

RECOVERY FROM ALCOHOLISM AND ADDICTION

Recovery from Alcoholism and Addiction:
A Phenomenological View of Lived Experience

by

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Abstract

Current writing and research on addiction recovery is inconclusive about what is effective in promoting recovery from alcoholism and drug addiction. This thesis focuses on the narrative commentaries of people currently in recovery in an effort to determine what elements may be common among them that promote and sustain their recovery conditions. In depth interviews were conducted with eight individuals who offered personal details about their addictions and their recovery. Analysis of their narratives reveals a variety of thematic conditions related to the maintenance of sobriety and other personal goals.

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Dedication

This thesis is dedicated to all of the tireless individuals who work daily to help substance abusers, alcoholics, drug addicts and those affected by alcohol and drug abuse, and to the many alcoholics and drug addicts who seek to, or are actively staying clean and sober by whatever means at their disposal, and all those who are so doing within the abstinence based, twelve step, peer support fellowships. In particular, I gratefully acknowledge and thank the eight individuals who in voluntary support of this research project shared both their stories of shame, anguish and despair, and their phenomenal recoveries from this dark place. Their recovery experiences are anonymously shared in these pages with the hope that their journeys will beneficially influence work with substance dependent people, alcoholics and drug addicts.

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Preface

My primary interest in addiction and recovery is with the phenomenon of recovery itself and specifically, what people who are in recovery would say about what seems to have helped them, given that addiction is often a fatal condition. In addition, I have a secondary interest originating from awareness that the addiction treatment field has long been engaged in debate and speculation about what works to facilitate an addict's achieving recovery. There are some explanations for this and I have attempted to outline them in this document.

I have observed convincing reasons that the various positions in the debates can be harmonized and reconciled without denying their core tenets. Many people in the field including those who utilize the support networks of twelve step recovery fellowships, have intuitively recognized for example, that abstinence and harm reduction approaches lie along the same continuum of population and needs, and that many of the methods used in various treatment paradigms, have many points of therapeutic connection.

After many years of encountering a significant number of people in sustained recovery, I decided to ask some of these recoverers what has helped them survive and maintain their recoveries in this often seemingly hopeless personal affliction. I became convinced that a suitably designed qualitative phenomenological study would reveal processes and mechanisms imbedded in their lived experience narratives of addiction and recovery that would prove useful to many in the field and many who seek to recover.

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Chapter 1: Introduction

Recovery from alcohol and drug addiction and dependence, although not well understood (National Institute on Drug Abuse, 2012), is considered by many to be a widespread phenomenon (Vaillant 1995; Center on Alcoholism, Substance Abuse and Addictions, 2011). In this regard, it could be considered a significant topic for further study (National Institute on Drug Abuse, 2012; National Framework for Action in Reducing the Harms Associated with Alcohol and Other Drugs and Substances in Canada, 2012). There are various opinions and explanations offered about what it is, what causes it to happen and what sustains it (White and Kurtz, 2005; Merta, 2001). From these various opinions have emerged much debate and even some controversy that has caused skepticism and disclaimers about the effectiveness and even the value of historical approaches and programs dedicated to addiction and dependency treatment (Sellman, 2009). Some even suggest that recovery is not a treatment outcome, but rather, a condition that happily exists in some and not in others (Tempier, Dell, Papequash, Duncan, and Tempier, 2011). An examination of treatment theory and methods with reference to disagreements and controversies, and of related supportive therapies used in treatment and aftercare, may serve to foster new understandings of effective approaches in this field and perhaps even some harmonization of approaches. Prochaska and Norcross, (2007) believe there are many areas of common ground in facilitating change which support a trans-theoretical view of treatment and recovery. In order to provide another context for understanding recovery, this study is an attempt to have people in recovery describe their experiences at a deeply personal level regarding the phenomenon in order to shed light on what helps and may help others.

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Some theorists believe that addiction and dependency issues are well described and understood (Merta, 2001), yet the collective understanding of the phenomenon continues to develop as we endeavour to gain more insight into what happens to those who struggle with the personal and social problem of addiction and dependency. A perusal of the National Institute on Drug Abuse, (2012), the Center on Alcoholism, Substance Abuse and Addictions, (2012), and the National Institute on Alcohol Abuse and Alcoholism, (2012) websites reveal a wealth of information available to everyone on the topic of addiction and recovery in general, but recovery from addiction remains poorly understood and defined (White, 2004). It is however, observable among alcoholics and addicts who pursue recovery through support and treatment programs at the community level and at the institutional level (Derry, 2009).

In this work, recovery is perceived as both a condition and as a context. In other words, it is the subject of this study, and it is also the context by which recovery is understood. This includes its being a deep personal issue and a social challenge. The view expressed in planning this work is that addiction and recovery can be seen as a deeply personal experience, which is best understood through delving into the lived experience of people in recovery. Qualitative phenomenology is currently the best way to try to develop a deeper and more meaningful understanding of this phenomenon.

Controversy and Varying Views of Addiction and Recovery

The disagreement and controversy about recovery can be understood and contextualized by seeing it through the lens of treatment variability (Marlatt and Donovan, 2005). The term ‘substance related disorder’ is found in the Diagnostic and Statistical Manual of Mental Disorders, IV. It refers to substance abuse and substance

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dependencies and this latter term has long been a part of the practical vocabulary together with the terms alcoholism and drug addiction (American Psychiatric Association, 1994).

The fact that there are multiple terms for this problem is indicative of the divergent and sometimes conflicting academic and practical positions held by people in the field. Often, these various terms are used interchangeably. Dependency is preferred by some practitioners and academics who indicate they do not like the word addiction, because this implies that alcoholism is a disease experienced and encountered by people that causes them to abuse substances. Some believe that these problems are simply learned behaviours which can be unlearned with motivation and therapy, and still others assert that drug and alcohol abuse are expressions of unconscious impulses from the psyche of a person, while others assert they are the result of unresolved developmental issues due to suppressed emotional incongruence (Merta, 2001).

The debates and controversies as reflected in part by theoretical and terminological differences seem to portray an inconclusive overall understanding of the problem and recovery from it, which may create difficulties for those who are afflicted and those who would help them.

The international addiction treatment field continues to be held back by ongoing battles between different camps. Professional rivalries and mutual disrespect between various groups, such as between researchers and clinicians, physicians and psychologists, neuroscientists and social scientists, residential workers and community workers, practitioners and managers, impede progress. (Sellman, 2009, page 105)

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Addiction and Recovery Terms of Reference

In this study, the words alcoholism and drug addiction denote what this study's 'clean and sober' participant respondents understand as the all encompassing predicament that they believed they were powerless to change. A common observation made about this in the operative terms frequently used to define addiction or alcoholism (Sunshine Coast Health Center, 2011) is that users seem to be compelled to use and abuse psychoactive substances, continue to do it in spite of the consequences and experience loss of control over how much and how often they engaged in it while their problems mount up with an ever increasing need to escape through more alcohol and/or drugs.

Some people who experience such difficulties tend to see it as abuse but not as addiction. It is sometimes asserted by those who struggle with this problem that alcohol and drug dependent people are not actually addicted and might even be able to drink or use drugs responsibly again if they had sufficient reason for it, and could manage their lives effectively within this context (Alcoholics Anonymous, 1939). Some suggest that some of these people actually are alcoholics or addicts but they just don't know it or accept it. However, it seems in nearly all cases that the continuing results of their abuse will intervene and they will in time come to understand and accept their condition and will engage in the total abstinence recovery path. They stress this point saying that according to the way they understand it, there is no middle ground in addiction; you either are or you are not an alcoholic or addict, it's up to you to decide for yourself.

Despite the controversy and disagreement, it seems to be widely agreed in treatment and counselling circles that addiction and dependency are afflictions that affect a person physically, emotionally, socially and spiritually. Both conditions are considered

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by some to have identifiable stages of development and outcomes (Hazelden Foundation, 2012). Most researchers and treatment experts seem to agree that addicts cannot engage in substance use/abuse or behaviours without issues such as relational conflict, emotional breakdown, economic insolvency and general social isolation from non-users developing from it (Center on Alcoholism, Substance Abuse and Addictions, 2012). For this reason many believe that complete abstinence is the only true solution along with some form of moral inventory and self change practices to deal with both the pre-disposing and resulting problems that were once ‘medicated’ with alcohol or drugs (American Medical Association 2012; National Institute of Drug Abuse, 2012).

Significance of Study

The clean and sober participants in this qualitative phenomenological research project have achieved something that few would have predicted. In order to provide another context for understanding recovery therefore, this study is an attempt to have them describe at a deeply personal level, their lived experience of the phenomenon, in order to shed light on what helps and may help others. In McCabe’s view, (2007) qualitative phenomenology is currently the best way to try to develop a deeper and more meaningful understanding of this phenomenon because it is a gentle, unobtrusive humanistic encounter between the participant and researcher.

The study’s findings illustrate that many recovery conditions described by the participants, are a shared, common experience and we can indeed speculate that the many thousands of their fellow recoverers who practice the same method, experience these as well. It could be suggested therefore, that these conditions contribute to achieving and

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sustaining recovery and are important for treatment practitioners, therapists and all those affected, to know about and be able to access.

Focus and Purpose

There seems to be little research focused on the personal and understood qualitative experience of recoverers themselves (Moos, Finney, and Cronkite, 1990). Neale, Allen, and Coombes (2005) point out that just three qualitative research based articles had been published the previous year in a specific journal, or about 2% of the research papers that it published in 2004. This qualitative research project, therefore, is intended and designed to provide a qualitative perspective on the phenomenon of recovery. It is also intended to focus attention on how a sub-group of the population of those struggling with alcoholism and drug addiction recovers from a condition they perceive and acknowledge as seeming to be beyond their control, and that of their familial, social and professional support networks.

Describing circumstances in the participants' personal lives that might affect their recovery trajectories are, for obvious reasons, beyond the scope of this study. Similarly, this study will not cover the vast topic of addiction causality about which, much has been written over the past one hundred and fifty odd years. While these issues are significant and are considered relevant, they are precluded from this study. Relative to the immediate purpose of this study of eight persons' recoveries, it is considered sufficient to explore the specific data emerging from their recovery narratives.

Research Question

Community based services and programs attempt to deal with the problem by referrals to the appropriate system based resources and to local support groups (Winnipeg

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Regional Health Authority, 2012; Alcoholics Anonymous Manitoba, 2012; Cocaine Anonymous of Manitoba, 2012).). Despite the controversy and variance in treatment approaches, long term ‘sober’ people can be observed and encountered with some regularity as members of treatment groups and programs in communities at large. It is not unusual to encounter people in a range of from one to sixty years abstinent sobriety.

Our central research question will therefore ask, what might these people share that could inform us about what they feel and believe works for them in their staying clean and sober, the better to understand the phenomenon of recovery?

For the purpose of this study, the operational definition used to describe recovery from addiction and dependency, is the gaining or maintaining of continuous abstinence from alcohol and other drugs followed by incremental positive change in lifestyle. The Betty Ford Center website, (2012) offers a similar consensus developed definition of recovery: “Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship.”

The object of this thesis is to provide information about recovery as experienced by individuals who have achieved it, in the hope that this will offer some new data, and perhaps even some insights. To provide suitable context for this endeavor, we include a study of the prominent literature that is available on the subject, and other relevant literature focused on programs, theoretical approaches to treatment and on the phenomenon of recovery in general,.

A description and definition of the method and the research theory is offered after a review of the relevant literature. As an extension of this, a description and report of this qualitative phenomenological investigation into the lived recovery experience of eight

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adult individuals who have been diagnosed by others and described by themselves as addicts and substance abusers is offered. A discussion on the data and a number of conclusions are offered along with recommendations for treatment professionals and others interested in the phenomenon of recovery; and, of course, for those still struggling with dependency, and for people in recovery who are looking for understanding about their own experience.

Chapter 2: Literature Review

Addiction Treatment

The phenomenon of recovery has been covered mostly from the perspectives of treatment outcomes (Marlatt and Donovan, 2005; Derry, 2009; White and Kurtz, 2005). Despite this, and perhaps partly because of it, there is a great deal of controversy and conjecture about what causes it to happen and what sustains it (National Institute on Drug Abuse, 2012). As Sellman (2009) suggested, it would appear to be important for addiction practitioners and administrators who seek to help alcoholics, drug addicts and substance dependent people recover, and who want to be able to understand and access best practices, to understand and perhaps even be able to reconcile some of the controversies in the treatment and rehabilitation field. This may lead to understanding recovery dynamics in new ways that could be applicable to their work (Prochaska and Norcross, 2007).

Substance related disorders are an enormous burden on individuals, families and whole societies (American Psychiatric Association, 1994). Affected individuals cause trauma and attachment problems for their spouses and children, who in turn tend to act out these deficits in their relationships, their workplaces and neighbourhoods. Some of them turn to substance abuse to medicate their feelings, often replicating the problems of the family member abuser (Wegshieder-Cruse, 1990). Many criminal behaviours are associated with alcohol and drug abuse causing costly and problematic public safety issues for societies (Andrews and Bonta, 2010; Correctional Service Canada, 2012).

When individuals engage in the use/abuse of legal or illegal psychoactive substances, a variety of outcomes occur (National Framework for Action in reducing the

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Harms Associated with Alcohol and Other Drugs and Substances in Canada, 2012). One of these outcomes is the response made to try to help these people recognize their problem and change whatever is required to alleviate the decline and dissipation they have brought on themselves.

Historical views of substance abuse and addiction

It is not difficult to find cultural and historical accounts of substance abuse problems throughout the ages up to and including the modern era. In the fifth century before the common era during the time in China known as the spring and autumn era, the famous scholar and philosopher Confucius (551-479) is said to have commented on the perils of alcohol. He warned that when a person takes a drink, the drink takes a drink and then the drink takes the person. Presumably he had noticed that some drinkers lose control of their lives to alcohol. The Bible and Koran similarly warn about intoxication and self-indulgence (Longenecker, 1994). Roman scholars have described the excesses of some citizens which included those involving drinking. Not much is known about it in the 'dark ages' after the fall of the Roman Empire but medieval literature contains accounts of various punishments for drunkenness and debauchery. After this period, there was a tendency to associate some alcohol and drug abusers with nefarious intentions and sorcery, yet there were people who seemed to escape punishment, indicating a degree of acceptance for lifestyle intoxication. In Shakespearean times, there seems to be both acceptance and condemnation perhaps as a result of social position. In the eighteenth and nineteenth centuries, when there was more interest in the origins of behaviour, abuse came to be associated with mental illness and moral weakness. There was a growing awareness of the abuser as someone who had something seriously wrong with them,

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which caused loss of control and debilitating dissipation. Inebriates could find themselves locked away in an asylum for years because it was thought that there was little or nothing that could be done to help.

It was in these times, however, that people became interested in finding some way that sufferers might be helped, usually through religious approaches. In 1840 there began a temperance club who called themselves the Washingtonian Total Abstinence Society. They became very influential in the latter half of the 1800s and created much interest in alcoholism and abstinence as a way out of it. There was also at this time the Women's Christian Temperance Union who linked Christian values with various social reforms, most notably alcohol temperance and abstinence (Tracy and Acker, 2004). Through these and other public and religious movements, the United States was a hotbed of political debate about the perils of alcoholism, and dependence on drugs such as opium, morphine and cocaine, culminating in 1919 with Prohibition. (Alcohol and Drugs History Society, 2012).

