Additionally, the very existence of co-existing problems, and other stigmatising contextual circumstances, may be revealed within discourse that is under the ‘control’ (content and form) of the client rather than the therapist.

2. The form of the narrative, and its structure, may reveal issues of coherence between traumatic events, developmental issues, and barriers to psychosocial integration, and the development of ‘adaptive’ coping mechanisms including addictive behaviours
3. The very process of structuring the narrative may bring a sense of coherence to the client thus being therapeutic in its own right.
4. The opportunity to relate their story allows the client to feel they are being heard and that resultant treatment planning is, in reality, collaborative and ‘creative rather than corrective’.
5. A narrative may better reveal the client’s perception of ‘wellbeing’ which is likely, based on the narratives that constituted this study, to comprise dimensions that, while related to their addictive behaviour(s), have more meaning to the client. Locating treatment goals within such client-determined ‘meanings’ may be more efficacious than service-oriented ‘reductionist’ outcomes of moderation or cessation of the addictive behaviours that are, in themselves adaptive mechanisms.

This research did not seek to provide support for a particular model of addiction though, due to my own academic background, the study was oriented towards the psychosocial domains of addictive behaviours. Additionally, I am employed in a treatment sector which has, perhaps unwittingly, been philosophically oriented to a biomedical approach to addiction and may, under the guise of current health reforms, see a reversal of recent trends towards truly multidisciplinary teams and models of treatment.

In advocating for eclecticism in treatment provision, I acknowledge that this thesis has critiqued the predominance of 12-step treatment modalities and the medical model. As Marlatt (1983, cited in Peele, 1985, p.151) contends, the modern disease model “... is little more than the old moral model (drinking as sinful behaviour) dressed up in sheep’s clothing (or at least a white coat)”. Peele (1985) equates the focus on abstinence, common to both models, as signifying repentance.

However it is not the models per se that concern me: the proponents of the former can cite the global support for 12-step programmes, and its successes. Indeed, in advocating for narrative modes of engagement with clients, I acknowledge that such accounts are integral to AA processes whereby meetings are constituted around lay accounts of addiction without need of scientific interpretations. Adherents of the medical model can also cite successes while significant advances in neurobiological explanations portend further pharmacological solutions to the alleviation of manifested addictive behaviours.

It is the universality of application that is ascribed to these models that this study suggests is erroneous and restrictive. As a colleague recently observed “... the weakness of the medical model is in its presumption of strength ...” (Caygill, 02 August 2011, personal communication). Participant narratives suggested alternative conceptualisations of addiction that, if aligned to treatment models that resonated with them, might have led to an earlier and more complete amelioration of their distress.

As Larkin, Wood and Griffiths (2006, p. 212) suggest, abandoning adherence to the disease model “... is potentially to dispense with a *top-down* diagnostic system for understanding addiction. It should be the basis for developing a more flexible and needs-led system of research, theory and practice. It can be reconciled with the meaningful accounts of clients and their contexts, and with the complex modelling of polygenic interactions which may eventually emerge from the molecular genetic work.”

This research was intended to “... influence a thoughtful reflective attentive practice by its revealing of the meaning of experience.” (Van der Zalm, 2000, p.211). Undoubtedly, that has occurred. While the process of conducting the literature review invoked considerable

reflection upon the merits of diverse theories of addiction, some of which are seldom evident in my own clinical practice, the engagement with participants' narratives of their experiences provoked a deal of thought regarding the underlying processes of change and how, as a clinician, I could best respond to the experiences of future clients.

Perhaps, most significantly, I have allayed my own perceived need to demonstrate adherence and unconditional commitment to any particular model of addiction. It is an understanding of all of these models that is required rather than a narrow and focussed philosophical orientation; eclecticism in treatment delivery remains paramount, a wide repertoire of 'evidence-based' interventions that are responsive to the needs and interpretations of the individual client. It is incumbent upon any practitioner to translate these insights into clinical practise and, as a clinician, to augment existing treatment processes with alternatives such as those informed by psychological constructivism.

The experience of hearing the stories of participants, and reflecting upon participants' interpretations of addictive behaviours and their associated constructs, revealed to me four enthralling and relevant themes. 'Dislocation' and 'adaptation', as well explicated by Alexander (2008), were evident, in varying forms and levels of intensity, throughout participant accounts of the initiation into, and development of, addictive behaviours. 'Dissonance' was expressed in terms of the understanding of distress, engendered by the constant interplay of 'functional' and 'dysfunctional' aspects of the behaviours as well as the more compelling relationship between the expression of those behaviours and underlying value systems. 'Reintegration' operated at both the level of the individual, expressed as a reintegration of value systems into life roles, as well at the social level of re-established relationships at interpersonal, community, societal and cultural levels and across all of those life domains.

However, I could not help but extend those themes into reflections on past developments, and trends, within the New Zealand addiction treatment sector. The experiences of the participants are, in fact, a metaphor for the services that should be responding to their needs.

Dislocation has been a constant theme within a sector exemplified by the disestablishment of many residential facilities; this has left a relatively small and narrowly-focussed range of longer-term treatment options for those whose overwhelming addictive behaviour necessitate such an opportunity. Outpatient alcohol and other drug treatment has been increasingly devolved to non-governmental organisations while treatment of problematic gambling has long been considered to reside outside of the public healthcare system. Several of those DHB's that have retained their substance-based addiction services have developed sometimes uneasy integrations of addiction and mental health workforces.

Adaptation has become a byword for the addiction treatment sector with facilities and long-term development of services being hamstrung by varying levels of political commitment. Within such funding environments addiction services have long been considered the 'poor cousin' of the mental health sector both in terms of financial and workforce recognition.

The development of CEP capability and brief intervention models of care are a reflection of international trends in the sector though the New Zealand experience suggests that a philosophical medicalisation of addiction treatment is as much an imperative as commitment to 'best practice'.