In more modern times, Gelinek (1942) conducted post prohibition era studies at Yale University at a time when interest in alcoholism and other forms of drug addiction was growing rapidly with the new age of psychology, motion pictures, radio broadcasting and the founding of Alcoholics Anonymous in 1935 and the publication of its book *Alcoholics Anonymous* in 1939. Gelinek's work was seminal in the categorization of the types and stages of alcoholism and many followed his lead, writing what is now a vast amount of information and research on alcoholism, drug addiction or 'dependency'. In the 1950s according to the National Institute on Drug Abuse, (2012), the American Medical Association began calling alcoholism and drug addiction a chronic, relapsing

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disease of the brain where compulsive drug seeking behaviors and drug abuse would continue despite the often devastating consequences.

The 1960s saw a counter cultural shift in America and to lesser extents in the UK and Canada. It was characterized by a significant departure from old mores and social rules about sex, social structures, drug use, and thrill seeking among the ‘baby boomer’ demographic. There was a virtual explosion of interest in and illicit use of drugs like marijuana, methamphetamines, and psychedelics such as peyote, psilocybin and LSD. The opposition to the war in Vietnam, perceived materialism and big corporate control of government focused drug use and abuse as a way to protest (Braunstein and Doyle, 2002). The 1970s and 80s saw the rise of cocaine and ‘crack’ cocaine, opiates and ‘designer drugs’, and the start of the so called war on drugs which has continued to date in various forms (National Institute on Drug Abuse, 2012).

There were human casualties of these upheavals including those created by the increased abuse of the legal drug alcohol. Academics, psychologists, psychiatrists, sociologists, social work and family systems therapists were quite challenged and often not in agreement about how to classify substance abuse issues (Marlatt and Donovan, 2005). It has been viewed as a manifestation of many constructs such as moral weakness, mental illness, psychological disorder or ‘complex’, medical illness or disease, and learned or adaptive behavior, to name but a few. Dependency and addiction have appeared in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994), in the criminal code, in medical models, religious categorizations of sin and in scholarly works about dysfunctional thinking and behaviours (Alcohol and Drugs History Society, 2012).

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With the inconclusive nature of the overall content of the literature (White, 2004; Sellman, 2010), there is fertile ground for divergence and the quite understandable biases of the medical, psychiatric, social work, sociological, psychological and religious communities in regard to interventions and helping methodologies.

Contemporary views on treatment

The current edition of the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV), discusses alcohol and drug problems as substance-related disorders. As a source of diagnostic criteria, its influence has been widespread, especially at the front lines of the psychological, psychiatric and medical fields. Its coverage of the problem includes two categories: ‘substance abuse’ which is the mal-adaptive use of psychoactive drugs leading to recurring adverse consequences; and ‘substance dependence’.

Dependence is characterized by a group of social, cognitive, behavioral and physiological symptoms relative to the person’s continued use/abuse of substances after harmful consequences. Diagnosis is made when three or more symptoms from the following list happen at any time during a twelve month period: tolerance, withdrawal, increasing dosage, a desire to cut down on use, increasing focus and effort to obtain and use substances with an increase in time to recover from the effects, important recreational, occupational and social patterns are broken down in favor of substance use/abuse, and continuing to use in spite of the consequences (American Psychiatric Association, 1994).

In a recent commentary on addiction and the as yet unpublished DSM-V, it is suggested that in comparison to the DSM-IV, it is even more prone to cultural relativism and dependence on psycho-social criteria. This creates a troubling generality to the criteria making them hard to apply, and especially so in view of the progress made in

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translational (animal) studies, genetic and brain imaging studies (Meyer, 2011). The DSM-V collapses the prior edition's two categories of 'substance abuse' and 'substance dependence' into one category which interestingly, they are calling 'addiction' (American Psychiatric Association, 1994).

In a very few jurisdictions such as Manitoba, Canada, treatment for substance dependence and addiction is supported and funded by the community and delivered primarily by the Addiction Foundation of Manitoba (AFM), but additionally through a number of funded agencies (Winnipeg Regional Health Authority, 2012). The primary method of intervention in such organizations tends to be behavioural and abstinence based. Most other jurisdictions in Canada and the United States tend to prefer and rely on treatment services delivered by private agencies and paid for by the patient or by insurance companies but they apply similar methods of intervention (McLellan, Lewis, O'Brien, and Kleber, 2000).

Founded in 1956, the AFM for many years followed a public information and treatment model grounded in the abstinence based, twelve step, peer supported method pioneered by AA. They provide many prevention and education materials and courses which describe how afflicted persons progress through stages of decline characterized by the frequency and severity of the problems in life areas such as social, employment, legal, financial, family, interpersonal, spiritual and health. They agree with reports that the expected outcome of untreated substance dependency or addiction is an earlier death from physiological, self-inflicted or other violent and accidental causes (American Medical Association, 2012). Currently, they could be described as large and eclectic enough to accommodate their original approach as well as harm reduction and systems

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approaches which support an understanding of substance disorders in addiction and dependency terms (Addiction Foundation of Manitoba, 2012).

The most common model of addiction treatment in Canada, the United States and the United Kingdom is the Minnesota Model originally developed over sixty years ago by the Hazelden Foundation in response to the spread and perceived success of Alcoholics Anonymous as well as to a shift in the understanding of alcoholism and addiction from a moral failure or mental disorder model to a disease model (Merta, 2001; Hazelden Foundation, 2010; Derry, 2009). The Minnesota Model of treatment has become one of the predominant approaches in North America. It has had a long history of support from health insurance providers, be they governmental or private, resulting in the characteristic three or four week length of residential treatment. The American Psychological Association, (2012) reports that in the United States, ninety three percent of treatment centres to one degree or another follow the Minnesota Model in their approach.

The model views addiction as a primary, chronic and progressive disease, a medical condition in and of itself with a naturally occurring history, which aspect was reinforced in 1956 by the American Medical Association. The Sunshine Coast Health Center, (2012) mentions there does not seem to be agreement within this model that it is a disease at all. Objection to the word disease appears to be about not giving addicts an easy excuse, in preference for holding them accountable for their behaviour (Correctional Service of Canada, 2012).

Programming is typically delivered in a residential setting and is characterized by the goal of abstinence and use of many of the self-help recovery principles of Alcoholics Anonymous. The intent of this model is to provide a humanistic and systematic method

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to encourage self-evaluation, acceptance of responsibility, relational integrity, accountability, spiritual development, and positive action. These practices are believed to be instrumental in maintaining abstinence and fostering personal growth (Tonigan, 2007). It has served as a template for many treatment providers but has evolved to become somewhat of a “big tent” paradigm. For example, humanistic and psychodynamic methodologies have been blended with cognitive behavioral and bio-psycho-social approaches. Practitioners with a wide variety of training and inclinations can be found within such an orientation (Derry, 2009).

Recovery in the Minnesota model can be described as a person’s gaining or regaining abstinence from all psychoactive substances and taking positive action which will foster their own positive personal growth leading to gains in physical health, emotional maturity, cognitive functioning and spiritual development. Patients are urged to get seriously involved with a twelve step fellowship peer support programs and do a rigorously honest moral self-examination and amends making that hopefully will result in some form of humility and spirituality based spiritual orientation taking place in their hearts and minds. They do not specify the parameters of spiritual growth, leaving that for clients to determine for themselves (Derry, 2009). In trans-theoretical terms, recovering addicts remain in the maintenance stage of change as opposed to the termination stage, and are well advised to keep on doing what seems to work especially staying involved in peer support circles such as those in the twelve step fellowships (Prochaska and Norcross, 2007; White and Kurtz, 2005). Treatment providers working from within this model seek to motivate participants to accept their affliction as life threatening if they persist in drug use or try to go it alone and get over it by themselves. In addition, pro-active and

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influential community proponents of Minnesota Model treatment facilities have set up pre and post treatment sober houses where recoverers can participate in peer support, a trusted mainstay of recovery (White, 2009; White & Kurtz, 2005).

Beyond the Minnesota Model, there are many other methods for assisting alcoholics and addicts achieve recovery. The following are some of the more common methods currently to be found in Canada, the UK and the United States. They will be discussed in terms of main principles, treatment methods and what recovery would be in their model. There are for example, community living based behavioural modification programs, private clinics that use a variety of techniques from aversion therapy to dietary supplements, and street level faith based operations that rescue addicts and provide them with care, food and counselling, often in a residential setting (Merta, 2001). Modern cities and even smaller communities have most or all of these kinds of treatment programs available to substance dependents and addicts. In addition there are the routinely available three or four week long residential treatment programs and associated aftercare programs if available, and one to one psychiatric, psychological and therapy/counselling resources. Sober living houses, most with abstinence requirements, help pre and post treatment clients, pre-court clients, parolees, and co-existing disorder clients who have mental health or cognitive functioning issues (Center on Alcoholism, Substance Abuse and Addictions, 2012).

Recovery in community living based, behavioural modification programs can be described as the extinguishing of problematic behaviours which include, of course, the substance abuse behaviours and their related interpersonal, social and criminality based behaviours. Concurrently, pro-social behaviours that contribute to either abstinence or

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controlled alcohol or drug use depending on how the treatment goal is defined, are reinforced (Marlatt and Donovan, 2005). This model is grounded in behaviourist psychology principles utilizing peer support and challenging (American Psychological Association, 2012). Proponents assert that recovery is mediated by the positive and negative social feedback inherent in living in a residential therapeutic community dedicated to providing this feedback. During their residency, recoverers can gain literacy and other educational skills as well as basic employability enhancing skills from working in the kitchen, laundry and maintenance departments. An example of this method is the Behavioural Health Foundation in Winnipeg, Manitoba. They claim that community living is the method and their residents progress through higher levels of responsibility until ready to function pro-socially in the community at large. Staff and residents alike function as change agents (Behavioural Health Foundation, 2012).

Recovery in the Christian based missions that rescue addicts concerns becoming abstinent from all psychoactive drugs, surrendering to and practicing the redemptive message of Jesus Christ as found in the new testament of the Bible, and the joining and being active in a compatible fundamentalist or evangelical Christian church . It would include social affiliation with members of the church congregations that support the mission, or simply with others affiliated with the mission. Religious conversion and spiritual transformation work to change a person's addiction orientation to a healed condition while social affiliation and peer support sustain maintenance of the healing. In Winnipeg, examples of this approach are operated by the Union Gospel Mission and Siloam Mission (Union Gospel Mission, 2011; Siloam Mission, 2012). Relatedly, male youth eighteen years and over with drug and alcohol problems can apply to Winnipeg's

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Teen Challenge for example, where again, outreach, treatment and aftercare is a matter of redemption through Christ and supportive peers who espouse and practice the same message (Teen Challenge, 2012). The Winnipeg division of the Salvation Army operates a faith based approach in their “Anchorage” sixty day, residential treatment program which runs in conjunction with a rescue outreach operation for men and women and a residence for pre and post treatment clients (Salvation Army, 2012).

Demographics can influence faith based recovery as exemplified in both organized and individual approaches involving Aboriginal elders and specifically trained people delivering a variation of the faith based model. The focus of these methods is on learning and practicing traditional Aboriginal culture and healing pathways (McCabe, 2007; Native Addiction Council of Manitoba, 2012; Winnipeg Regional Health Authority, 2012) while abstaining from drugs and alcohol. Patients are urged to follow spiritual pathways of healing and stay involved in traditional Aboriginal cultural activities and with peers. A person would be urged to acknowledge the Great Spirit or Creator as God and the source of healing. Recovery then is part of the transformative embracement of the seven sacred teachings, traditional spiritual healing practices such as the healing sweat lodge ceremony and community ceremonies such as the sundance and naming ceremony.

Related to this approach are recoveries beginning when an addict or substance dependent person reaches out for help to his/her minister, priest, pastor, rabbi, Native elder or imam. This individualized approach begins, as do many therapeutic and faith based interventions, with assessment, counselling and recovery planning anchored in the redemptive and transformative power of faith in Jesus Christ, The Creator, Yahweh or

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Allah (Neff, Shorkey, and Windsor, 2006). Ongoing recovery would be characterized by devotion to specific faith based and family activities, abstinence or tightly moderated alcohol or other legal drug (e.g. prescription drugs) use, and the progressive positive improvement in presenting problems as well as improved relational or marital and family functioning. Recovery could also, but not necessarily, include referral to a compatible established in / out patient treatment program to facilitate problem solving and self-awareness followed by regular support from a spiritual advisor.

Recovery, as conceived by some private clinics, would for example, involve a variety of cognitive behavioural, humanistic and psychodynamic approaches together with targeting identified needs in a person's health and wellness areas (Passages Malibu, 2012; American Psychological Association, 2012). Recovery would be defined in terms of the client's presenting problems which would of course include substance abuse, family or relationship functioning, plus financial, employment, education, and legal areas. Abstinence would not necessarily be a recovery goal but moderation and legality of substance use would be. A holistic, eclectic, relational and highly individualized program of treatment and support combine to define and motivate recovery (White and Kurtz, 2005).

Recovery in typical residential and non-residential, intensive substance abuse treatment programs not operated within the Minnesota model depends on the theoretical orientation of the provider (White and Kurtz, 2005). A search and perusal of addiction treatment websites indicates that orientations and methods are diverse in this category. Abstinence is a recovery goal for most clients with a minority urged to develop moderation in use. Recovery would therefore include some measure of substance use

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modification with concurrent improvement in life areas where problems were identified. Recovery would be supported by the individualized selection and application of appropriate family systems, psycho-social, humanistic, existential and cognitive behavioral therapeutic approaches by the treatment team or the client's counsellor (Passages Malibu, 2012).

Efficacy of supportive therapies in treatment

The psycho-social view of alcohol and drug dependency suggests that negative substance abuse behaviours are adaptive and changing them is fairly straightforward (Merta, 2001). If the painful dysfunctional relationship between a person and his or her social environment are identified as the force driving the substance abuse and they are understood and corrected, the person's stress level will be decreased and the need for the adaptive self-medicating will no longer be operative. Prochaska and Norcross (2007) discuss evidence showing that clients receiving varying kinds of counselling had significantly reduced drug use after therapy than did clients who had no therapy. Implicit in the psycho-social approach is that addiction does not actually exist nor is there any physiological component because the dysfunctional drug abuse behaviours cease after a person solves their problems. Recovery would be defined in terms of problems having been solved with more appropriate psychological and social adaptations resulting in improved feelings of wellbeing (White and Kurtz, 2005). Abstinence is therefore irrelevant and not a requirement after therapy.

The bio-psycho-social perspective promotes similar approaches with an additional focus on physiological factors including genetic and pre-dispositional influences. Adherents recommend doing comprehensive case assessments that capture the biological,

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psychological and social aspects of the individual's life that are affected by substance abuse in the hope that this information would improve recovery outcomes. Implicit here is the assertion that there are physiological issues such as craving, tolerance and differential substance sensitivities which are exacerbated by obsessive / compulsive thoughts and urges (Donovan and Marlatt, 1988). Genetic predisposition plays a role and the model clearly asserts an unstoppable predicament for which abstinence and therapy, including group therapy, are the only effective treatment conditions required for the establishment of healthy living (Sunshine Coast Health Center, 2012).

Practitioners of cognitive behavioural (CBT) methods for treating substance abusers, dependents and alcoholic/addicts have a different set of theoretical underpinnings evolving from the combination of behavioural psychology and cognitive therapy where a person's thinking; i.e. attitudes, values and beliefs, and cognitive distortions and misconceptions influence emotion and behaviour. Changing self-defeating thoughts and behaviours is the goal of therapy and recovery from addiction would be described as eliminating attitudes, values and beliefs and distortions/misconceptions that lead to high risk situations and behaviours which would include drug abuse. Relapse prevention then, is a key part of therapy for addicts (Bandura 1977; Correctional Service Canada, 2012).