Dissonance: While such models have relevance and utility in the sector they may be serving to unnecessarily limit the development of alternative, or optimum, treatment opportunities. McLellan, McKay, Forman, Cacciola and Kemp (2005) identified similar trends in the USA addiction treatment sector over the preceding decade observing that, despite a prevailing medical model of addiction, clients were being denied the continuing care afforded other chronic medical conditions. In lamenting the poor outcomes associated with brief and time-limited treatment regimes, without longer-term follow-up consistent with a relapsing condition, McLellan et al. (2005) advocate 'concurrent recovery monitoring' to assess clients' progress in achieving psychosocial integration across all life domains.

However, McLellan et al.'s (2005) treatise is very influenced by a 'disease' conceptualisation of addictive behaviours which, when translated to longer-term treatment opportunities in New Zealand, invariably means admission to a residential programme. Such residential facilities

espouse abstinence as a requisite goal and imposition of a particular model of addictive behaviours upon attendees. Accordingly, and regardless of their own conceptualisation, clients are initiated into a (possibly) new and stigmatising social identity. Treatment invariably includes group formats which may be difficult experiences for people whose compromised psychosocial integration has led to adaptive behaviours such as social isolation or avoidance. Rather than therapeutic ‘exposure’ to a social environment, such enforced participation may expose attendees to dominating discourses both from fellow attendees and facilitators. Further, such discourse is occurring in the context of estrangement from any remaining ‘functional’ supports that remain in the participant’s life thus constituting a further sense of dislocation.

That residential programmes have, in recent years, incorporated ‘community reinforcement’ components, alongside of the ‘core’ 12-step model, would suggest that Alexander’s (2008) accentuation of psychosocial integration, in the aetiology and alleviation of addictive behaviours, is appropriate.

Reintegration: While McLellan et al.’s (2005) vision is unashamedly ‘disease’ oriented, his vision of on-going ‘recovery monitoring’ need not be confined to the follow-up programmes provided by residential facilities, nor the often recommended engagement in a community-based 12-step programme. Nor need such an initiative impose onerous or prohibitive commitments, in terms of workforce inputs or other resources, upon the specialist addiction services.

Based on the participant narratives, a follow-up programme may be of benefit to clients regardless of whether they respond to either a ‘harm reduction’ modality, in which controlled use of the addictive behaviour is an acceptable outcome, or abstinence-focussed interventions. Whether such clients engage in narrative re-authoring, or an alternative intervention, the process of psychosocial integration may be ‘a work in progress’ that can benefit from opportunities to evaluate their personal pursuit of well-being as they have defined that construct to be.

Participants suggested that they had enjoyed the opportunity to tell their stories, on their own terms, and that the process was deemed to have been cathartic and fulfilling. Two participants queried whether such a (narrative) process could be included within actual treatment programmes while three cited the benefit of this opportunity as a ‘follow-up’ to the (supposedly) brief treatment modalities that they had most recently engaged in. It was not so much the duration of their treatments that was in question (as all three had experienced extended engagements for a variety of reasons) but a sense of ‘premature’ disengagement that had been engendered at the time of ‘discharge’ from the service. While accepting their own need to pursue their personal visions of reintegration the therapeutic relationship was described as a valuable forum for monitoring their progress in reversing entrenched adaptive behaviours. One participant envisaged a monthly “catch-up” over the three months following completion of treatment.

Treatment providers have trumpeted their initiatives in elevating ‘consumer advisor’ roles within their strategic policy and planning activities. We have given our clients a voice, perhaps it is time we began listening.

6.2 Recommendations for Future Study

Further investigation into the efficacy of narrative therapies for addictive behaviours is warranted. In particular, the utility of such interventions, given the prevailing ‘brief treatment’ mind-set that exists in the New Zealand health sector, is necessary. It is suggested that narrative therapeutic interventions may be a useful adjunct to MI, or MI adaptations, in clinical settings.

This study supports and encourages further research into the benefits of narrative modes of enquiry compared with ‘typical’ forms of assessment. If treatment planning is entirely contingent upon such assessment it is imperative that we get it right.

Following on from these recommendations, it is necessary that narrative modes of enquiry and treatment are within the capabilities of the clinicians that our clients will encounter. Obviously, this has implications for the selection and training of the future AOD workforce.

6.3 Limitations of the Study

This study had a relatively small number of participants. A larger sample would, obviously, have provided a greater diversity of data without, perhaps, affording the study a superior depth of understandings. An obvious limitation of this study is that tobacco use was not addressed.

All three of the clients who had experienced problematic gambling had previously attended the (alcohol and other drug) service at which I am employed for treatment of substance-based addictive behaviours. While this reflects the extent of concurrent addictive behaviours, as well as the co-existing (mental health) problems identified by some participants, it may have compromised participants' explication of gambling-related understandings.

Participants were, in the main, known to me prior to their recruitment for the study. While this provided a unique opportunity to examine and compare narrative modes of enquiry and treatment with the comprehensive assessments that had occurred upon entry to treatment, it may also have compromised the diversity of understandings of addictive behaviours. A number of participants, would, particularly, have experienced and possibly been influenced by my own rather holistic perspectives of 'recovery'.

6.4 Implications of the Study

This study raises questions about the strategic direction of addiction treatment services in New Zealand. It challenges the almost universal acceptance of particular models of addiction, the trend whereby adherents of (the disciplines associated with) those models will dominate the treatment sector, and the resultant limitation of treatment options offered to those experiencing

addictive behaviours. It suggests that our clients, who know their circumstances far better than any clinician can hope to do, or can possibly do using current modes of enquiry and assessment, should have the opportunity to tell their stories, convey their understandings, and express their notions of ‘recovery’ in terms of hopes and aspirations for the future.

This study found that participants responded to a mode of engagement whereby their narratives were privileged. Several indicated that the process delivered them a sense of ‘coherence’ and added layers of meaning to their prior understandings. I found meanings in participants’ interpretations that could have informed their treatments and, possibly, facilitated earlier resolution of their presenting problems.

In recognising the financial imperatives of a cash-strapped health sector that, perhaps understandably, endorses brief and highly-‘manualised’ treatment options, this study suggests that the use of narratives may offer a useful and cost-effective therapeutic model for some clients. Further, and as suggested by one participant, the duration of the intervention could be extended to allow for a limited monthly ‘follow-up’ programme following initial treatment. In terms of actual clinician input, a total of a few hours to monitor the ‘re-authoring’ process would seem negligible compared to the possible outcomes for the client, and possibly reduced re-referrals. However, treatment providers would need to consider and accept the implications of extended caseloads including their responsibilities for ‘risk management’.

6.5 Concluding Comments

“Journeys of Recovery” becomes “Paths of Discovery”

An initial working title for this research was “Journeys of Recovery”. That title had been rejected on two seemingly contradictory counts:

Firstly, it quickly became apparent that the metaphor of a ‘journey’ did not adequately encapsulate the range of experiences, emotions and revelations that I was being privileged to

share. A ‘journey’ suggests a travel monologue undertaken by a discrete entity departing from a fixed departure point and with a predetermined destination. Seldom did a participant identify a single event or point in their narrative which represented a definitive point of departure; similarly, while achievement of abstinence might, perhaps, reflect such a destination the analogy failed to adequately portray the controlled-use solutions which had been ‘discovered’ by a number of the study participants. Most surprisingly, these outcomes were not described as being, necessarily, a full and final resolution of their experience of addictive behaviours. Rather, they represented achievement of a condition where their moderate use of the behaviour or substance was not considered problematic, harmful, or distressing to themselves or their significant others. These accounts were devoid of naive expressions of everlasting homeostasis but rather a confidence that any escalation of use, or change in consequences of that use, could be addressed in the same way as any other adverse event in their lives.

Secondly, the notion of ‘recovery’ had implied pathology too consistent with the disease model of addiction. While the conception of ‘recovery’ intended was that of having achieved a resolution to problematic behaviours or substance addiction, rather than the incomplete progress suggested by adherents of 12-step modalities, the distinction remained as problematic to me as it did to at least one of the study participants. This discomfort could not be assuaged by my acceptance of the suitability of 12-step modalities for some clients or the wonderful and selfless work undertaken by many proponents of that philosophy. It also concerned me that the term is embraced by eminent addiction researchers (Koski-Jannes, 2002), whose work continues to inspire me and guide my practice, seemingly without the disquiet that I had failed to reconcile.

In my clinical practice I have consistently adopted the alternative term ‘wellness’ and proffered that concept to clients as a possible goal of our ‘therapeutic alliance’. I consider ‘wellness’ to represent consistency with a biopsychosocial approach. While careful to examine how addictive behaviours pervade all life domains, I consider that an unremitting focus on the client’s addictive behaviours can serve to reinforce the ‘addict identity’.

The experience of participating in this study has led me to a compelling insight that is exemplified by Duncan and Miller's (2000, p. 184) observation that "... the client's map provides the best guide to the therapeutic territory. The therapist is a coadventurer, exploring the landscape and encountering multiple vantage points while crossing the terrain of the client's theory of change."

References

- Adams, P.J. (2008). *Fragmented intimacy: Addiction in a social world*. New York: Springer.
- Adlaf, E.M., Hamilton, H.A., Wu, F., & Noh, S. (2009). Adolescent stigma towards drug addiction: Effects of age and drug use behaviour. *Addictive Behaviors*, 34, 360-364
- Aitken, C. (2011). Interview with Clare Aitken. *Dapaanz Bulletin*, 8(2), p.4
- Alexander, B.K. (1988). The disease and adaptive models of addiction: A framework evaluation. In S. Peele (Ed.). *Visions of addiction* (pp. 45-66). Lexington: Lexington Books.
- Alexander, B.K. (2001). *The roots of addiction in free market society*. Vancouver: Canadian Centre for Policy Alternatives.
- Alexander, B.K. (2008). *The globalization of addiction: A study in poverty of the spirit*. Oxford: Oxford University Press.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed, text rev). Washington, DC: Author
- Anderson, H. (2011). *Postmodern social construction therapies (draft)*. Retrieved June 19, 2011, from <http://www.harleneanderson.org/writings/postmoderntherapieschapter.htm>
- Bailey, L. (2005). Control and desire: The issue of identify in popular discourses of addiction." *Addiction Research and Theory*, 13(6), 535-543.
- Baker, T.B. (1988). Models of addiction: Introduction to the special issue. *Journal of Abnormal Psychology* 97(2), 115-117.
- Barkley, J. (2009). Commentary. Biopsychosocial assessment: Why the biopsychosocial and rarely the social? *Journal of Canadian Academy of Child and Adolescent Psychiatry* 18(4), 344-347.
- Bartz, R. (1999). Beyond the biopsychosocial model – new approaches to doctor-patient interactions. *Journal of Family Practice*, 48(8), 601-607.
- Berridge, V. (1999). *Opium and the people: Opiate use and drug control policy in nineteenth and early twentieth century England*. London: Free Association Books.
- Borg, M. & Davidson, L. (2008). The nature of recovery as lived in everyday experience. *Journal of Mental Health*, 17(2), 129-140.