Schema Therapy is a method within the CBT School and according to Young, Klosko and Weishaar (2003), there are 18 schemas which are described as deeply engrained combinations of self-defeating negative beliefs about oneself that contribute to the development of habitual problematic cognitive behavioural coping patterns including those involving use and abuse of substances. If the therapist and client determine that

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abstinence is a definite requirement, the treatment plan would very likely include peer support where abstinence related attitudes, values, beliefs and behaviour are essential and reinforced. If a client is willing to progress toward clean and sober healthy living, he/she will quickly learn many of the cognitive and behavioural restructuring techniques practiced by sober peers (National Institute on Drug Abuse, 2012).

The psychodynamic approach asserts that substance abuse, dependency and addiction are symptoms of deeper emotional issues which must be understood and resolved before the client can improve, cease the alcohol or drug abuse and begin recovery (Margolis and Zweben, 2011; Psychodynamic Therapy, 2012). This suggests that a client should focus on these aspects first while either abstaining from or moderating their substance use. Recovery would be understood as the client's gaining instrumental insight and using this to make healthier lifestyle and relational choices leading to abstinence or modified use.

The humanistic method, which is closely connected to the existential school, adopts a positive view of humanity emphasizing our uniqueness and potential as individuals (Smith-Jones, 2012). Therapists in this school are concerned with exploring the nature of relationship, love, self-actualization, empathy, authenticity and individual strength in order to help patients grow and change. It facilitates self-directed means for them to begin problem solving and repairing relationships. In therapy clients would explore the absence of the core conditions of non-judgmental empathy, unconditional positive regard and congruence in childhood, with a view toward discovering possible self restricting emotional blockages (Corey, 2001) With these core conditions established

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in therapy, addict clients can make significant insight gains in their commitment to recovery and change (Prochaska & Norcross, 2007; White & Kurtz, 2005).

Therapists working from a family systems perspective view family problems as originating within the family group dynamic rather than from the individual. Family systems models (and learning models) appear to reject notions that addiction is a disease preferring to suggest that is rather a learned maladaptive and self-defeating strategy of self-medicating the experience of environmental pain and suffering (Marlatt and Donovan, 2005). The complex family system has its own characteristics and patterns of interacting and it is from within these that substance abuse and other personal problems originate (Corey, 2001). Family systems therapists help individual members understand how their childhood family functioned, what their role was at the time and how this directs their role in the family at present. Addicts would receive individual therapy and in some practices, family members would be brought into therapy as well for the purpose of identifying relational deficits and dysfunctional patterns of problem solving.

Theoretically, the need to medicate problems and feelings with substances will decrease as progress is made in treatment. Family systems practitioners have difficulty accepting the term addiction as it implies a medical model understanding where treating symptoms does not address the real problem of family dysfunction. Progress in the systems perspective however, permits an acknowledgement of organic pathologies in the substance abusing client which abstinence or moderation will deal with as family dysfunction is treated (Sunshine Coast Health Center, 2012; White & Kurtz, 2005).

Twelve step fellowship recovery from addiction (Alcoholics Anonymous, 1939) is characterized by an emphasis on total abstinence from alcohol, engagement in

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fellowship, autonomous local organization, no governance, few rules, self-help in conjunction with peer mentorship (i.e. sponsorship), voluntary service to others in recovery and to the fellowship, and the practice of twelve suggested steps. These steps call for admission and acceptance of alcoholism, openness to help from any spiritual or religious sources, self-examination, confession of personal defects, willingness to change, making amends to people and/or organizations that were harmed, personal responsibility, prayer and meditation and helping other alcoholics in their struggle to stay sober. They do this mindful of twelve traditions that suggest how individual fellowship groups (chapters) and their members should conduct themselves, their meetings and other endeavours such as service to hospitals, detox facilities and treatment centers (Alcoholics Anonymous, 1939; Alcoholics Anonymous, 2012). Cocaine Anonymous (2012) and Narcotics Anonymous (2012) have an almost identical structure with changes in emphasis relative to recovery and lifestyle. Relapse is not condemned but rather, suggested as an opportunity to learn. It is understood that changing one's dysfunctional ways is highly recommended because the substance abuse was a symptom of underlying personal issues.

Many alcoholics and addicts have recovered through affiliation with these fellowships which can now be found throughout the world (Alcoholics Anonymous, 2012; Vaillant, 1995; Center on Alcoholism, Substance Abuse and Addictions, 2012). This has had a significant effect on the substance abuse and addiction prevention, education and treatment fields as evidenced by the widespread use of the Minnesota Model of addiction treatment (Derry, 2009).

Theoretical similarities

Treatment should lead to recovery by exposing clients to what is believed to be efficacious (White & Kurtz, 2005). We have looked at a number of commonly used treatment approaches and supportive therapies for addiction and dependency. By and Large, and primarily due to the widespread and use of the Minnesota Model, the humanistic approaches with their strong emphasis on the therapeutic relationship, freedom, choice, responsibility and long hidden emotional content, are often combined with psychodynamic approaches and peer support in treatment (Derry, 2009; White & Kurtz, 2005). Group Therapy and one to one counselling tend to be favoured treatment approaches when combined with residential community living. However, due to individual differences in clients such as personality, level of involvement with alcohol and drugs, family dynamics and their individual responsiveness or learning styles (Andrews and Bonta, 2010), variations of method and technique are often necessitated.

In terms of commonalities in supportive therapies, Prochaska & Norcross (2007) discuss some relevant points in their treatise on psychotherapeutic systems offering a trans-theoretical perspective as an integrative framework that practitioners can use to increase intervention effectiveness. They believe that although the most widely used psychological interventions for treating addiction differ, they agree on the processes that occur as change happens. These processes include self-awareness, self and environmental re-evaluation, consciousness raising, dramatic relief, personal and social and self liberation, commitment, counter conditioning, reinforcement management, stimulus control and helping relationships. They assert that consistent effort using treatment strategies that make gains in these areas will yield results (Prochaska & Norcross, 2007).

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White, (2009) comments on humanistic approaches supporting recovery where he believes most treatment centers are theoretically oriented but in need of what he views as a much needed resource. He believes that inclusion of peer support would greatly enhance and even transform the ability of current systemic programming to facilitate longer periods of recovery for society's most severely addicted persons.

In a general review of addiction treatment in the last 40 years Woody, (2009) suggests that studies of psychosocial treatments are benefiting the field and advancing our knowledge base beyond its mostly pharmacological content. A widely used and studied beneficial psychosocial treatment for example, has been relapse prevention programming followed by counselling.

Simpson, (2009) suggests the treatment literature generally supports the efficacy of techniques that bolster motivation, improved cognitive functioning, behavioural reinforcement therapy and peer/social network building. His view supports the position that therapists can indeed help substance abusers and addicts get on with the business of rebuilding their lives prior to and after abstinence is established through creative combination of learning models and peer support (Bandura, 1977).

There seems then to be agreement that a range of differing treatment and supportive therapies have positive outcomes. In Sellman's view (2009), psycho-social methods were at the forefront of treatment prior to today's new age of pharmacotherapies. Twenty years of research has identified four main approaches to treatment: cognitive behavioral therapy, twelve step based endeavors, motivational enhancement therapy, and social and behavioral network therapy. A prominent

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randomized outcome study did not identify any significant differences in these approaches, suggesting that any of them could be used successfully.

Practitioners who are able to provide a variety of methods and approaches are more likely to facilitate positive outcomes across a broader spectrum of clients (White & Kurtz, 2005; White, 2009). The fact that there are many approaches to treating human dysfunction including addiction seems to be a good thing (Prochaska and Norcross, 2007). As pointed out at the beginning of this section however, recovery appears to not be well understood given the emphasis differing schools of thought place on preferred approaches (Sellman, 2009).

Treatment Controversies

After many years of treatment program design, development and delivery with the clearly recognizable influence of the Minnesota Model and ongoing advances in psychotherapeutic theory and practice, there is an avenue available for assessing treatment outcomes with the goal of identifying best practices. Yet treatment outcome research has been slow in coming (Tonigan, 2007). Currently the Canadian federal government is developing an evidence based Drug Treatment Strategy in the hope of addressing much of the controversy surrounding the theoretical and practical dimensions of addiction treatment. There is strong impetus for assessing outcomes from Minnesota Model approaches because there is a dearth of studies in this area (National Framework for Action in Reducing the Harms Associated with Alcohol and Other Drugs and Substances in Canada, 2012). While considering this, we will look at some relevant aspects where differences of opinion are most apparent and perhaps even causing difficulty in our understanding of recovery.

Is addiction a disease?

The disease model states that some people develop a distinct physical and psychopathological condition that renders them incapable of drinking or using drugs in moderation. Treatment implications include working with the individual to accept their diagnosis and practice a life of abstinence from alcohol and other drugs (National Institute on Drug Abuse, 2012). In many treatment centres, the disease model has been blended with other models leading to much confusion among clinicians and people in recovery. For example, AA is often considered the basis for the disease model, when in fact the AA book makes little reference to the cause of alcoholism but rather the solution to alcoholism (Sunshine Coast Health Center, 2011; Center on Alcoholism, Substance Abuse and Addictions, 2012; Alcoholics Anonymous, 1939).

The disease model owes much of its existence to the influence of articles that have appeared in medical journals and to the American Medical Association's endorsing this stance in the 1950s (American Medical Association, 2012; National Institute on Drug Abuse, 2012). In addition, new developments in brain imaging (Volkow, Fowler, and Wang, 2003) seem to be a way for supporters of the disease model to argue their case. The American Society of Addiction Medicine (ASAM) website (2012) now includes a definition of addiction which asserts that it is "a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations". In contrast, the Time Healthland (2012) website was quick to respond to this new definition suggesting that ASAM's definition was formulated in part, to remove the stigma from addictive disorders. They go on to suggest that such neurobiological labelling may not

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have any positive effect, and may even exacerbate stigmatization. Those who prefer the learning model of addiction however, reject notions that addiction is a disease preferring to assert that is rather, a learned maladaptive and self-defeating strategy (Marlatt and Donovan, 2005).

Abstinence or harm reduction?

With regard to an orientation that can raise debate, harm reduction health care should be looked at in comparison with abstinence orientations. To begin, some societies and cultures such as Canadian, American, U.K. and Northern European, have a long history of endeavours aimed at helping the mentally ill, addicts and people who apparently cannot help themselves (Marlatt, 1996). In this area of human services delivery systems including the workers on the front lines, care is provided even while knowing that many of their clients are likely to be in a similar state next day and the days and weeks after that. Some of these clients are alcoholics and addicts who unfortunately, succumb to their affliction without ever getting well, while others get well periodically but relapse and end up on the street doing crimes, begging or prostituting themselves (Main Street Project, 2012).

Simply put, these societal efforts target the reduction of harms caused by people with various medical, mental health, and related conditions. The harms in question are both to themselves and to society. Some of these people are addicts, others are offenders, some are homeless or are sex trade workers, and others are chronically disenfranchised, dysfunctional persons, while some are an aggregate or combination of these circumstances. For many reasons, they seem to be less likely to respond to interventions than others in the mainstream population (Marlatt, 1996). The philosophical and

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psychological orientation behind approaches made to help such people and the organizations and agencies who deliver services and care, have come to be known as following a harm reduction model where saving lives and reducing harm to the living is the immediate priority while abstinence or cures are not, except perhaps as an ideal outcome later on (Winnipeg Regional Health Authority, 2011; Marlatt and Donovan, 2005).

In contrast, but specifically with regard to addiction treatment, supporters of the abstinence model suggest that clients need to continually strive for total abstinence from any and all psychoactive drugs, even prescribed drugs which can often lead to dependencies and where great care needs to be taken by health care providers in supervising this area of risk (Hazelden Foundation, 2012; Derry, 2009; National Institute on Alcohol Abuse and Alcoholism, 2012; Addiction Foundation of Manitoba, 2012; Winnipeg Regional Health Authority, 2012).

Ideological conflicts have arisen from these seemingly opposite perspectives where one side asserts that harm reduction strategies are a way of buying time during which the person could finally become abstinent or otherwise ameliorate their alcohol and other drugs (AOD) situation (Vancouver Area Network of Drug Users, 2012; Methadone Intervention and Needle Exchange, 2012). The opposing view would suggest that abstinence is the most effective harm reduction strategy for addicts and ultimately, the only solution. Because it seems to be associated with the abstinence view by many, the book *Alcoholics Anonymous*, (1939) says that although they are abstinence based with about half their numbers eventually achieving this goal, another half improve to varying

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degrees which suggests that this group may, by definition, be practicing a form of harm reduction on their own (Alcoholics Anonymous, 2012).

Learning or humanistic approaches?

This area has to some extent, been discussed in the earlier section about whether addiction is a disease, with Sellman (2009) asserting that CBT, a learning model, was as effective as other methods. Behavioural and cognitive behavioural therapies assert that what appears to be addiction is actually a set of learned behaviours with their associated self-defeating attitudes, values and beliefs. It is best treated in directive ways, with relapse prevention programming for example, emphasizing risk reducing positive choices in high risk situations (Correctional Service of Canada, 2012). The humanistic method along with existential, gestalt and client-centered therapy, emphasizes a non-directive approach where a person is afforded non-judgemental empathy, unconditional positive regard and the time and freedom to explore, choose and actualize better ways of getting along in their world (Prochaska & Norcross 2007; White & Kurtz, 2005).

The controversy in part, seems to concern the importance of relational dynamic conditions between clients and therapists and the time necessary to accomplish change (Margolis and Zweben, 2011; Andrews and Bonta, 2010). The Correctional Service of Canada (2012) asserts that in their system there is a negative correlation between measures of criminality (which include substance abuse and addiction variables) and the effectiveness of non-directive programming and therapy whereas there is a positive correlation between directive CBT relapse prevention methods and decreases in criminality.

Conclusion

A review of the literature on addiction treatment and recovery suggests that there is a broad range of opinions about how alcoholics, addicts and dependent drug abusers might be able to achieve and sustain a state of recovery. As we will see below, clearly, there is some degree of common ground in treatment approaches and outcomes, but also revealed in the literature were controversies between differing perspectives at service delivery, social policy and psychological treatment levels.

While this may be true, recovery from addiction can be observed and appears to be a phenomenon inasmuch as it is not clear what causes and sustains it. There is an impetus therefore, for tapping into what successful recoverers themselves have to say about their experience in recovery. Viewed through a phenomenological lens, their stories may add to knowledge about what sustains recovery and is helpful to the community of those seeking recovery and those who would help them.

Chapter 3: Methodology

The main objective of this section is to describe the decisions, definitions and methods used in carrying out this research project. It was mentioned earlier that recovery is present and observable in communities and that many of these recoveries had resulted from a variety of treatment and intervention approaches. In its attempt to explore what people in recovery would say about their personal experiences of addiction and recovery, this research effort employed the research technique referred to as qualitative phenomenology (QP) which, in Patton's view (2002), asserts that:

... human beings make sense of experience and transform experience into consciousness, both individually and as shared meaning. This requires methodologically, carefully and thoroughly capturing and describing how people experience some phenomenon - how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others. To gather such data, one must gather in-depth interviews with people who have *directly* experienced the phenomenon of interest; that is, they have "lived experience" as opposed to second hand experience. (Patton, 2002, page 104)

Further, qualitative methodologies are those that produce findings not generated by statistical processes or any dedicated forms of measuring or counting (Patton, 2002). Hoepfl, (1997) makes the distinction between qualitative and quantitative research asserting that the former endeavours to uncover understand and extrapolate to like situations, whereas the latter tries to establish correlation and causality by analyzing

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quantified variables. Some consider the phenomenological approach to be a philosophical orientation and an important tool within the scope of qualitative methodologies (Trochim, 2006). McMillan and Wergin (2002) assert that in a qualitative phenomenological study the central area of interest and dependent variable is the phenomenon itself; in this case, recovery from drugs and/or alcohol addiction.