- Brooking, R. (2009). The need for a substantial increase in funding for addiction treatment: How big should the + sign be? Accessed 20 May 2011, <http://www.rethinking.org.nz/.../newsletter%20PDF/.../02%20090809%20Addiction%20Funding.pdf>
- Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.
- Burrell, M.J. & Jaffe, A.J. (1999). Personal meaning, drug use, and addiction: An evolutionary constructivist perspective. *Journal of Constructivist Psychology*, 12, 41-63.
- Cameron, D., Manik, G., Bird, R., & Sinonwalia, A. (2002). What may we be learning from so-called spontaneous remission in ethnic minorities? *Addiction Research and Theory*, 10, 175-182.
- Carandang, C.G. (2009). Response to Commentary: Biopsychosocial assessment: why the biopsychosocial and rarely the social? *Journal of Canadian Academy of Child & Adolescent Psychiatry* 18(4): 348.
- Chiari, G. and M. L. Nuzzo (2010). *Constructivist psychotherapy: A narrative hermeneutic approach*. London: Routledge.
- Coombs, R.H. & Howatt (2005). *The addiction counselor's desk reference*. Hoboken: John Wiley & Sons.
- Corrigan, P.W., Watson, A.C., & Miller, F.E. (2006). Blame, shame and contamination: The impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology*, 20(2), 239-246.
- Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among five traditions* (2nd Ed). Thousand Oaks, CA: Sage
- DiClemente, C. (2003). *Addiction and change: How addictions develop and addicted people recover*. New York: The Guildford Press.
- Dowd, T. E. (1999). *Comparative treatments of substance abuse*. New York: Springer Publishing Company.
- Drewery, W., Winslade, J., & Monk, G. (2000). Resisting the dominating story: Towards a deeper understanding of narrative therapy. In R. A. Neimeyer and J. D. Raskin (Eds.) *Constructions of Disorder* (pp. 243-264). Washington, DC: American Psychological Association.

- Drug and Alcohol Findings (2011) Therapist effectiveness: implications for accountability and patient care. 11-5
- Duncan, B.L. & Miller, S.D. (2000). The client's theory of change: Consulting the client in the integrative process. *Journal of Psychotherapy Integration*, 10(2), 169-187.
- Editor (2005). Addiction and its sciences: introduction to a new *Addiction* series. *Addiction*, 100, p.1577.
- Ellemers, N., Spears, R., & Doosje, B. (2002). Self and social identity. *Annual Review of Psychology* 53, 161-186.
- Epstein, E.K. (1996). Socially constructing substance use and abuse. Towards a greater diversity and humanity in the theories and practices of drug treatment. *Journal of Systemic Therapies*, 15(2), 1-12
- Finlay, L. (2008). A dance between the reduction and reflexivity: explicating the phenomenological psychological attitude. *Journal of Phenomenological Psychology*, 39: 1-132.
- Frances, A. (2010). DSM5 addiction swallows substance abuse. *Psychiatric Times March*: 1-3.
- Frank, A. W. (1995). *The Wounded Storyteller*. Chicago: The University of Chicago Press.
- Freedman, J. & Combs G. (2000). Narrative therapy with couples.. In F. M. Datillo & L. J. Bevilacqua (Eds.). *Comparative treatments for relationship dysfunction*. (pp. 342-361). New York: Springer Publishing Company.
- Frese, F.J., Stanley, J., Kress, K., & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric Services*, 52(11), 1462-1468.
- Goncalves, O.F., Y. Korman, et al. (2000). Constructing psychopathology from a cognitive narrative perspective. In R.A. Neimeyer and J. D. Raskin (Eds.). *Constructions of Disorder*. (265-284). Washington, DC: American Psychological Association.
- Goodman, A. (2009). The neurobiological development of addiction. *Psychiatric Times*, 26(9), 1-14.
- Gossop, M. (1996). Book review: "Abnormal Psychology", *Addiction*, 91(1), 153-153.

- Gossop, M., Eiser, J.R., & Ward, E. (1982). The addict's perceptions of their own drug-taking: implications for the treatment of drug dependence. *Addictive Behaviors*, 7(2), 189-194.
- Griffiths, M. (2005). A 'components' model of addiction within a biopsychosocial framework. *Journal of Substance Use*, 10(4), 191-197.
- Halpern, J. H. (2002). Addiction is a disease. *Psychiatric Times* 19(1), 1-5.
- Hammersley, R., Jenkins, R., & Reid, M. (2001). Cannabis use and social identity. *Addiction Research & Theory* 9(2), 133-150.
- Hanninen, V. & Koski-Jannes, A. (1999). Narratives of recovery from addictive behaviours. *Addiction*, 94(12), 1837-1848.
- Herman, J. (2005). The need for a transitional model. *Families, Systems & Health* 23(4), 372-376.
- Johnson, T.J., Pfenninger, D.T., & Klion, R.E. (2000). Constructing and deconstructing transitive diagnosis. In R.A. Neimeyer & J.D. Raskin (Eds.), *Constructions of disorder: Meaning-making frameworks for psychotherapy* (pp. 145-174). Washington, DC: American Psychological Association.
- Keane, H. (2004). Disorders of Desire: Addiction and problems of intimacy. *Journal of Medical Humanities*, 25(3), 189-204.
- Kellogg, S. (1993). Identity and recovery. *Psychotherapy* 30(2): 235-244.
- Khantzian, E. G. & Albanese, M.J. (2008). *Understanding addiction as self medication: Finding hope behind the pain*. Lanham: Rowman & Littlefield Publishers.
- Klingemann, H. & Bergmark, A. (2006). The legitimacy of addiction treatment in a world of smart people. *Addiction*, 101(9), 1230-1237.
- Klingemann, H., Sobell, M.B., and Sobell, L.C. (2009). Continuities and change in self-change research. *Addiction*, 105, 1510-1518.
- Koski-Jannes, A. (2002). Social and personal identify projects in the recovery of addictive behaviours. *Addiction Research & Theory*, 10(2), 183-202.
- Koski-Jannes, A. (2010). Presentation to SSA Annual Symposium, York: Author
- Larkin, M. & Griffiths, M.D. (2002). Experience of addiction and recovery: The case for subjective accounts. *Addiction Research & Theory*, 10(3), 281-311

- Larkin, M., Wood, R.T.A., & Griffiths, M.D. (2006). Towards addiction as relationship. *Addiction Research and Theory*, 14(3), 207-215.
- Liamputtong, P., & Ezzy, D. (2005). *Qualitative Research Methods* (2nd ed). Melbourne: Oxford University Press.
- Lock, A., Epston, D., & Maisel, R. (2004). Countering that which is called anorexia. *Narrative Inquiry*, 14, 275-301.
- MacEwan, I. (2011). Opinion: Addiction as a continuing care strategy. *Dapaanz Bulletin*, 8(2), 3-4.
- Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors*, 21, 779-788.
- McIntosh, J., & McKeganey, N. (2000). Addicts narratives of recovery from drug use: constructing a non-addict identity. *Social Science & Medicine*, 50(10), 1501-1510
- McKeganey, N. (1995). Editorial: Quantitative and qualitative research in the addictions: an unhelpful divide. *Addiction*, 90, 749-751.
- McLellan, A.T., McKay, J.R., Forman, R., Cacciola, J., & Kemp, J. (2005). Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring. *Addiction*, 100, 447-458.
- Merlo, L. J. and Gold, M.S. (2008). Addiction research and treatment. *Psychiatric Times*, 25(7), 1-11.
- Midland District Health Board (2011). Alcohol & Drug Qualifications for Clinical Positions in Midland Region: Discussion Paper. Palmerston North: Midland District Health Boards Mental Health & Addiction Regional Network.
- Miller, W.R., & Kurtz, E. (1994). Models of alcoholism used in treatment: Contrasting AA and other perspectives with which it is often confused. *Journal of Studies on Alcohol*, March, 159-166.
- Miller, W.R., & Rollnick, S. (2002). Facilitating Change. In W.R. Miller & S. Rollnick (eds.) *Motivational Interviewing* (2nd ed.). (pp.20-29). New York: The Guildford Press.
- Miller, P.G., Strang, J., & Miller, P.M. (2010). Introduction. In P.G. Miller, J. Strang, & P.M. Miller (Es) *Addiction Research Methods*. (pp, 1-8). Oxford: Wiley-Blackwell
- Ministerial Committee on Drug Policy (2007). *National Drug Policy 2007-2012*. Wellington: Ministry of Health.

- Ministry of Health (2006). *Preventing and minimising gambling harm 2007-2010: Draft three-year service plan and proposed problem gambling levy calculations*. Wellington: Ministry of Health.
- Ministry of Health (2010). *Service delivery for people with co-existing mental health and addiction problems: Integrated solutions*. Wellington: Ministry of Health.
- National Addiction Centre and Matua Raki (2007). *Orientation to the addiction treatment field: Aotearoa New Zealand*. Christchurch: University of Otago.
- National Committee for Addiction Treatment (NCAT) (2008). *Investing in addiction treatment.: A resource for funders, planners, purchasers and policy makers*. Christchurch: NCAT.
- National Committee for Addiction Treatment (NCAT) (2010). *Gambling affects one in eight New Zealanders*. Wellington: NCAT
- Neale, J., Allen, D., & Coombes, L. (2005). Qualitative research methods within the addictions. *Addiction*, 100(11), 1584-1593.
- Neighbors, C., Larimer, M.E., Lostutter, T.W., & Woods, B.A. (2006). Harm reduction and individually focused alcohol prevention. *International Journal of Drug Policy*, 17, 304-309.
- Neimeyer, R. A. (2006). Narrating the dialogical self: Towards an expanded toolbox for the counselling psychologist. *Counselling Psychology Quarterly*, 19(1), 105-120.
- Norcross, J. C., & Wampold, B.E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy*, 48(1), 98 -102.
- NZ Law Commission (2009). *Alcohol in our Lives: An Issues Paper on the Reform of New Zealand's Liquor Laws*. Wellington: NZ Law Commission.
- Orford, J. (2005). Disabling the public interest: gambling strategies and policies for Britain, *Addiction*, 100(9), 1219-1225.
- Orford, J. (2008). Asking the right questions in the right way: the need for a shift in research on psychological treatments for addiction. *Addiction*, 10, 886-892.
- Packer, M. (1985). Hermeneutic inquiry in the study of human conduct. *American Psychologist*, 40, 1081-1093.
- Peake, T.H., Nussbaum, B.D., & Tindell, S.D. (2002). Clinical and counselling supervision references: Trends and needs. *Psychotherapy: Theory, Research,*

- Practice, Training*, 39(1), 114-125.
- Peele, S. (1985). *The meaning of addiction: An unconventional view*. San Francisco: Jossey-Bass Inc
- Peele, S. (1987). A moral vision of addiction. *Journal of Drug Issues*, 17(2), 187-215
- Prins, E. H. (1995). *Maturing out: An empirical study of personal histories and processes in hard drug addictions*. Rotterdam: Van Gorcum.
- Raskin, J. D. & Lewandowski, A.M. (2000). The Construction of Disorder as Human Enterprise. In R. A. Neimeyer and J. D Raskin (eds.). *Constructions of Disorder*. (pp. 15-40). Washington: American Psychological Association.
- Roesler, C. (2006). A narratological methodology for identifying archetypal story patterns in autobiographical narratives. *Journal of Analytical Psychology*, 51, 573-586.
- Rothschild, D. (2010). Partners in Treatment: Relational psychoanalysis and harm reduction therapy. *Journal of Clinical Psychology: In Session*, 66(2), 136-149.
- Slack, A. (2009). *Costs of Harmful Alcohol and Drug Use*. Wellington: BERL.
- Slutske, W. S., Piasecki, T.M., Blazczynski, A. et al. (2010). Pathological gambling recovery in the absence of abstinence. *Addiction*, 105: 2169-2175.
- Stall, R., & Biernacki, P. (1986). Spontaneous remission from the problematic use of substances: An inductive model derived from a comparative analysis of the alcohol, opiate, tobacco, and food/obesity literatures. *The International Journal of the Addictions*, 21(1), 1-23.
- Steffan, V. (1997). Life stories and shared experience. *Social Science & Medicine*, 45(1), 99-111.
- Stevens, P. and R. L. Smith (2000). *Substance Abuse Counseling: Theory and Practice*. Upper Saddle River: Prentice Hall.
- Tavakoli (2009). A closer evaluation of current methods in psychiatric assessments: A challenge for the biopsychosocial model. *Psychiatry*, 6(2), 25-30.
- Thombs, D. L. (2006). *Introduction to addictive behaviors*. New York, NY: The Guildford Press.
- Todd, F. (2011). Opinion: What goes up ...? Risky times for the addiction sector. *Dapaanz Bulletin*, 8(2), p. 2