In this study, an attempt has been made to draw out and assess the personal and subjective feelings, interpretations and meanings that participants apply to their lived experience of addiction and recovery.

Research Technique: Participant Selection Criteria and Recruitment

Participants: Eight participants were selected based on a set of relevant criteria. They were chosen from within the membership of the Alcoholics Anonymous (AA) and Cocaine Anonymous (CA) support groups. Although this was not a requirement for selection, it created a recruitment source from among a population of people professionally, and self-identified as being in recovery. The applied participant inclusion criteria were that each participant had to be in abstinent recovery for at least three years and be over eighteen years old. For purposes of balance and diversity, four participants were to be female and four male. For the same reasons, four were AA members and four were CA members. Participants were expected to be maintaining their involvement in their fellowship's standard process of meeting attendance, having a sponsor, assisting other members and working the twelve suggested steps of the program.

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For a variety of reasons, selection was a challenging task requiring careful thought and planning. For obvious reasons, it would not have been an acceptable idea to attempt recruitment by approaching treatment centres, members of the clergy or churches, therapists, doctors or anyone who would be ethically bound to protect client identity. However, my personal and professional experience placed me in a first-person situation of knowing people in recovery. Could these people be approached to participate? The answer proved to be yes. My thesis committee approved my thesis proposal and the University of Manitoba Education and Nursing Research Ethics Board granted ethical approval. People could be approached and asked to voluntarily participate in this study, given that the approach was made with full disclosure of details and the commitment of providing a letter of informed consent and a post-interview copy of the final interview transcript for their comments and the adding, changing or deletion of any information during a subsequent meeting for this purpose.

The recruitment process was initiated by approaching one person I knew whom I believed met the selection criteria. This person agreed in principle to participate and was sent the requisite information, ethics approval and consent letter, which package was studied and returned with the letter of consent signed, indicating her willingness to participate. She suggested others who were thought to meet the criteria. Gradually a pool of potential participants was identified by virtue of having some acquaintance with me or from being suggested by others with whom I spoke. I then made the same approach to these people as made to the above woman, endeavouring to build in diversity and balance as outlined above. This required travelling around to several AA and CA circles, introducing myself and asking for individuals' participation in the study and in some

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situations, meeting in coffee shops for a discussion. The response was quite positive with only two people pulling out after receiving their information packages and just a few indications of non interest from people approached. In total, three of the eight participants were previously known to me, three of the CA participants had had some previous involvement with NA. All participants indicated their familiarity with the narrative process to be used in this study because it is also the format used in meetings they attend. No attempt was made to control for race, income level, or related factors such as whether they lived in an affluent neighbourhood or less affluent neighbourhood, or if they were employed or not.

Data collection

Private interviews were conducted with each participant that lasted for sixty to ninety minutes on average. Each participant was interviewed only once. Interviews were recorded such that data could be downloaded to a computer for further mechanical processing such as data transcription and storage. A late model digital IC voice recorder was used in all the interviews. Data was then immediately downloaded from this recorder to a portable memory device and then downloaded from this to the confidential transcriptionist's computer. Once transcribed and printed, the interview file was erased from this person's computer with only a copy of it remaining in the researcher's computer.

The eight in-depth interviews were deliberately unstructured in order to allow participants as much freedom and comfort to express thoughts and feelings as they arose naturally (McCabe, 2007). Empathic responses from the researcher and the occasional prompt or question were all that were needed to keep the participants in their story. To

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further facilitate a participant's comfort, I opened the interviews with a brief introductory discourse to refresh the participants recollection about what was going to take place.

There were no prepared questions for participants to use as a guide. Notes and observations were made during the interviews. All interviews were done in the participants' own residences with two exceptions when the participant's workplace office was used.

The data collection process ran quite smoothly and uneventfully. It was expected however, that with some participants, deep emotions might be brought out in the course of their telling their story and I was aware of my need to be ready for this. All the participants experienced some emotional and animated moments and my response was to communicate acceptance with empathic reflection which seemed to support their regaining their composure and willingness to continue. All participants finished their interviews when they were ready.

Data analysis and interpretation

In preparing for analysis, transcripts and field notes were thoroughly and repeatedly studied in order to gain a strong sense of the participants and the details of their stories. Nagy, Hesse-Biber and Leavy (2006) indicate that in phenomenology, there are numerous personal understandings of how people experience intrinsically important aspects of living and there was in fact some degree of variance in how addicts experience addiction and recovery. With this in mind, the initial task was to begin the sorting out of relevant information, ideas, beliefs and concepts in order to identify various content categories, trends, themes, reoccurrences, and any connectivity of these themes.

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The process was initiated by reading the transcripts and noting significant words and phrases in the text with a brief annotation in the margin. Frequently, this annotation of significant discourse took the form of interpretive words or phrases such as ‘was inspired’, “really tried”, “felt grateful” or “puts her heart into it”, “believes in the fellowship”, “accepts himself”, “has positive expectations”, “connects with others”, “surrendering” and “constancy”, etc. This was the first level of attempting to understand what the meaning of a particular experience was to the person expressing it.

In all cases, a list of all such word and phrase annotations was made at the end of a transcript with their relevant line numbers, in the order in which they appeared. Then a master list of these words and phrases was made from these eight lists which again included line numbers but also the pseudonym initial of the person who gave them. This facilitated an enumeration or tally of the number of times a significant condition or factor was mentioned by the participants. In this way a pool of data was assembled from the narratives. A table of recovery factors and their frequency of mention is in Appendix A.

The research design included the use of a volunteer co-interpreter. The person selected for this task had been the senior counsellor at a long term, Winnipeg residential addiction treatment center and had many years of intervention and counselling experience. He agreed to read all the transcripts, make notes and comments and in general, identify, like the primary researcher, what seemed to be operative in the recovery narratives. A smaller but similar list of factors was thus developed permitting an almost seamless co-mingling of data in the master list.

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The final level of phenomenological analysis concerned studying all the factors in the master list and identifying those with a common meaning in the participants' recoveries. These common meaning themes had then to be given names which bespoke what their meaning was interpreted to be relative to the participants' recoveries. Individual recovery factors were thus assigned to these meaning categories. This work prepared the way for discussing the results of analysis and interpretation in Chapter 4, mindful of the goal of this research which was to try to facilitate a credible understanding of how addicts actually achieve and maintain recovery.

Data analysis was a lengthy process of reading and re-reading the transcripts. It took several weeks to get through the process which included the annotation of significant discourse. Transcripts tend to be somewhat difficult to fathom at first, because they are an inaudible representation of audible speech, and it was necessary therefore, to sometimes go back to the recording and find the meaning from the audible version which, by nature, we tend to find more communicative. One transcript was almost 1000 lines long because the participant had much to say and spoke quickly. On average it was not particularly difficult to discern the meaning of discourse. It was more challenging to sort out the general thematic meaning of groups of factors. What helped was the recognition for example, that many factors were about helpful and instrumental interpersonal dynamics between an individual and his / her peers or close friends, or about how clearly and strongly individuals indicated their belief in and trust of their AA or CA group or in the overall program of recovery they found in these fellowships.

In making assertions as to some mechanism of recovery efficacy as inherent in a thematic category, it was necessary to find examples of discourse in the transcripts that

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really encapsulated the meaning of what the participant experienced that was for them, so important. Such text passages were often the ones infused with deep, clear certainty, in other words, it was in how an individual spoke. Also useful were passages that really were succinct in what was helpful. Tentative discourse tended not to be useful in this regard. Some participants tended to be quite a bit more declarative than others, one in particular, while several had a particularly sincere way of denoting meaningful and important conditions that they believed supported their recoveries.

Research Design Credibility

Although validity and reliability are not considered necessary in QP, efforts were made to reduce the influence of researcher bias in a similar QP study of Aboriginal healing conditions and processes; McCabe, (2007) suggests that although interviewer objectivity may not be a high priority of the interviews, one should endeavor to eliminate researcher bias in data collection. With this in mind the researcher endeavored as much as possible to bracket his beliefs and knowledge during data collection, analysis and interpretation (Aspers, 2004; LeVasseur, 2003; Richardson, 1999). Although there is some disagreement over one's ability to achieve this, the researcher attempted to do this as much as possible.

In discussing the alternatively used concept of validity in this qualitative study, it is interesting to note that many researchers have developed their own concepts of it and have often used what they consider to be more relevant terms, such as credibility, quality, rigorousness and trustworthiness to suggest that a study is valid (Lincoln and Guba, 1985). The writer concurs with this position. Qualitative research design should include ways to enhance credibility and trustworthiness so that peers and other readers will

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consider the methods as trustworthy as those of the quantitative researcher, which many research consumers tend to trust without question.

In this study, attention was focused on how often participants mentioned conditions or factors that seemed to be influencing recovery. This proved useful in the results chapter where fifty eight of them were organized, in part, by how often they received mention, as well as to they're being about feelings, thoughts, spirituality or behaviors. Frequency of mention, although important, was only one of several credibility related considerations.

Care was taken in this study to try as much as possible to ensure that what was studied is actually that which was intended to be studied. Therefore, to in part support credibility, interview guidelines were sent out to the eight participants together with their letter of informed consent and ethics approval certificate, introducing them to the simple narrative process wherein they would describe their lived experience of recovery in their twelve step recovery fellowships and what they believed helped them. The guidelines were intended to facilitate the congruence of intent, process and results. Adding to this was the similar informative discussion held in the recruitment process and another very brief one just before the interview started.

Further, what participants disclosed as helpful in their recoveries can be considered to be what they actually believed to be helpful, given that they are being honest and sincere. This constructivist perspective means that what a person has come to believe is that which is real or valid for that individual (Glaserfeld, 1984). My reflective responses and gentle prompts during the interviews were a further assurance that their discourse was as reasonably on topic and thorough as it could be. Congruence in the

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observations and interpretations of the researcher and co-interpreter were recognized as a further means to support credibility, as was all of the participants declaring in the post interview de-briefing, that their transcript was an accurate representation of what they intended to say and that there was no need to add to, delete, or change anything they said.

Additional credibility factors concerned whether or not the results achieved would be consistent with repetitions (Joppe, 2000), and whether they would be representative of a broader population of recovering addicts, permitting specific generalizations. In this regard, participants were as much as was possible, selected at random after it was evident they would meet the criteria for inclusion in the study. As mentioned earlier, the QP design employed in this study is a trusted method of gaining intimate access to a person's understanding and interpretation of the lived experience of a phenomenon. By chance or intention, if other researchers employed the same methods and got similar results, this qualitative triangulation should increase the credibility of the study's findings.

The rules set for inclusion or exclusion of data are were a further means to support credibility by showing for example, that only directly connected evidence is used relative to the research question. In this study, speculative assertion about what is important and perhaps instrumental in recovery included all of the conditions or factors that indicated that a certain feeling, activity, belief or circumstance was somehow significant in their recovery. Rules for excluding data included not discussing irrelevant input and erstwhile speculation made by participants when they seem not to know what to say, or because the information was elicited by an interviewer misstep such as a leading prompt.

The Choice of Qualitative Phenomenology to Access Imbedded Recovery Data

In the course of listening to and recording the participants' narratives, there was the requirement and opportunity to observe their demeanor. As they relived a profoundly painful, meaningful and transformative personal experience, the simple act of telling their story, even after several or many year's sobriety, had a perceivable, deeply felt impact as indicated by their tears, posture and intonation. In terms of the QP methodology chosen for this study, the re-telling of their personal narratives appeared to be an empowering experience for all participants. I began to speculate that this was an indication of something unique they carry with them and frequently reflect on by themselves, with fellow recoverers and with others in their lives. This self-perceived sense of having survived appeared to be part of the overall condition of being an alcoholic or addict in recovery.

Put into a composite summary, it would sound something like "I have been to hell and back but I'm still here and I'm so totally amazed and grateful that I didn't die when I should have and others did". Their narratives of loves, losses, rage, pain, victories, and humiliations appear to have a special meaning and power that is a part of their lived experience, but about which, participants did not comment on directly during the interviews. I would speculate that for them, this sense of survivorship created a very meaningful identity in comparison to people in the so called normal population. Indeed, given that the participants were describing experiences that by now were well past in their lives, the effect of openly talking about them indicates that this seems to have been retained. The participants' AA and CA meetings and related social encounters are a daily

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forum for sharing their shared lived experience of addiction and recovery and this may suggest that this in itself may be instrumental in recovery.

Qualitative phenomenology therefore, was seen as the best way to access the inner meanings of the lived experience the participants shared relative to what helped to establish and sustain recovery. Given that care was taken to ensure credibility in the overall design, the analysis of the participants narratives should answer our research question which was “what could people in stable recovery tell us about what recovery is like and what sustains it”. The Betty Ford Center, (2012) defines recovery as “a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship”. Recoveries, as we have said, are experienced by some people whom the Sunshine Coast Health Center, (2012) suggested were compelled to use and abuse psychoactive substances, continued to do it in spite of the consequences and experienced loss of control over how much and how often they engaged in it.

The narratives of individual recoveries are eminently worth exploring because as the literature suggests, recovery itself is still thought to be inadequately understood and described, and people in recovery themselves are a much needed source of information on this topic.

Chapter 4: Results

This study was guided by the following research question: What might people who are at varying ranges of recovery share in common and describe in a narrative of this lived experience; how does what they feel and believe influence their sobriety; how might their understanding help others? In this section we will address these concerns by examining information embedded in the participants' narratives of lived experience.

The Overarching Meaning of Lived Experience in Recovery

Careful review and annotation of the interview transcripts yielded 58 significant factors which, when studied, indicated many manifestations and levels of inter-relational processes which the participants mentioned as being nurturing and even healing. With this perspective, it could be seen that this overarching aspect of the data was part of a strong humanistic process imbedded in six other thematic categories. These categories seemed to exemplify ways that the participants' lived experiences were sustaining their recoveries. The overarching theme permeating the participants' recovery was given the name "Healing Relationships" to communicate how this word denotes some qualitative processes and relational aspects of lived experiences that enabled simple humanistic processes of mutual care and support to support their recovery. Twelve conditions or factors which appear in appendix A seemed to consistently exemplify this form of efficacy and personal agency.

These factors are: connectedness - sponsorship (i.e., mentorship relationships) - identifying with and relating to others - encountering each other at meetings - tolerance, forgiveness and love - socialization outside of meetings - healthy friendships - the

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synergy of the circle (i.e. of their gatherings) - respect for others - belonging - brotherhood, sisterhood, and feeling positively influenced.

Sponsoring others (which includes being sponsored) is that supportive and nurturing desire to give and receive in recovery. Sponsoring others has benefits that derive from the change from a selfish orientation to an others-centred orientation and the inner commitment and effort put into it. Brooklyn had this to say about his long sponsorship trips to an out of town youth facility: "...there is an incredibly valuable component to that. I am now a sponsor and have two sponsees and I get so much out of talking to them and I get to relive my own story and remember the insanity that I lived through, and I get to process it and look it over and work it over, and I also get to live out what these kids are going through and say I have been there and know exactly where that's going to lead".