- Törrönen, J. (2003). The Finnish press's political position on alcohol between 1993 and 2000. *Addiction*, 98(3), 281-290.
- Truan, F. (1993). Addiction as a social construction: a postempirical view. *Journal of Psychology*, 127(5), 489-499.
- United Kingdom Drug Policy Consensus (2008). *A vision of recovery*. Retrieved 22 May 2011, from [http:// www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf](http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf)
- Vaillant, G.E. (1983) *The natural history of alcoholism*. Cambridge, MA: Harvard University Press.
- Valle, R., King, M., & Halling, S. (1989). An Introduction to Existential-Phenomenological Thought in Psychology. In R.S. Valle & S. Halling (Eds.). *Existential Phenomenological perspectives in Psychology*. (pp. 3-16). New York: Plenum Press
- Van der Zalm, J. E. (2000). Hermeneutic-phenomenology: providing living knowledge for nursing practice. *Journal of Advanced Nursing* 31(1), 211-218.
- Van Manen, M. (1990). *Researching lived experience: Human Science for an action sensitive pedagogy*. Ontario: The University of Western Ontario.
- Vromans, L., & Schweitzer, R. (2011). Narrative therapy for adults with major depressive disorder: Improved symptom and interpersonal outcomes. *Psychotherapy Research*, 21(1), 4-15
- Wagner, C. & Sanchez, F.P. (2002). The role of values in Motivational Interviewing. In W.R. Miller and S. Rollnick (Eds.). *Motivational Interviewing* (2nd ed.) (pp. 284-299). New York: The Guildford Press. 284- 296
- Walters, G. D. (1996). Addiction and identity: exploring the possibility of a relationship." *Psychology of Addictive Behaviors*, 10(1), 9-17.
- West, R. (2006). *Theory of Addiction*. Oxford: Blackwell Publishing.
- Westerman, M. A. (2007). Integrating the parts of the biopsychosocial model. *Philosophy, Psychiatry & Psychology*, 14(4), 321-326.
- Weston, W. W. (2005). Patient-centred Medicine: A guide to the biopsychosocial model. *Families, Systems & Health*, 23(4), 387-405.
- White, W.L., Evans, A.C., & Lamb, R. (2009). Reducing addiction-related social stigma. *Counselor*, 10(6), 52-58.

- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, Norton.
- Young, L. B. (2011). Alcoholism and identity: How an alternative framing of identity can facilitate Alcoholics Anonymous research. *Addiction Research & Theory*, 19(3), 213-223.
- Yule, A., and Wilens, T. (2011). Familial influences on adolescent substance use: Modifying behaviour to reduce risk. *Psychiatric Times*, 28(1), 1-5.

18 October 2010

Professor Andrew J Lock
Massey University
School of Psychology
Turitea Campus
Palmerston North

Attention: Peter Ashton

Dear Professor Lock

Re: Ethics ref: **URB/10/07/025** (please quote in all correspondence)
Study title: Stories of Addiction
Investigators: Professor Andrew J Lock, Mr Peter Robert Ashton

This study was given ethical approval by the Upper South B Regional Ethics Committee on 18 October 2010. A list of members of the Committee is attached.

Approved Documents

- Information sheet version 2
- Consent form version 2

This approval is valid until 1 May 2011, provided that Annual Progress Reports are submitted (see below).

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment
- information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by 1 May 2011. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

Requirements for the Reporting of Serious Adverse Events (SAEs)

For the purposes of the individual reporting of SAEs occurring in this study, the Committee is satisfied that the study's monitoring arrangements are appropriate.

SAEs occurring in this study must be individually reported to the Committee within 7-15 days only where they:

- are *unexpected* because they are not outlined in the investigator's brochure, and
- are not defined study end-points (e.g. death or hospitalisation), and
- occur in patients located in New Zealand, and
- if the study involves blinding, result in a decision to break the study code.

There is no requirement for the individual reporting to ethics committees of SAEs that do not meet all of these criteria. However, if your study is overseen by a data monitoring committee, copies of its letters of recommendation to the Principal Investigator should be forwarded to the Committee as soon as possible.

Please see www.ethicscommittees.health.govt.nz for more information on the reporting of SAEs, and to download the SAE Report Form.

We wish you all the best with your study.

Yours sincerely

Diana J. Whipp

Mrs Diana Whipp

Administrator Upper South B Regional Ethics Committee

Email: diana_whipp@moh.govt.nz



MASSEY UNIVERSITY

COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

1

Principal Investigator:

Andrew J. Lock
Professor
School of Psychology
Massey University
Turitea Campus
PALMERSTON NORTH
Tel: (06) 3569-099 Ext 2061
Tel (emergency): 0800 627739

Researcher:

Peter R. Ashton
Alcohol and Other Drugs Practitioner
Rata Alcohol and Other Drugs Service
West Coast District Health Board
High Street
GREYMOUTH
Tel: (03) 769 7805
Tel (emergency): 0800 104141,
027 3089280

Stories of Addiction *Ngāa Korero e Pūuwaia*

You are invited to take part in a research project which will investigate the processes by which addictive behaviours develop, are reinforced, and may be addressed. This research will involve participants relating their individual stories with particular regard to their journey into their addiction(s) and their experiences of addiction(s), including gambling.

This study has received ethical approval from the Upper South B Regional Ethics Committee, ethics reference number URB/10/07/025.

Following a full explanation of the study, and being provided with this Information Sheet, you are requested to advise the Researcher (at the address/telephone number provided above) within 7 days if you wish to participate in this research.

Your participation is entirely voluntary. You do not have to take part in this study and, if you choose not to take part, this will not affect any future access to care or treatment.

If you do agree to take part in the study, you are free to withdraw from the study at any time, without having to give a reason, and this will in no way affect your future or continuing health care.

Participation in this study will be stopped should any harmful effects occur or if it is believed that it is not in your best interests to continue.

Aims of the study

This research will seek to identify those components of client stories that may facilitate self-directed change processes within a small group representing substance abusing and/or gambling behaviours.

- a) It will examine the language of addiction and how such language underpins self and social identities and consequent motivation to initiate behavioural change;
- b) it will seek to place such factors within the context of major models of addiction and provide comment on their adequacy within contemporary treatment models;
- c) it will attempt to identify how individual stories may direct the processes of change within an individualised treatment plan.

Through the use of qualitative research methods, and thematic analysis in particular, this research will explore the social meanings attached to substance abuse and/or gambling and the social processes that create and reinforce such meanings.

This research is in part fulfilment (thesis) of a Master of Arts Degree in Psychology.

Participants

Participants will be identified by advertising in health-care and community facilities, and by what is called “the snowballing effect” whereby friends or others suggest someone who might be interested and eligible for the study. Only between 6 and 8 participants will be included in this research due to the amount of data likely to be generated. Among the inclusion criteria for participation in the study are the following:

You must be at least 18 years of age

You must be willing to provide demographic data such as age, gender, ethnicity, and occupational status.

You must have gambled and/or used substances in a problematic way in the three months prior to the telling of your story.

You must be able to relate your experiences and the meaning of gambling and/or substance use in your daily life.

You must agree to have your story audio-recorded.

Where will the data collection take place and what will be involved?

It is intended that the data collection will take place at the premises occupied by Rata Alcohol and Other Drugs Service where you can take part in the research in safe and comfortable surroundings and where privacy can be assured.

It is anticipated that you will relate your story over one to two visits of around two hours each. However, no time limit will be placed on the sessions which would continue until you feel that you have fully described your experiences. A further visit may be requested so that the Researcher can present you with a transcript of the previous sessions and seek clarification or verification of any information provided. At the conclusion of the analysis and reporting stage, you will be invited to a further visit to receive feedback on the research and information regarding access to the completed thesis, and to uplift a transcript of your story, should you so desire.

What will happen during the sessions?

1st meeting (introductory) inviting participation and explaining the study): The Researcher will confirm that you meet the inclusion criteria above and that you are fully informed as to all aspects of the research including privacy and confidentiality conditions, the aims of the study, process and methods, data analysis, feedback, and publication of the research findings. Consent documents will be discussed, and when the criteria for informed consent have been met, you will be invited to sign the Consent Form. Demographic information will be obtained and a suitable date and time will be agreed for data gathering.

1st session (data gathering): You will be asked to describe your 'journey' into problematic substance use and/or gambling behaviours. Following principles of thematic analysis, a broadly chronological account will be sought; however, as much as possible, the Researcher will not interrupt or seek clarification of your story-telling as it is important that it truly reflect the experiences and meaning of addiction as experienced by you. You will be encouraged to relate your personal story unencumbered by any preconceived definitions, expectations, or conceptual frameworks on the part of the Researcher.

At the conclusion of the session, you will be asked to relate any concerns that you may have resulting from the telling of your story and any follow-up that you may require.

If required you will be invited to attend a 2nd data-gathering session.

Final meeting (feedback): The Researcher will invite you to hear the results of the study and means of accessing the final published research. You will again be invited to express any concerns you may have regarding your participation and your personal progression from addiction: should there be any concerns identified appropriate referrals will be made for you. You may take a copy of the transcript with you.

During the research, all audio recordings and transcripts will be held in secure storage on the premises of Rata Alcohol and Other Drugs Service. At the conclusion of the study, all such materials will be placed into long-term secure storage for a period of 10 years in accordance with protocols for health data. You may choose to make a copy of your transcript available to health providers for therapeutic purposes however that will be your own responsibility.

It is expected that stories will be gathered by the researcher before December 2010 and that the study will be completed by April 2011.

Benefits, risks and safety:

While the purpose of this study is to contribute to available research on addictive processes, and thereby enhance therapeutic treatment, you may find that telling your story is of benefit to you. There is considerable research to indicate that the telling of one's personal story allows people to understand their situations and find new directions for their lives.

It is hoped that you will find that the time involved (2 to 6 hours), and any inconvenience incurred, will be worthwhile. In appreciation of your contribution to this study, you may choose from either a petrol or supermarket voucher, to the value of \$20.00.

There are no anticipated or perceived risks for you, however, the process of telling one's story can sometimes invoke painful memories and may cause distress. You can terminate sessions at any time, or withdraw from the study, if you find that your continued participation is difficult. Likewise, the Researcher will terminate any sessions, or continued participation, if the process is considered or perceived to be causing you undue distress. Under such circumstances, appropriate counselling services will be made available or referrals made in accordance with your wishes.