Participants commented on their meeting attendance and it would seem this factor is one of the key relational factors. In the various twelve step fellowships as described to me in the interviews, there was an observable belief that frequent meeting attendance was one of the best ways to ensure not drinking or using drugs. Art was clear about this: "For some reason I had it in my head that I had to get going because if I sat too long I'd be in trouble, right? So I got there at 7:00 o'clock in the evening and I had to fart around for two hours because it was a 9:00 o'clock meeting...and it was cold too, but anyways I was there and I put up the tables and that's what it was all about, getting to those meetings and doing these things." Art wanted what he could see that others had and he was willing to make the effort and proud that he did. Art had more to say on this: "9:00 o'clock was the big meeting for the End of the Line group and there would be like sixty or seventy

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people there in that basement and I can still remember going there because getting to a meeting was so important.”

Jacey said, “So I had a lot of free time open. So I went to three meetings a day and that was just because, yeah, I was very interested in what people had to say.” Jack put it like this: “I get to go to a meeting and walk in: my friends are there and we share things and we can laugh, if somebody says they’re having a problem, we care. If I say...I’m having a problem...people come over and put their arm around me and try to figure out if they can help me, give me some advice. People care and what I’ve learned is...if you look into their eyes...then you make sure that afterwards, you talk to them and the person will say you’re right, I’ve had a lousy weekend and I’m struggling with this.” When someone at a meeting asked him how he did it, Art said: “And for the first time ever I said I’m going to go with the God thing, and I never said that before.”

Rhonda was inspired by her recovery experiences to tolerate and forgive. “It allowed me to be open to people. It’s allowed me to forgive people, and probably bigger, to forgive myself,” thus enhancing her own relational skills. She later took a job working in the treatment field. Some recoverers meet many diverse people in recovery and build a social circle which extends beyond their recovery group, further expanding their relational and support horizons.

Respect for others appeared in many ways in the narratives and seemed to simply be part of the efficacious bond participants had with others in recovery. Art exemplified this care for his fellow addicts, sober or not. “That fellow I used to drink with...passed away from alcoholism because he couldn’t find a power greater than himself because the booze was just that...my first key tag is in his coffin in Lake Manitoba Narrows and I

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miss that man...he taught me very quickly and that was how I really found out about a power greater than myself.”

Positive peer associations can create fertile ground for developing or improving beneficial relational processes. In this milieu, tolerance for others, forgiveness for having been hurt or victimized and love for your fellow human are significant choices that when first made and then rewarded in some personal way, tend to gain credibility as right things to do. This process can more importantly, be a template for other like choices which can in general, account for a much more benevolent relationship with the world, promoting positive behaviour, reinforcement, and resultant learning and positive self-regard.

Through this overarching relational process, significant attachment and isolation issues for example, are incrementally mitigated by simple and innocuous gestures, like befriending a newcomer getting him or her a cup of coffee, chatting them up at a meeting or taking them out after a meeting and spending time listening to their story and sharing their own. These kinds of activities begin to happen in meetings. Art said, “And he knows when he comes in that you’re not alone, but you have to understand what love is and you have to understand that it’s that simple smile, it’s that laughter in the room, it’s that fellowship that replaces all the (pause)...that is a bond that you cannot live without.”

In their fellowship surroundings then, the participants can experience a corrective process for attachment and trauma issues, and a form of universality, instillation of hope, altruism, learning, role modeling, cohesiveness, existential acceptance, catharsis and insight.

The Meaning of Other Lived Experiences in Recovery

In the light of this overarching efficacious context, six thematic categories emerged from other factors of lived experience. They were called Hope, Change and Growth, Trusting Reliance, New Found Meaning and Purpose, Humility and Spiritual Transformation. “Hope” could be seen as a major gain made in the social and interpersonal milieu in which the participants moved. It may be that hope leads to more positive feelings about self and the environment which can lead to self-efficacy oriented thoughts and feelings and behaviour.

Factors such as: belief in yourself - feeling valued and accepted - feeling included a part of, not alone - hope and positive expectation - feeling on track, and courage, exemplified hope as being a crucial dimension of lived experience in recovery. Tina said, “Yeah, I read a line in one of my books that, you know, on the other side of fear is courage, but you have to go through the fear to get to the courage” which we believe is a component of hope. Jack put it another way: “We would read a page, paragraph, two pages whatever, and I can remember some of it but when we go around and share, everybody is telling or interpreting it for me and I feel it, it’s not just words, it’s a story and I come out of there feeling tremendous.” Brooklyn discovered he could fit in, and he experienced hope when he started attending an AA group in Ontario. “And Sudbury was great because they had a gay AA group there and that’s probably the first time I ever felt I really fit in in recovery... because anytime previous...I always felt like there was, you know, no one I could identify with...and I have this idea that I am somehow terminally unique.” It could be suggested that the instillation of hope is a key therapeutic process

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operating in a variety of groups including, we suggest, the recovery groups attended by the participants.

In terms of hope and positive expectations, Brooklyn lit up when he came to describing his future plans. “I have big expectations actually. Currently, my partner is finishing his master’s in English, and then I want to go bridge my paramedic degree to a nursing diploma, and then he’s going to do his PhD. And then I want to do my master’s in nurse practitioner, and then I want to join an international medical aid organization and go help in Africa or southeast Asia.”

“Change and growth” was identified as another major area in the lived experience of recovery. The participants became members of recovery groups where abstinence and change were understood to be prerequisites of recovery. Participants had all accumulated from three to fifteen years abstinence from alcohol and drugs, and notwithstanding the ongoing daily importance of this, they were concerned with getting back to some sense of social and personal normalcy. Change and growth became implicit recovery goals for them as they continued to attend their groups and gatherings where these topics were expressed in terms of factors such as: doing the steps - willingness - putting in the effort - desire to change - constancy and perseverance - gaining insight - seeing the progress in yourself - healing the shame - gaining self-esteem - a new self-awareness, and clarity of discernment.

Factors in this category seemed to speak to an apparent recognition by the participants that personal change was actually happening so something must be working. Seeing the progress in yourself evokes an understanding that a new sense of self was emerging out of the chaos in their lives. This was mentioned above as a form of early

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empowerment imbedded right in their personal narratives. Billy seemed to have experienced an attitudinal shift when reflecting that ... “I find that the longer I’m sober and if I meet somebody that’s arrogant, it’s my higher power’s way of showing me to take a look in the mirror - and seeing the arrogance in myself.....it’s all a learning experience and I’ve got a long way to go but I’m a hell of a lot better than I used to be. I’ve been told that by other people.” Awareness of changes can inspire and motivate the kind of living that ensures that it continues to sustain recovery.

In practical terms, change and growth are a potent reinforcement for having done the right things. Rhonda put it this way. “If I look back to the person I was and not just the addiction piece of me, it’s like a different person. Yes I can see that I was really skinny and crazy and had big bags under my eyes but even take away all of that, it’s like watching a movie of someone else, so that’s how I kind of know something has happened or changed.”

Putting in the effort was about what the participants discussed as not doing anything half way. They seemed to be clear about having to do the work before getting the result; work that was necessary in the correction of their personal shortcomings and the healing of guilt and shame. They also seemed to be aware of the need for pushing through the numerous old negative self-management habits that can be impediments to personal growth. Jacey suggested that newcomers should realize that “the key elements are to go to a lot of meetings. I think that is important because you get a lot of different ideas and people will explain what their comprehension of what the steps are.” She emphasized it was important to “read the book...I find answers in the book.” Art said, “If you sit down to wait (for others to do it for you), you’ll be laying on the trail to the

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finish line with your bones, and the road to recovery is lined with the bones of those that sat down to wait and that's true, and it's the same with that trail. You got to get up and you got to finish it." He was aware of the need to grow and the dangers of backsliding as well as how important constancy and perseverance are in regulating and balancing recovery needs and everyday living needs.

His willingness to work at it appears to be a vitally important attitudinal factor involved in applying yourself to the many doing or action oriented parts of recovery. Without willingness, the critically important desire to change that was a product of the pain of active addiction, may wither. Jacey commented on one of her first meetings: "I remember I got there and I was told that this woman is going to be your sponsor...and I said okay...and they told me you should get up there and get your 24 hour token, and I said okay. I just didn't have anything in me to fight and I figure these people are sober and I'm just going to listen to their suggestions." Brooklyn went further when someone admonished him about what kind of life he was facing: "Oh my god, so I was pretty scared; probably scared enough to actually want to do, well, my full effort in recovery because I have had a taste of prison now."

Other aspects of change and growth are more aspirational in nature and about contemplating what life could be like if one was to succeed in changing. It could be suggested that this liberating latter aspect is about a person's desire for the lifestyle gains to be had by changing. After she got some sober time in and had made two career changes, Jacey shared about wanting to be creative. "I decided I wanted to get into welding. I always wanted to go to art school but I was always torn between the

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practicalities of it because artists don't make money...so now I'm in (welding) school and...I really like it.”

Doing the steps appears to be one of the most important parts of change and growth. The recovery literature available to, and embraced by the participants suggests that each of the twelve steps involves a principle of recovery and so all must be taken. Rhonda recounted that she was able to make gains in self-esteem and self-awareness. “Well, I learned...I did my steps for one thing. So you know the steps by going through that process. I learned about forgiveness. I had a lot more self-esteem and self-worth, I learned about love and caring. I started letting people in.” Anna quoted a line from her AA book: “Rarely have we seen a person fail who has thoroughly followed our path...that's as simple as it gets. If you...work the steps, if you listen to other people in the program, you'll make it.” This comment also seems to be infused with clarity of discernment about a range of recovery matters in general.

Another meaning category dimension of lived experience was “trusting reliance”, into which factors such as: belief in the fellowship and program - trusting outside help - feeling safe and protected - admiring another recoverer, and being inspired by another recoverer. It could be suggested that acquiring trust is a vital part of feeling and believing that things are going to work out. This could, like hope, lead to gains in self-efficacy which can then lead to goal setting and trying out new activities which lead to the changes recoverers want to make to regain health, wellness, dignity and prosperity. This kind of learning could be seen as fairly routine in the participants peer supported recovery environment and there are usually opportunities to augment these gains with professional counselling.

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Belief in their twelve step fellowships and its program seems to have been a key feature for the participants in their lived experience of recovery 'Billy' summed it up like this. "I've found AA to be wonderful in so many ways because I'm with my own kind - that's the first and foremost, the most important thing. To me it's the most important learning facility in the world for me because I've learned so much in there. I've seen people come in who are young, old, female, male, black, white, gay, straight, rich, poor; everything imaginable and when I get to know them, I realize we that are all the same under the skin."

Jacey summed up her belief in her recovery group. "And I know for certain that, you know, in the tough times, that's what I've leaned on. I mean, I think it's a package deal. I think going to meetings and reading the book and talking to other alcoholics and addicts and even especially doing the service work - I think it's so many of those things that's helped me but I think front and center, it's my faith and that has really seen me through the darkest times because I mean, all those little adages that stick with all the things that people have that I have listened to people say in meetings over the time I have been sober, that certainly helps too."

This trusting reliance in what she is engaged in can be extrapolated to be about her whole peer recovery experience being empowering. As Anna put it, "And she asked me, how would I have done (in taking chemotherapy for cancer) without this program? And I said I would have crumbled...into a million pieces with this diagnosis. This program has given me so much strength...I sailed through treatment...my doctors can't believe it...they are going to give me gold stars."

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The way that the participants described their relationship with each other and their recovery experiences with the fellowship and program suggested that there was really something tangible to trust and rely on especially when there were difficult passages in life to get through. Jacey recounted her grief and loss when her brother died. “The last couple of years have actually been probably the most challenging years of my life because...my brother committed suicide...everything I had known and come to trust and believe and my values, like everything just instantly got changed around...I was starting to feel really good and I had this really good relationship with the God of my understanding and my whole life was in a good place. I didn’t think to go back drinking though...I guess what really helped me was having people. The next day I went to an AA meeting...because I always felt comfortable there and I shared with the group what had happened.” In this regard, she felt safe and protected and inspired by other recoverers whom she admired and modeled herself after. These endeavours created concrete memories and the learning of what can be perceived to be, and function as reliable relapse prevention commodities like good habits, firm beliefs and values upon which, one can trust and rely when beset with unruly thoughts, urges and emotions.

As a part of their progress in recovery, participants described a “new found meaning and purpose” to their lives which like the other lived experience meaning categories, seemed to be fostering relapse prevention empowerment through altruism and self-efficacy. Factors in this category included meaning and purpose, service, commitment, altruistic intention, certainty care and passion, being involved and invested, gaining wisdom and meaning, teaching others and being a positive influence.

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The realization that their life has value and means something special in some way, can thus be efficacious in recovery. Jacey put it this way. “I was a secretary for residential and non-residential (treatment) programming and...I would fill in for taking the bookings for Dr. ----- and doing the pre-admission process. I really felt kind of connected...I really felt like I was part of an organization that was helping other people and that was good for me.”

In this way, she could view the calamity of her active addiction as an experience that prepared her for working in the addiction field and helping others in recovery. Some go further and experience a sense of mission as evidenced in the giving back by paying forward, altruistic work of participants like Brooklyn and Art and participant Jack who when feeling a bit uncomfortable and out of place at an AA conference, found a spiritual meaning in it, thinking, “I said you know, God wants me to be here and...alright, let’s go, let’s sit down and do something. Everything works out if you believe that these things are happening to you for a reason.”

In terms of further recovery gains after building some clean and sober time, the participants experienced a healing of old wounds with resultant improvement in feelings and beliefs about meaning and purpose, which in turn, leads to positive action. This provides a basis for relating to and accepting others, and an understanding that trauma, shame, and alienation had created an inner emptiness in them which could now be filled with purposeful relationships and meaningful activities. They may develop sensitivity for these needs in other recoverers, especially newcomers, and become effective supporters of their recovery. Bonding through un-judged vulnerability is deeply moving, and for newcomers, is an immediate component of meaning, purpose, serenity and hope. They

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can say to themselves, I'm a recovering alcoholic or addict and that's fine with me. Tina put it this way regarding her first meetings. "There was no expectation other than me to be an addict and broken and want to recover." From Art's narrative, it was clear that he saw his life to now be about serving others in CA while practicing what he had learned from other recoverers.

Over time in recovery, the participants can be afforded an insight producing look at the continuum of their pre-dispositional issues, their downfall and ongoing recovery, enabling them to make sense of it and even find a humble satisfaction and serenity in having survived at all. It is no surprise then, that Jacey, Rhonda and Brooklyn transform this experience into purposeful work in the many branches of human services including health care and addiction treatment work.

Commitment and altruistic intention were factors fitting into this category by virtue of their perceived importance in building the motivational and attitude adjustment energy needed for staying involved in recovery activities and helping others. Art was adamant about this. "You know what, I kept those goddam room keys for two years. I opened up every Wednesday and Friday." He was definitely committed to ensuring that the meeting room was open because he wanted to give back to his fellow recoverers what he had been given. Brooklyn talked of his supporters urging him to action. "Like I've gone out to 'Compass' in Portage La Prairie to talk to little kid addicts." He was grateful for the support and encouragement when he was doubtful he could do it. Anna spoke of altruistic intention this way. "The most important one is the old golden rule; you should treat other people the way you would like to be treated. I certainly never did that before, and I never thought of the other guy. Practicing these principles is...being the best person

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I can be. For the first time in my life I care deeply about what I do and how I affect other people.”

Participants spoke of being involved and invested in recovery. What they said above about their commitment and willingness to helping others and their being involved in service are indications of this factor. Service was frequently mentioned in the context of what participants felt their lives should be about. Service is a broad name for activities that involve fellowship members in voluntarily doing anything that promotes the recovery prospects of other recoverers. Participants believed it to have a positive impact on them. Brooklyn said this about speaking at a youth addiction facility. “And that was really cathartic, a really healthy healing experience for me. Just to talk to 14 or 15 year olds and be like, I have been exactly where you are, hating myself and getting high about it.”