General:

Possible questions that may arise:

1. *Will my GP be told that I am in the study?*

If you are not a current client of Rata Alcohol and Other Drugs Service, no one will be informed of your participation unless you request it, or some further counselling is considered appropriate. No referral will be made without your knowledge, however, if there are any safety concerns or risks of harm to self or others, the Researcher will advise you of the need to disclose such risk to appropriate services.

If you are currently a client of Rata Alcohol and Other Drugs Service, your participation will need to be discussed with the Manager of that service, and your Case Manager, to ensure that it does not interfere or interrupt your treatment plan; this discussion will only occur after you have given consent in writing.

2. *What will happen at the end of the study?*

At the end of the study, transcripts and audio-recordings will be placed into secure storage for the required 10 years. Your continued confidentiality will be assured.

If you wish, or the Researcher believes it to be in your best interests, referrals to other treatment providers can be discussed.

3. *Where can I get more information about the study?*

You can contact either the Researcher, or the Principal Researcher, listed on the front page of this Information Sheet. Remember, you can ask any questions and address any concerns that you may have during the initial meeting, or any subsequent sessions. Your participation is entirely voluntary and you may decide not to proceed at that, or any later, stage.

4. *If I need an interpreter, can one be provided?*

Interpreters will not be available as the nature of the study, thematic analysis, relies upon your story being able to be clearly understood and analysed by the Researcher; this may not be possible if an interpreter is needed.

5. *May I have a friend, family or whānau support me to understand the risks and/or benefits of this study and any other explanation I may require?*

Yes. You should be entirely comfortable about participating in this study and you are encouraged to fully understand any risks, benefits, and all aspects of your participation.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:

Free phone: 0800 555 050
Free fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

Confidentiality

No material that could personally identify you will be used in any reports on this study.

No transcripts will bear your name. Instead, a numerical code will be used to identify the transcript as yours (e.g., 75). The list identifying you with a particular transcript will be kept by the Manager of Rata Alcohol and Other Drugs Service to ensure that no person, other than the Researcher, can ever identify the transcript as yours.

As previously mentioned, all transcribing of audio recordings will be done by the Researcher and the transcripts will only be seen by the Researcher and/or Principal Researcher and the Manager of Rata Alcohol and Other Drugs Service who will ensure safe and secure storage; transcripts and audio recordings will be securely stored on the premises of Rata Alcohol and Other Drugs Service.

The final thesis will use pseudonyms (aliases or assumed names) if and when a direct quotation is applicable. If you wish you may choose a pseudonym.

Results

Your participation in this research is greatly appreciated and the Researcher wishes to ensure that you have the opportunity to be involved after the data collection is completed. As previously mentioned, you will be invited to a final session to discuss the results and to learn about accessing the published study.



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

1

CONSENT FORM

Stories of Addiction

Ngāa korero e Puuwaia

(Please circle answer)

I wish to have an interpreter

Yes

No

E hiahia ana ahau ki tetahi kaiwhaka
Maori/kaiwhaka pakeha korero

Yes

No

I have read and I understand the information sheet dated 03/09/10 for volunteers taking part in the study designed to investigate stories of addiction.

I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time, and this will in no way affect my future/continuing health care.

I have had this project explained to me by the researcher (Peter Ashton).

I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.

03/09/10

Stories of Addiction

Version 2

I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.

I understand that the data gathering will be stopped if it should appear to be harmful to me.

I have had time to consider whether to take part in the study.

I know whom to contact if I have any questions about the study in general.

I know whom to contact if I experience any adverse thoughts, emotions, or behaviours as a result of my participation in the study.

I consent to the telling of my story being audio-taped.

I am aware that I can request the researcher to discuss the outcomes of the study with me and/or advise ways that I can access the published study when available.

I understand that the researcher will notify appropriate services if it is considered that there are safety concerns or a risk to myself or others.

I _____ (full name) hereby consent to
take part in this study.

Date:

Signature:

Researcher/Co-investigator:

Peter Robert Ashton

Contact phone number

(weekday):

(03) 7682805

(emergency)

027 3089280, 0800 104141

Principal Investigator:

Andrew J Lock

Contact phone number

(weekday)

(06) 350-5673,

(emergency)

0800 627739

Project explained by:

Peter Ashton

Project role:

Researcher/Co-investigator

Signature:

Date:

Stories of Addiction



Peter Ashton (MA candidate) and Professor Andrew Lock (Massey University) invite you to participate in research in part fulfillment (thesis) of a Master of Arts Degree in Psychology.

Background

Existing models of addiction offer contradictory explanations of the causes of addictive behaviours and the means by which people can address such behaviours. Accounts of individuals' experiences provide valuable information regarding the language used, and identities assumed, by people experiencing addiction. Importantly, such stories can direct processes of change for such individuals.

Aim of the Study

This research seeks to investigate the processes by which addictive behaviours develop, are reinforced, and may be addressed. It will involve participants telling their individual stories with particular regard to their journey into their addiction(s), and their experiences of addiction(s) including gambling, in order that these can be related to existing models of addiction.

What does your participation involve?

If you are over 18 years of age and have experienced problematic substance use and/or gambling behaviours, within the past 3 months, we would appreciate you offering to tell your story. We anticipate that this may take between 2 and 6 hours of your time and possibly require 3 sessions for addressing issues such as confidentiality and any perceived risks, audio-taping of your story, and providing feedback.

Possible Benefits

There is considerable research to indicate that the telling of one's personal story allows people to understand their situations and find new directions for their lives.

Questions

If you are interested in participating in this research please contact:

Peter Ashton (Researcher and MA Candidate) on (03) 769 7805 Ext 2648 or email peter.ashton@westcoastdhb.health.nz to request the Information Sheet and ask any questions.

All enquiries will be treated in the strictest confidence and you may choose not to participate, or to end your participation, at any time without further explanation.