Art appeared to be filled with certainty, care and passion when he said, “And the thing was, like in the first five and a half months, is that I said I was going to be there (at a meeting) and damn it, I had to be there. I would get up and I would do a morning meeting and I would take off at 7:00 to get to the 8:30 meeting”. Similarly, Tina who admits to sometimes overstretching herself in terms of service, reports “So now, right now I’m area delegate, I’m convention chair, I’m GSR for the ladies group, I am treasurer of the area, I have got my sponsees and I do service work at both my groups way too much. I have a daytime job and a night time job and I have three children, and I sing in a band on weekends.”

There was no question as to her certainty, care, passion and commitment to being involved and invested in service and she was observedly proud of herself. Brooklyn too

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was proud and said this about it. “Being of service you know, that is a huge value to me because when I really look at it, the times when I felt most happy and most complete has been when I have been of service. What has gotten me out of my own emotions and my selfishness...it’s been when I’ve gotten out of myself and ...I don’t want to go to Compass, but ----- says I’m going so I better f’ing go, and then I go and I come back and I’m like humming a new tune and life is grand in a way I wouldn’t have thought it would be.” Brooklyn and the others had found meaning and purpose from their lived experiences in recovery and in so doing, grew in recovery wisdom, and the ability to foster and support others which they all did through, among other activities, active sponsorship of newcomers and veteran recoverers alike.

“Humility” was a dimension of lived experience in recovery that was present more by implication than direct report but it appeared to be very instrumental in sustaining recovery given that these recovery factors were seen as contributing to it: accepting responsibility - gratitude and satisfaction - learning from the pain - humility - attitude adjustment - honesty, and openness.

When studying the above factors, it seemed that humility as a lived experience, albeit a somewhat submerged example of it can function to tap previously inaccessible potential abilities sufficient to interrupt urges, motivate doing the right thing, or to not do the wrong thing. It becomes part of relapse preventing attitudinal dispositions.

In the early parts of their narratives, participants described circumstances and occurrences that were painful and humiliating. Some of these were discussed above as a means in recovery, to acquiring a beneficial sense of meaning and purpose. Similarly, many of these types of painful experiences can be the means of adopting a more humble

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approach to living in this world. Learning from this pain and adjusting their attitudes was a choice that they could make if they wanted to feel better about their lives. Billy, for example, said, “You know, those are the kinds of people I would wrongly judge because I met people like that in AA and some of them suffered far worse than me with all the stuff they had, and then I realized nobody in this life has it made; nobody has it better than me.” Billy also seemed to have experienced an attitudinal shift when reflecting that “I find that the longer I’m sober and if I meet somebody that’s arrogant, it’s my higher power’s way of showing me to take a look at myself.”

Accepting responsibility was something the participants said was necessary for changing and shedding the old ways of thinking and behaving that lead them to relapse. Tina was clear about this regarding her home group. “So I stayed at Flora House because I thought to myself, in how badly I had screwed up my life... whatever you did before you came in this room, do the exact opposite... I don’t need a f’ing date because my biggest addiction is bad relationships, that’s the one that probably comes ‘way before all the other things that happened in my life.” She had stopped blaming others and accepted her own need to change. Anna commented on how reading her AA book brought her to a new realization about her alcoholic condition, effectively right sizing her self-awareness or, in other words, adopting a more humble attitude. “I went home and read the big book and I saw myself in every page.”

Sections of narrative used to exemplify other categories of lived experience are also relevant in showing that the participants felt grateful for being sober, finding a job, reconciling with estranged spouses or children and other similar positive experiences, but they could also feel happy and satisfied which is similar but includes the very ordinary

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dimension of just feeling good. It became apparent that the participants had discovered that feeling good or satisfied could evolve into gratitude which may function to help put recollections of past misery into perspective, rendering them less likely to stir up thoughts of drinking or using. More importantly, gratitude may be effective in motivating participants to give back and develop an altruistic orientation in relation to peers and even strangers.

Jacey says that in her practicing the principles of recovery, she aspired to be "...a better human being in general and being more honest with not only myself but other people and being more genuine and being humble, exhibiting care and passion toward others; being selfless and that's what I think when we practice these principles in all our affairs," as her AA book suggests that she do.

Tina spoke of being open and honest too. "I'm breakable, I'm falling apart, I'm a f'ing wreck in here, my life sucks, my family treats me like shit, my ex-husband doesn't pay for anything. At Flora House, I could say that...I could be broken there and that's what was important to me about a home group. There was no expectation other than being an addict and broken and wanting to recover." Humility then is that attitudinal dimension of lived experience that the participants used to ward off the kinds of negative thinking they learned to recognize as a risk for relapse.

"Spiritual transformation" is the final category of the meaning in the participants' shared lived experience of recovery. It includes the recovery factors of: open to God and spirituality - faith - surrender - seeing God work through others - knowing God's will for you - prayer and meditation, and feeling blessed. It concerned what the eight participants believed helped in a spiritual way. Spirituality, as some understand it, is that part of our

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humanity that is attuned to transcendental experiences; the kind that so many cultures and individuals within them have known about and described as something that carried them when they needed it most.

All participants mentioned conditions that they experienced as profoundly meaningful without being religious in nature although most occasionally used the word God or higher power. These very meaningful experiences were visible in the overarching healing relationships category and were relevant in terms of what the relational dimension of recovery meant to them in the other thematic areas. There was something that appeared to be very empowering in their shared experience of connectedness, sponsorship, identifying with and relating to others, encountering each other at meetings, tolerance, forgiveness and love, socialization with recovery peers outside of meetings, having healthy friendships, feeling the synergy of the circle, having respect for others and being respected, belonging, feeling brotherhood and sisterhood, and feeling positively influenced. It kept them coming back, staying involved, and doing what was suggested by helping peers and others with more clean and sober time. It helped prevent relapse.

It was suggested earlier that in recovery, spirituality was felt by the participants in different ways. Some members might consider their positive relational experiences as just empowering in the sense that the program and their helping peers are a power greater than themselves. Spiritual appeared to be a concept that was broad enough for all the participants to relate to. Tina mentioned it in terms of faith. "I still have my spiritual side. So that if I do unto others as done to me, you know, that's good orderly direction...so that's where my faith comes in. I attach to that all the time. All the time! Some people go to church, some people can pray and whatever. I don't pray...I talk to my gods

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constantly, they are with me...I want that contact because...that's my journey. We took those twelve steps...we took this framework of the program and heard what they said and used it, and you can't go wrong, you just can't go wrong."

Some participants indicated that they were open to God and spirituality and even to prayer, and that they were influenced by seeing God work through others. Art was clear on this. "And for the first time ever I said I'm going to go with the God thing and I never said that before." It may be that he and the others meant that they had acquired an ability to transcend their previous inability to abstain from alcohol and drugs and get through the difficulties encountered in their recoveries.

Letting go or surrendering was something the participants all did in working the twelve step program where they had to consider an admission of powerlessness as their first step clearly suggests. Surrender would seem to play a part then, in their accepting the fact that among other things, they can't drink or use drugs, have to work the program, acknowledge faults and wrongs done; make amends to people you have harmed and just do what more seasoned peers say they did to recover. This is what Brooklyn chose to embrace in order to avoid a life of crime and prisons. A critical attitudinal shift seems to have occurred in the participants' surrendering to these conditions, enabling them to be willing to reach out for help and comply with whatever is offered.

Surrender appeared to be a key concept for Billy's admitting he was an alcoholic. "I was drinking 24 beers a day and the wife and I are splitting up and I don't know what to do and he the doctor kept on saying are you an alcoholic? ... and finally I say yeah I'm an alcoholic, and he suggested that I make an appointment with the AFM... he just said here's what you do and if you have the desire, you are going to do it... I was ten minutes

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late for the appointment and they said sorry, you are going to have to re-book and that would have been maybe an excuse to go back drinking and I said to hell with it...just drive me to the Health Sciences Centre, and I spent the next five days in detox.” He just let go and did what was indicated.

In their combined recovery experiences and activities, the participants seemed to have built themselves a healing relationships based; and a faith, hope, trust, meaning and purpose, humility, change and growth oriented immunity from the urges and distorted thinking that plagued them in the past and still cause occasional difficulties. In this way, there appeared to be a synergy among the overarching relational dimension and the six other categories of meaning in the shared lived experience of recovery, and in phenomenological terms, it was apparent that perhaps this could be interpreted by the participants as a power greater than themselves. It may be that synergy may be an operative principle when contemplating the phenomenon of recovery experienced by the participants. This almost entirely non-religious approach can evolve later on for some into a belief in a God of their own understanding and as such, is a personal choice a member makes in the light of their own circumstances. One participant believed in the power of the universe, another was Christian, others were more comfortable with the higher power idea, and others talked of God. A few participants sensed that they could feel God’s will for them. Art summed it all up, declaring, “It’s in the journey itself, it’s just that simple, and come to realize it you will grow with it, but it’s that spiritual thing that comes into your life”.

Chapter 5: Conclusions

In the introduction and literature review, we contemplated that although there are many ways to help substance dependent and alcohol / drug addicted people recover, recovery itself was not well described nor understood and could be considered a phenomenon. There are however, many addicts in the community who can be observed to be in recovery. Not all, but many of them are members of one of the twelve step, abstinence based fellowships such as Alcoholics Anonymous whose method and program has been adapted by the Narcotics Anonymous and Cocaine Anonymous fellowships as well as Gamblers Anonymous, Overeaters Anonymous, Sexaholics Anonymous, and numerous others who believe the method works. Because of my past career in the addiction treatment and corrections field and my own thirty seven year long journey of recovery, I was acquainted with a great many people in recovery, many of whom are recovering within AA, CA and NA. This proved fortuitous in recruiting research participants because of their independence from systemic confidentiality requirements. They were approachable. Potential others in recovery were either unknown, untraceable, or their identity was protected.

Although this was not to be an exclusive study of twelve step fellowship recovery, it was thought that clean and sober members of such organizations would certainly be able to respond to the research question which was: what could a group of addicts in stable recovery tell us about what recovery is like, and what sustains it. In Heyman's view (2009), the twelve step method continues to be a significantly utilized way for alcoholics and drug addicts to survive their problem, making their approach worthy of study. The narratives of people in recovery could be very valuable to those who work in

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the addiction prevention, education and treatment fields as well as to those seeking to recover, because of the already mentioned serious shortage of this kind of research in relevant journals of addiction, treatment, and counselling.

Understanding Efficacy in the Participants' Abstinence Based, Twelve Step Fellowship, Peer Supported Recovery

Thematic categories of the lived experience meanings shared by the participants in their recoveries suggests that clearly, there are subtle, yet powerful processes in play which result from all of the various feelings, thoughts and activities that recoverers experience. These were called recovery conditions or factors. There were fifty eight of these identified in the narratives.

One overarching category of lived experience meanings emerged and was called healing relationships to communicate how efficacious relational and interpersonal connections between recoverers sustained their finding the strength to maintain abstinence and overcome the challenges of daily living. Bonding through un-judged vulnerability is deeply moving, and for newcomers, is an immediate component of meaning, purpose, serenity and hope (Heyman, 2009). Healing relationships seemed also to infiltrate and be operative in six more meaning categories, each with its own characteristic relevance to a recoverer's further gaining abilities and skills in recovery. It was all seen as being very much an interactive process. These six categories were: humility, hope, change and growth, spiritual transformation, trusting reliance and new found purpose and meaning. Very briefly, according to their own testimony, developing these areas was how our study group was seen to be maintaining abstinence and growth in recovery.

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In the results section, these categories and factors were discussed in functionality terms, relative to the research question and sub question. To describe this answer in one sentence, our recovering participants told us that with only their fellowship's literature, the support of other recovering peers, and some limited support from other sources, they had put together a design for living which dismantled the obsessions and urges to drink or use drugs and to grow in their ability to avoid or solve problems, re-connect to the systems and people in their world, and generally get along in life as happier, healthier sober human beings. In their fellowships then, the participants can experience a corrective process for attachment and trauma issues, and a form of universality, instillation of hope, altruism, learning, role modeling, cohesiveness, existential acceptance, catharsis and insight, all well known to facilitate empowerment and change in members who are part of encounter groups (Yalom and Leszcz, 2005).

In one way or another, our participants all indicated their finding and being empowered by some manifestation of a power greater than themselves, or higher power, or a God of their own understanding. Not surprisingly, Tonigan, (2007) found a significant positive correlation between fellowship meeting attendance and measures of spirituality. Spirituality, as has been suggested, may develop from interpersonal and relational experiences (Alper, 2006), and it was something the participants all indicated was a source of strength in one form or another. Indeed, their recovery "big book" describes this eventuality as the main objective of the whole twelve step program which CA and NA have adopted with only minor changes relative to their focus on drug addiction.

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Interestingly, it can be observed that there are also a fair number of agnostics, atheists and other spiritually adverse types of fellowship peers who are comfortable with their own understanding of what higher power means in relational terms, and continue to be involved in recovery like the study group. Alper (2006) and Wilson (1998) assert that we are genetically encoded for this attachment-like experience which, they suggest, is part of our spiritual awareness capacity and by extension, a potential source of spiritual strength to the participants. In this respect our gender balanced study group could be considered to be a good cross section of typical urban twelve step recoverers who have achieved several years sobriety, because in some way, they all have developed some aspect of the enabling power concept sufficient to sustain recovery regardless of their ethnicity, age, affluence, or education. For these people, addiction itself seems to have levelled the playing field of recovery through the efficacious influence of humility.

Of note, the participants tended to be circumspect about their spiritual self-awareness inasmuch as they did not go on at length when recounting spirituality or God. Rather, they tended to get somewhat animated when talking about what it felt like not to be judged or to fit in and feel a part of a fellowship of people with a common problem and common solution. White (2009) asserts that this is a very empowering and motivating peer support process for people in recovery. I would speculate their spiritual modesty could be accounted for by a subtle fellowship ethic to not push your own variety of spiritual awareness because it can turn others off. It seems to have been a good strategy for their fellowship founders to not try to dictate what alcoholics or addicts need to believe, pointing out rather, that all twelve steps are but suggestions. They were astute enough to know that being directive would have meant defiance, pushback and possible

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failure, and decided to leave it to the individual to figure out for themselves, which facilitated the overall relational dynamic to take precedence.

In suggesting how the various thematic categories and respective lived experience factors were instrumental and efficacious for the participants, it became clear that after abstinence is established, the whole process they were engaged in is, in some way, about relapse prevention. This was discussed in the earlier chapters as precisely what addicts need to be able to do, but can't on their own will power. Paradoxically, they voluntarily surrender to this powerlessness idea, gradually accepting it as a given in their lives. When this "large pill" has been swallowed, the individuals in recovery can focus their personal agency on modeling recovery along with other recoverers, thereby experiencing the subtle benefit of recovering together, as opposed to alone and disconnected with little or no effective support.

This form of trusting reliance could, like hope, lead to gains in self-efficacy which can then lead to goal setting and trying out new activities which lead to what Prochaska and Norcross (2007) call social liberation, and to the changes recoverers want to make to regain health, wellness, dignity and prosperity. Steigerwald and Stone (1999) discuss how this form of cognitive restructuring is commonplace in twelve step fellowship recovery and works best with professional counselling. This process can more importantly, be a template for other good choices and, in general, account for a much more benevolent relationship with the world, promoting consistent positive behaviour, reinforcement, and resultant learning and positive self-regard (Bandura, 1977). Relatedly, it may be that the recovery factors that make up 'hope' lead to more positive feelings about self and the environment which can lead to thoughts and feelings of self-efficacy. For example,

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Miller (1991) and Vaillant (2007) assert that self-efficacy correlates positively with a number of recovery gains. In Yalom and Leszcz's (2005) view, the instillation of hope is a key therapeutic process operating in a variety of groups including, we suggest, the recovery groups attended by the participants. Further, as pointed out above, many of the therapeutic processes described by these authors, also appear to develop from activities and associations in the participant' home groups.

In broad terms, relative to the results of this study as well as from having a long personal association with people in twelve step recovery, we could speculate about what could be spiritual about going to a meeting, or going for coffee with peers, or driving a newcomer home? The answer lies in how it reportedly made the participants feel and how that gradually got them to come to believe that the whole 'program' seems to be a spiritually empowering process with a quiet, invisible synergy. In contemplating his options, Art summed it up this way: "I can only relate them my experience. There was love, there was loss of life and I mean it's not 'til you realize that simple spiritual thing of that smile and then to understand what love truly is - that it's just the smile of a child looking back at you for the first time, that daughter that hardly knew you and she's five years old and you are making a relationship with her for the first time..... I've grown up finally and it's all thanks to this program. Working the twelve steps has given me my life back. But if you do lip service like I did, you will be a miserable cantankerous bastard ready to go out at any time, and it's for the likes of the sponsor that comes before you, that stands in front of you, that sits here such as-----, that makes you want to do it".

What Art and the others described does not happen to all who show up at their club room doors. It has never been a very accurate practice to guess who is going to stay

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and who is not. Many leave disgruntled for various reasons, some return, some do not. Too many die from addiction. Others get well for a while and relapse, returning, or not, but overall, make an improvement. Years of experience in the field suggests that this would seem to mirror the patterns in other pathways to recovery. An important part of this picture however, is the problematic influence that mental health issues can have on a person's disposition to recover (Co-occurring Mental Health & Substance Use Disorders Initiative, 2012).

Recovery from addiction has not been nearly as predictable an outcome as recovery from other afflictions (Heyman, 2009), but what our study suggests in terms of the earlier mentioned power of a recoverer's personal narrative, is that if a recovery seeker has hit the right brick wall and is motivated and ready, has encountered the right kind of care or helpers who say the right thing at the right time in the right place, and he or she does what our participants did, they might recover too. Key conditions seem to be about how bad they want it, how willing they are to go to any lengths to get it and how honest they are about holding themselves accountable for really trying. In addition, in some personally meaningful way they need to self-admit as alcoholics or addicts and take the phenomenological step of identifying the meaning of their addiction experience as 'powerlessness'.

Powerlessness implies that in order to survive, something has to somehow happen that first, shuts down their drive to do it by themselves and second, directs their attention to doing what seems to work for their peers. Surrendering to powerlessness seems to be an effective way to start the process of finding what we described from the narratives, as an overarching healing relational efficacy working in and through six more dimensions of

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lived experience to empower effort and overcome urges. Metaphorically, spiritual experience of whatever description seems to cracks the code, as it were, for regaining lost cognitive, emotional and physical powers (Alper, 2006).

Behind this outcome of awakening the participants' own self efficacy and the efficacy mechanisms we saw as inherent in the various categories of shared lived experiences, are a chain of positive cognitive, emotional and behavioural outcomes that in turn triggered others, bringing about abstinence and recovery gains that we are calling the phenomenon of recovery (Steigerwald and Stone, 1999). For example, it was stated that in the healing relationships category, there were clusters of factors with the common theme of interpersonal and social connectedness and mutual acceptance that engendered being a part of, and fitting in. Experiencing them frequently over time would lead hypothetically, to feeling worthy, of value, trusted, important, significant, etc. This would then lead to believing that you are ok and things were going to be ok. This would lead to belief that you can do it, you can get through this, you are capable. This then would lead to choosing the abstinence option of a relapse chain and therefore, dodging out of high risk situations, places, gatherings and encounters (Gorski, 1997). One could then be free to look for and find that job or educational program, or to making amends to people whom you have harmed, taking care of your health better, or working to regain the love and support of a significant other.

This would lead to belief in what you were doing, hope that there was some sort of power in all of this which, when realized, then produced faith, self-efficacy positive action, learning and the cementing of new 'others centred' attitudes and values (Vaillant,

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1995). This led to growth in emotional self-management and maturity. All of this led to much better lifestyle choices and therefore a better lifestyle.

The outcome experience of this synergistic chain was that you are in recovery, you're doing it, you're sober and this eventuality was, like virtue, its own reward. Fifty eight lived experience recovery factors engendered a synergy in the participants that was a force multiplier of individual factors which alone would not account for the phenomenon of recovery, but together they can and do account for it. It can be suggested that slow to change personal flaws inhibit parts of this overall process, but they do not shut it down, allowing a recoverer to make mistakes without relapsing. The new power in this synergy could get stronger yet with more good choices and a recoverer's choosing to understand it as a manifestation of spiritual or God's power, could open new chains and synergies which yield a certainty, care and passion for this way of recovering. When this empowerment experience was contemplated against the backdrop of what life used to be like, it clearly was a phenomenon.

Sadly, picking up alcohol, cocaine, or opiates, etc. can shut the process down. It is a grave risk to experiment with other substances or behaviours that are known to trigger drug seeking and relapse. Trying to use these substances and do twelve step recovery has proven to be a hopeless experience for would be recoverers, to paraphrase participant Rhonda who had heard this at meetings and experienced it for herself.

Comparisons of the Participants' Methods to Other Pathways to Recovery

The literature review outlined other pathways to recovery from dependent, destructive substance abuse and addiction. The behavioural modification community example is a type of abstinent, residential recovery method where learning to live in co-

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operative harmony with other people with problems while working in the laundry or kitchen to support the community, facilitates learning new life skills and attitudes which might support becoming abstinent from alcohol and drugs. Some who enter these communities stay for up to a year or even longer, growing in cognitive and emotional maturity. Some might eventually be hired as staff which could reinforce their commitment to sobriety. If we were to do a study similar to this one with residents of such a community, some of the same or similar recovery factors may emerge.

Typically these communities do not support a member's attending a twelve step fellowship while living there, preferring a systems and psycho-social understanding of how personal effort in learning to live with others and being productive is all a recoverer needs to do to stay clean and sober. Interestingly, parts of this model are compatible with the participants' twelve step model which suggests that they need to change their relationship with the world and develop or re-learn attitudes and skills that support sobriety. Everyone is a part of psycho-social systems. The fellowships are systems within the much larger social environment where members eventually should be able to function, as should people who participate in the above community approach. Fellowship recovery is not considered a destination type of outcome, rather, it is thought of as a lifelong journey taken with the support of peers. In the behaviour modification, community method however, you eventually have to leave and go it alone or progress with perhaps a helping professional and you may choose to drink or use again if you think you can control it. If you can't consistently control it, you face needing to be abstinent and if you can't manage abstinence on your own, then you may have to choose to go back to community living or try a twelve step fellowship, or try some other way.

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A variation of this strategy is the sober transitional housing community where abstinence, mutual co-operation and sharing in the workload are required (Two-Ten Recovery, 2012). Usually a tenant is required to be abstinent, work, look for work or attend school. Anyone caught using substances is asked to leave. If the recovery house has theoretical compatibilities with a Minnesota model type treatment facility, and often even if it does not, residents can be required to attend twelve step group meetings. When tenants are supporting each other in this community living environment, positive relational outcomes could be expected and a number of tenants may become active and ongoing AA, CA or NA members. These sober houses are very useful both pre and post treatment and are often used by the correctional system as an alternative to incarceration (Winnipeg Drug Treatment Court, 2012) or for parolee supervision needs. Some offenders live in these houses voluntarily before trial in order to demonstrate an attempt to get substance abuse problems under control.

Another example is faith based community recovery typically found within a network of street level recovery missions (Union Gospel Mission, 2012) which typically, are linked to Christian church communities whose members welcome recoverers to their midst. Typically, the missions and churches are evangelical or fundamentalist. They may also be linked to faith based recovery houses which support people until they can find their own lodgings (Barnabas House, 2012). A variation of the faith based approach combines addiction treatment workshops with twelve step and biblical recovery principles and optional church services and fellowship (Finding Freedom, 2012). There is an emphasis on biblical teachings as the central modality for healing fear, guilt, shame and relationship deficits through God's forgiveness. This would hypothetically result in

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an addict or substance dependent person acquiring a new moral compass and a faith that can be relied on to keep you clean and sober. Abstinence is required in mission residences and substance use means having to leave although a relapser is encouraged to return as soon as possible after sobering up.

Again, if a similar study was conducted with clean and sober members of the faith based recovery approach, some of the same recovery factors would likely appear. There is little doubt in that there can be, and to some degree is, a harmonious interchange of members who attend twelve step fellowships and faith based communities. The only requirement the fellowships have for membership is a desire to stop drinking or using drugs. Spirituality is encouraged but not forced.

Another type of recovery involves going through one of the many primary (28 day) or less available secondary (40 to 90 day) treatment programs where one would be exposed to psycho-educational addiction recovery workshops, group therapy, one to one counselling and aftercare. If the program was operated within the criteria of the Minnesota model (Tamarack Recovery Centre, 2012), clients would have a great deal of exposure to twelve step recovery meetings, principles and members. In addition, there would likely be opportunities for the more motivated client to connect with aftercare support and a variety of external therapy resources where they might make gains through exposure to various mainstream therapies available in most communities.

This treatment oriented approach is sometimes viewed by some clients as the actual solution to their substance abuse problems and a number of them resist joining or staying very long in the twelve step fellowship program milieu or involving themselves in other people based post treatment supports. Others who complete treatment do, as

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above, cooperate with referrals to external counselling or therapy resources which are typically quite secular and sometimes quite systems oriented with some built in resistance to what they often perceive as the twelve step fellowships' medical model approach. The treatment program route to recovery sees a majority (80-90 percent) of completers relapse within the first year, but this fact is an accepted outcome given what clients and program providers alike are up against in terms of just how difficult it is for people to overcome addiction and substance dependence. Their hope is that completers continue to try and eventually get it. Treatment success stories where clients establish abstinence and better lifestyles are frequently clients who find a comfortable place in one of the twelve step fellowships, although there are some who succeed through other means, or generally improve in the harm reduction sense.

Other non-Minnesota model treatment programs offer an eclectic assortment of therapeutic approaches depending on the orientation of the providers who very often lean toward the learning model as exemplified in behaviour modification, and cognitive behavioural relapse prevention methods. These programs are typically very secular in their belief that recovery is an exercise in un-learning all the anti-social coping behaviours of active addiction. Correctional programming in Canada's federal prisons is an example of this approach and proponents base their beliefs on a range of quantitative studies of what works with offenders (Correctional Service of Canada, 2012).

Twelve step fellowship recovery serendipitously compliments many of the best aspects of some of the well-known psychotherapy orientations and proponents of these may see their paradigms reflected in fellowship recovery (Vaillant, 2007). For example, existentialist and humanistic approaches would recognize the extraordinarily empathic

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and relational aspect of fellowship recovery. They would see recoverers having to make peace with their pasts and opening up the vast opportunities for choosing to change and grow, therein finding purpose, humility, meaning, trust, hope and spirituality. Cognitive behaviourists would appreciate the active investment in change and growth that fellowship members attempt with positive thinking and perseverance to counter distorted thinking and emotions; they would see the efficacy of how getting a better result from the world through better behaviour, grows better attitudes, values and beliefs some of which would be spiritual in nature. Psychodynamic practitioners would recognize how fellowship members recognize their substance abuse as a symptom of underlying issues which need to be addressed through the self-examination steps if recovery is to be achieved. Those who espouse Narrative Therapy would see how fellowship recoverers construct their new story from the ashes of the past and their dysfunctional relationship to the problem while establishing a positive and egalitarian relationship with their sponsors.

Recovery from addiction within the twelve step fellowships is not a manifestation of any one psychological, social or systems orientation. It appears that AA (and now CA and NA) built in a number of simple efficacy mechanisms into their approach, which fact is acknowledged in their literature where it describes how the founders and early members borrowed helping principles from the medical, psychological and spiritual communities of the day. They believe they can discover who they authentically are behind the self destructive personas that substance abuse has brought about. To some extent it remains mysterious to many people how such a diverse population of addicts get well at all although the power inherent in the inspired human spirit has been, and is evident in almost all cultures in a multitude of ways (Alper, 2006). It is visible in

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theologies, literature, oral histories, music, theatre, and other aspects of cultures. “Faith can move mountains” is an established genre in the entertainment industry.

From personal observation, the success rate in the fellowships sometimes seems to be overestimated by proponents and consistently underestimated by detractors. It has been very difficult for quantitative researchers to get an accurate picture of this general statistic because fellowship members have not proven amenable to being researched (Heyman, 2009). They prefer to remain anonymous and not get involved in studies done by outsiders because their fellowships are unfunded private organizations for members only. McKellar, Stewart and Humphreys (2003) did a longitudinal quantitative study on 2000 subjects to establish the nature of the correlation between sobriety and AA membership. They found a positive correlation and suggested it was due to involvement with AA activities and practices rather than to subjects’ personal characteristics.

In bringing this comparison of fellowship recovery to other ways to a close, it can be suggested that there are so many elements of established psychological principles and practices evident in twelve step fellowship recovery that it seems unsound to ignore this fact in preference for believing otherwise. It would seem to be similarly unsound to ignore the efficacy of the spiritual and peer based self-help orientation of fellowship pathways in favour of standing instead on one’s personal or professional theoretical bias. People in the field and fellowship members alike should recognize that many people are not compatible with twelve step methods and need other methods. Fellowship members and treatment practitioners or therapists alike need to recognize first, that they don’t hold the patent on self-improvement, and second, that they have too much in common to perpetuate the squabbling that still exists.

The Personal Experience and Impact of Doing This Study

After thirty two years working in the education, addiction and corrections systems, and recently as executive director of a long term residential addiction treatment centre, I have become intimately acquainted with the many aspects of substance abuse, dependencies and addiction. I have listened to many stories and personally observed both the shattering results of, and the phenomenal recoveries from, all manner of substance abuse afflictions. One of the stories is my own. I am an active and ongoing member of one of the twelve step fellowships and recently celebrated thirty seven years of continuous sobriety. I have seen situations that seemed impossible turn around after alcoholics and drug addicts turned to a twelve step fellowship. I have seen people try but leave in frustration or confusion. I have also seen others die in isolation and pain leaving their friends and families to grieve. Still others simply got control of themselves and stayed out of trouble whether abstinent or not in what theoreticians are calling spontaneous recovery.

The phenomenon of twelve step fellowship recovery has never ceased to amaze me and I have always been curious about how people with intense dysfunctions and horrific track records actually experience transformation. This journey begins on their abstinence date and after a varying period of working the program with their recovery peers, emerge much the better for wear, as it were. Therefore, in my studies toward the Master's degree in Education, Guidance and Counselling program, I chose the thesis based path and decided to do a study of what recovering people report helped them in staying sober and leading a productive life. I proposed a qualitative research project using phenomenological methods to uncover what were the shared meanings of this lived

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experience, thereby providing insight into efficacy mechanisms developed and brought to bear against the seemingly impossible task for an alcoholic or addict to become totally abstinent and make important changes to sustain recovery.

It is clear that in conducting this research project, there was an emic, or insider perspective to 'bracket' so it would not create bias in the study. There was also an etic, or outsider role to play as objective listener, observer, analyst and reporter. Phenomenology requires a certain amount of personal intuition and my life experiences and learning were both instrumental and potentially biasing in this endeavour. This may appear to be a limitation but that is a matter of opinion. To a degree I embraced my personal history as a recoverer and my having worked in the field. Yet I decided to try to control for bias by letting the data speak for itself. To this end, I used many quotes to let the participants say what was needed to illustrate the meaning of their lived experience. Beyond the quotes used, there was much more narrative that exemplified the meanings to be made from the participants' narratives.

I believe that qualitative research has frequently been conducted by people who have some degree of experience and expertise with their research topic. This raises the question of whether bias and objectivity can really be bracketed. I would suggest that the answer is, not entirely, but by sticking to the actual data, I would assert that that objectivity can be found by focusing on what the *participants* believed about their recoveries. What remains in the "not entirely" aspect is my own training and experience which in phenomenology, facilitates a wider and more accurate range of interpretation, nuance and speculation.

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It was a moving experience to listen and respond to the eight people who courageously told me their story. I was aware of my identification with much of the content and feelings expressed as well as feeling their trust. I became aware of an observable phenomenon in the people as they were telling their stories. I described this and included it in chapter three as a commentary on the unique characteristics of qualitative phenomenology. Simply stated, there was something uniquely compelling going on in the participants' delivering their recollection of who they were, where they had been and who they are now. I suggested that this was an aspect of early personal empowerment in recovery which seems to be retained and useful over time, especially in the humanistic relational dimensions of recovery in the form bonding through self disclosure. These people held in their minds and hearts, the actual transformation experience of having come from an impossible and hopeless place to peace and safety. My hope for them is that it illuminates the rest of their lives conferring on them an instrumental identity that consistently stimulates faith, hope and courage.

The experience of interviewing the participants and interpreting their addiction and recovery narratives has had the effect of increasing my own understanding of recovery and personal change. It has supported my ongoing commitment to recovery through the methods the participants are using, and it has made me very grateful to not have perished years ago from the same condition they have.

Twelve Step Fellowships in Relation to Systems

Substance addiction and dependence are enormous burdens on societies and in response, both the public and private sectors have for some sixty years or more, developed strategies and programming to deal with it. These sectors have always had an

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interesting relationship with first AA and later, with the smaller fellowships of NA and CA. In accordance with their traditions however (Appendix B), the fellowships do not ally themselves with outside organizations such as governments or industry, nor do they comment on external issues; yet they do seek to make themselves available to these sectors, confident in their ability to help addicts get back on their feet (Alcoholics Anonymous, 2012). They seek to “carry the message”. However, outside organizations can and do develop prevention, education and treatment strategies based in part on twelve step fellowship recovery principles and wisdom. This was how the Minnesota model of treatment came into being. In cities, the “General Service Assembly” of the relevant AA area will have members of the Cooperation With the Professional Community committee involved in seeking ways of informing and working collegially with doctors, psychiatrists, psychologists, lawyers, therapists, nursing associations, treatment centers, and employee assistance program administrators. The voices and energies of the fellowships are still sought and valued by many sectors in their work with addicts because they have many years of proven effectiveness as recoverers and advocates.

Many individual fellowship members therefore, readily co-operate with hospitals, prisons, treatment facilities, the military, public school systems and colleges, employers and labor unions to show that recovery is possible for those who are willing to make an honest effort. Members do many kinds of service work with these organizations and local fellowship advisory bodies facilitate their members’ developing some structure, skills and abilities in carrying the message to alcoholics and addicts.

Treatment, Support and Aftercare

The majority of treatment facilities in North America are Minnesota Model or a combination of this model with elements of others. I consider this to be a positive circumstance because of the strong humanistic approaches usually found in these operations. As well, they build in associations with twelve step fellowship support which, as we have seen, have such a wide range of beneficial interpersonal, social, psychological, spiritual and common sense qualities.

In the last several years, there has been a considerable push from public sector treatment funders for treatment providers to show some evidence that treatment actually works. The Canadian Federal Drug Treatment Strategy is an example of this. They rightly claim that e.g., the Minnesota model has not been subjected to serious quantitative outcome studies and they are calling for this to be done by as many treatment program providers as possible. They believe this would provide valuable information about what works and what does not. This movement toward evidence supported program delivery is a sound approach to improving treatment, support and aftercare but it is not without some built in difficulties for both providers and researchers, such as tracking program completers and getting them to disclose personal information. In addition, there are expenditures in time, money and human resources which are for smaller not for profit operators, a major obstacle. However, I recommend that outcome studies be conducted and suggest that among many recovery contingencies that could be studied, the nature of the correlation of the recovery conditions or factors variables described in chapter four, would be a good place to start. The question then would be for example, what is the nature of the correlation between levels of trust, humility, meaning and purpose etc. and

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length of abstinence and measures of contentment and emotional maturity? Or, what is the nature of the correlation between indicators of good performance while in treatment with length of abstinence and other positive outcome measures. This kind of research can have a significant effect on best practices.

Based on what this study's participants suggested helped them in recovery, and also upon anecdotal evidence from local treatment providers including the center I directed for three years, I believe that facilitating treatment clients' participation in twelve step fellowships is still a positive part of treatment. Further, with regard to the results of this study, I would recommend that specific aspects of treatment be informed by the 58 factors involved in healing relationships and the six other categories of meaning. As one participant put it, "this program has the right juice". If treatment facilities, therapists, helping agencies and correctional programming rely solely on cognitive behavioural psycho-educational approaches, their clients will be missing out on the very meaningful and effective humanistic methods inherent in peer support and therapeutic community dynamics.

Building these kinds of activities into a rich and responsive after care program is essential to maximize post treatment progress because some post treatment clients who may be twelve step fellowships adverse, would benefit from other post treatment peer associations.

One of the obvious problems that clients deal with following treatment is that after some time which varies from person to person, complacency can set in. This is to be expected because it seems to be normal for people to think that after good things are continuing to happen in their lives even after they have let up a bit on meetings or

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hanging out with other members, it is okay to cut back on practicing the program or stop attending meetings or roundups, thinking mission accomplished. A certain amount of easing up may be acceptable but stopping to do the very things that are accountable for recovery is a serious risk for relapse. Because of the blame, rationalization, intellectualization and minimizing skills addicts have developed, and a propensity for narcissistic attitudes, addicts have short memories and can slip back to denying that a problem even exists and there being any need to take it seriously. Attendance at fellowship and aftercare meetings mitigates this denial in those capable of the self honesty required to stay on track.

Concluding Statements

I would recommend that everyone involved in addiction issues take a serious look at efficacy mechanisms identified in this study of recovery. My hope is that this will inform methods of intervention, treatment, aftercare, harm reduction and various therapeutic approaches, and serve to mitigate factionalism and methodological conflicts. I further recommend that both qualitative and quantitative researchers continue to seek collaborative partnerships with the three fellowships mentioned in this study. In addition, I recommend that fellowship members seek to understand the mostly hidden efficacy mechanisms that they are practicing, the better to instil hope, confidence and self efficacy.

In terms of the recovery fellowships that the participants were members of, I am concerned that readers might incorrectly get the impression that I believe that they are havens of wonderful people doing wonderful things where addicts can go and get wonderful results. A few of the eight participants mentioned issues they had with other

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members or differences of opinion and other minor difficulties but I should reiterate that the research concerned what was helpful, not what was not helpful, and in that sense they tended to not mention things that they had problems with. I got the sense that they took the high road and got past irritating people and situations realizing that this was after all, the kind of attitude and response that they were called to demonstrate in difficult situations.

The contrast between the observable effectiveness in our participants' fellowship lived experience and the unfortunate negative experiences that some individuals have had in the fellowships requires some discussion at this point. I would first say that it has been my experience that the fellowships are populated by people who are in various stages of recovery and they are all coming and going or staying; working the program, or not working it, the way they want to do it. There are no leaders, disciplinary boards, regulations or other means of social structuring or hierarchy such as one might find in a service club or fraternal organization. There are just the twelve traditions and the injunction to treat others the way you would want to be treated. People have all the freedom they can handle. It works surprisingly well but there are sometimes the same interpersonal rivalries, envy, gossip, cliques etc. that one might find in any social group. Things do not always run smoothly but in spite of that, on average, things run very effectively due to the altruism, care, dedication and love of the regulars who put their "egos" aside for the greater good of everyone especially the newcomers.

The risk for anyone who hears of an incident of e.g., predatory or fraudulent behaviour by some person at a meeting or other place where members congregate is that they generalize that this is normal in the fellowships. It is not the norm but negative

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behaviour does happen especially if members who have a degree of influence condone it or worse, do it themselves. I have always had the notion that negative behaviour should not be too surprising given the lifestyles people come in with. In general most of the fellowship groups take care of negative people and behaviour by trying in various ways to influence them, confronting them, warning vulnerable newcomers about them, or informing the person's sponsor that their sponsee needs some attention. In a worst case scenario, the unresponsive perpetrator can be asked to move on.

Unfortunately, the closer an observer gets to inner city street level fellowships where good role models are most needed, the more frequent are the examples of negative behaviour. At street level, one finds a higher percentage of anti-social and criminal attitudes and people with these find their way into the fellowships often because they have been directed there by bail supervisors, parole and probation officers and opportunistic lawyers seeking a break from the judge. This can turn out to be a good circumstance for them but it always has the potential to become negative for others, unless the person can restrain themselves long enough to do some serious changing.

In my thirty seven years of fellowship association, I have been able to observe and be part of many other people's recovery experiences and from this perspective, I can say that AA, CA and NA are positive organization. They are not however, for everyone struggling with substance abuse as the comings and goings of newcomers and relapsers would indicate. Those who like it and want to do it this way, end up staying.

The people who witness this most intimately and who have a reasonably accurate idea of the success stories are their fellow recoverers. Friends, family, employers, union representatives, probation and parole officers, treatment staff, neighbours and fellow

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employees also see addicts recover. I know of members who relapsed never to return and others who start and never look back. It has however, always been and will likely continue to be, difficult to actually count and otherwise quantitatively measure recoveries in the fellowships but as stated, I do recommend that researchers continue to design and conduct outcome studies, the better to inform best methods.

In regard to the references I have made to inner city street level environments, I have observed that there is a shortfall of resources for recovering people in this milieu with the exception of some limited health care resources, missions and harm reduction outposts (Main Street Project, 2012). It would be very beneficial for these resources to more consistently refer clients to the various fellowships and in turn, the three fellowships could ensure that members either start new groups in these areas or step up the pace of solid volunteerism from urban fellowship groups. Local and provincial governments should ensure that relevant non-profit and grass roots organizations are adequately funded, otherwise they are forced to waste their human resources on fund raising when they should focus on building and improving their programming. Further, civic governments and regional health authorities should re-familiarize their community partners' staff with the fundamentals of the substance abuse prevention concepts and strategies model, the better to help facilitate efficiencies and effectiveness in these organizations. Twelve step fellowships however, will not accept outside funds from any source (tradition seven) and do not endorse, finance, or lend their name to any related facility or outside enterprise (tradition six). Christian run missions should ensure that their clients attend fellowship gatherings and activities as well as their own so that addicts can benefit from both and freely choose where they feel most comfortable.

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There are many opportunities being lost by provincial community corrections (probation) departments in that they will not pay for residential treatment programming as federal corrections does for parolees. They are aware that programming in the community is more effective than programming inside institutions. Also, it is not clear that community corrections staff are making the best use of AA's Cooperation With the Professional Community committee members. These people can be identified through local AA Intergroup offices or simply through a member they know or a third party who knows a member. Individual probation staff should be able to refer an amenable client to cooperating individuals in AA, CA and NA and likely would if they understood and trusted the tremendous potential for recovery in these fellowships.

Finally, I wish to say that in studying the phenomenon of recovery from a qualitative phenomenological perspective, I have in an intimate and unique way, been privy to the essence of the shared recovery narratives of eight volunteer research participants. I have presented in these pages, an analysis of what their shared lived experiences meant to them in a way that suggests how it works for them. I have presented for context, a brief look at addiction treatment and some common therapeutic methodologies. I have described how the participants experienced recovery in their twelve step, abstinence based, peer support fellowships and made recommendations based on what the participants said was instrumental in their recoveries. I hope it helps people, that was the purpose of the study.

Limitations

Unfortunately, in relation to the stated purpose and focus of my research, it was quite beyond the scope of this thesis to include a comprehensive treatise on alcoholism,

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drug addiction or chemical dependency in causal terms or to summarize this vast topic for readers who may wish to become fluent in the area. There is a wealth of informative materials about every aspect of this topic available online, in bookstores and in libraries and I recommend these resources to curious readers. We have through a phenomenological lens, focused on eight recovery narratives in the hope that this will help readers better understand what these recoverers believed helped them and could help others. Readers will gain a good working understanding of how addiction and recovery are currently understood after perusal of the reference material.

In sum, I believe the participants' path to recovery to be a fruitful journey through turmoil, effort, time and joy in the company of fellow addicts where the result at the end of the day is much larger than the sum of its parts; where instead of being in a jail, detox facility, homeless or dead, a person can go to bed sober saying to themselves "I have tried today and I am sober and that is good enough for me, tomorrow is another day". They may not even be aware of it but they have been engaged in something very near to the spiritual side of their humanity, and whether God is or is not, it does not matter because through their own honesty, openmindedness and willingness informed choices, they have awakened something spiritual within themselves powerful enough to neutralize any thought or urge to drink or use drugs. Some, it would seem, have indeed discovered a God of their own understanding, others, a safe inner fulfillment and expectation that tomorrow will turn out just fine. At the same time they have been relearning how to live and to change with some very practical tools thereby building for themselves a framework to maintain their spiritual awakening, their healing of old wounds, and their practical strength. This is a strong relapse prevention strategy that works for those who

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want to recover this way and choose to apply themselves. Anna summed it all up saying, “It’s everybody trying to do the same thing. Everybody is looking for the same answers, to be well, to be rid of this monkey on our backs, to go to a place where nobody judges you, to go to a place where people take your hand and care about you walking into these rooms. Where are you going to find that?” Her friends in the fellowships would say “Right here! But keep coming back, we need you.”

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Appendix A

FREQUENCY OF RECOVERY FACTOR OCCURRENCE OUT OF 8 PARTICIPANTS			
7 or 8	5 or 6	3 or 4	1 or 2
<ul style="list-style-type: none"> • connectedness • being sponsored • sponsoring others • willingness • desire to change • surrender • service • doing steps • putting in the effort • faith • gratitude and satisfaction • belief in the fellowship and program • belief in yourself • accepting responsibility • constancy and perseverance <p style="text-align: center;">15 total</p>	<ul style="list-style-type: none"> • identifying with and relating to others • inspired by another member • feeling valued, accepted • feeling included, a part of, not alone • encountering each other, meetings • tolerance, forgiveness and love • socialization outside of meetings • commitment • altruistic intention • openness • gaining insight • certainty, care and passion • feeling on track • healthy friendships • seeing the progress in yourself • healing the shame • clarity of discernment • hope and positive expectation • learning from the pain <p style="text-align: center;">19 total</p>	<ul style="list-style-type: none"> • respect for others • brotherhood, sisterhood • belonging • synergy of the circle • courage • being involved and invested • gaining wisdom and meaning • a new self-awareness • humility • feeling blessed • feeling safe and protected • open to God and spirituality • prayer and meditation • gaining self esteem • honesty • meaning and purpose • attitude adjustment <p style="text-align: center;">17 total</p>	<ul style="list-style-type: none"> • admiration of another member • feeling positively influenced • being a positive influence • teaching others • seeing God work through others • knowing God’s will for yourself • trusting outside help <p style="text-align: center;">7 total</p>

Appendix B

**The Original Twelve Steps of Alcoholics Anonymous
(which NA and CA adopted for their fellowships)**

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

Appendix C

**The Twelve Traditions of Alcoholics Anonymous
(which NA and CA have adopted)**

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non-professional, but our service centres may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.