HONOURING STRENGTH:

OVERCOMING ADDICTION IDENTITIES

by

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ABSTRACT

This thesis explores how some people manage their relationship with / without alcohol in ways that do not seem to harmonize with status quo discussions of alcohol abuse and recovery. My question was: How do the experiences and needs of those overcoming addiction independently of 12-step / disease-model culture impact social work practice? This qualitative study explores experiences of seven "outsider" participants. Two quit drinking completely without the help of addiction therapy or self-help groups; the remaining five participants reclaimed a manageable relationship with alcohol after years of dedication to 12-step programs. The participants' experiences are explored using a social constructionist cultural model. Issues regarding the political context of addiction counselling are explored reflecting my 20 years of experience in this field, and implications including assessment and resource development for social work practitioners are discussed.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

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CHAPTER ONE

INTRODUCTION

> I bought into this belief that everything I was, was because of alcohol. So I was basing who I believed I was on my supposed greatest weakness. Now that's tough. How do you get ahead? (Judy)[3]

People have been coping with the negative consequences of drinking alcohol since the beginning of civilization. However, how causes and consequences associated with drinking problems are defined varies according to culture. For example, modern western perspectives of alcohol addiction management are heavily influenced by medical positivist research (Peele, 1989). In contrast to positivist traditions, cultural studies theorists (Alasuutari, 1992; Bannerman, 2000; Denzin, 1993; Gusfield, 1996; Pinderhughes, 1989) have played an instrumental role in informing my research of alcohol problems and recovery. As Pinderhughes (1989) observes, "Culture determines how we see a problem and how we express it…" and culture can "determine what specific symptoms people experience, whom they seek out for help, and what they regard as helpful" (p.13). Key concepts that are useful from cultural studies include the valuing of discipline-jumping and genre-jumping;[4] bricolage;[5] polyvocality;[6] and incompletion or non-closure of knowledge. These concepts embrace some postmodern assumptions: that

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[3] The examining committee recommended after the defence of this document that single spacing quotations would "better serve communication and improve the appearance of the final document," as recommended in the fifth edition of the Publication Manual of the American Psychological Association, p. 325.

[4] Borrowing concepts simultaneously from anthropology, sociology, psychology, and even semantics for the purpose of describing experience within and between cultures.

[5] The process of assembling knowledge from other knowledges. Postmodernists would argue that all concepts are borrowed, and that we are all *bricoleurs* (Brooker, 1999)

[6] The concept that there are multiple perspectives, which inform us about how we consider our world.

reality is subjective in relation to our experience, and that experience is informed by more than one framework. Consequently, knowledge itself is as relative as our self-awareness in relation to people we observe (Furman & Ahola, 1992; O'Hanlon, 1993; White, 1993).

This study was developed based on a relatively regular phenomenon I have witnessed, which has fascinated me throughout my 20-year career as an addictions counsellor. I have witnessed individuals who were able to establish a more meaningful identity in relationship with alcohol after many years as an "alcoholic"[7] or "alcohol-dependent" person. This has occurred in spite of a general belief among addiction treatment professionals that anyone coerced into addiction counselling must be truly sick, and must warrant a "substance-dependent for life" label. Consequently, these persons achieved their success by methods outside the boundaries of traditional disease rhetoric and intervention.

A Note About Terminology

The current addiction treatment / service field utilizes many therapeutic frameworks, each of which has its own clinical language. For example, the common terms *assessment* and *treatment* denote processes widely used in the field that reflect the influence of medical culture and practice (Shaffer, 1997; Winter, Stinchfield, Opland, Weller, & Latimer, 2000). As a result, people who see counsellors, social workers, and other professional addiction specialists, and who prefer to deal with addiction on their own terms, often find that their efforts continue to be judged through the metaphors and perspectives of a problem-focused, scientific, or "recovery" culture. For example, a

person who is struggling on his or her own is often categorized as "in denial" (Winegar, Stephens, & Varney, 1987), "contemplative" (DiClemente & Prochaska, 1985), "suffering post–acute withdrawal syndrome" (Gorski & Miller, 1986) or the "abstinence violation effect" (Marlatt, 1985). A host of 12-step-related judgements can also be used, such as "she hasn't accepted yet" or "he's a dry-drunk" (AA, 1976). The problem-focused paradigms often avoid attending to people's successful efforts, unless they conform to the framework. Meanwhile, success outside of treatment may also be interpreted in a variety of ways, from "self-remission" and "natural recovery" (Granfield & Cloud, 1996; Sobell, Ellingstad, & Sobell, 2000) to "not having the disease" (AA, 1976).

Terminology has therefore been an issue integral to this study. This research reflects my constructions of meaning, based on theoretical, experiential, and personal preference. Consequently, some of the terms I use in this study deserve explanation.

Culture

Culture is a multiple-meaning term. Theorists have identified common culture as the "values and practices of everyday life within a community" (Brooker, 1999, p. 35). This popular appeal to the life of the common person is conceptually distinguishable from other philosophical perspectives of society such as Marxism (with its focus on the economy), or perspectives promoting class segregation (Brooker, 1999). Since the political dynamics of multiple views about people is a central focus of this research, I will use the term *culture* not as a benign entity assuming common experience, but rather as a

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[7] A self-proclaimed title, usually relating to some involvement with the fellowship of Alcoholics Anonymous (AA, 1976). Due to the plethora of models on addiction and their political assumptions about

political concept similar to the postmodern notion of "dominant culture" (Brooker, 1999; Filingham, 1993). I view dominant culture as the socio-political authority that can objectify, classify, and subjugate people for the purpose of the privileged. Examples of this authority are demonstrated at every social level, from legislators to the bully in the schoolyard.

Another way that I use the term culture is to define different groups of persons who are committed to a common purpose, and invested in a rhetorical view, often with etiological assumptions that provide criteria with which to make judgements. Often these groups maintain a protective, exclusionary policy of membership, with their own forms of cultural capital or "possession of knowledge, accomplishments, formal and informal qualifications by which an individual may gain entry and secure a position in particular social circles" (Brooker, 1999, p. 46). For example, in the Alcoholics Anonymous (AA) fellowship, the only written requirement for membership is "a desire to stop drinking" (AA, 1976, p. 564). Formal and informal rituals tend nevertheless to create political currencies, such as the length of sobriety, the severity of the alcohol problem (often described as the "best worst" story), working the steps of the program, the extent of original text recalled from memory, the number of persons sponsored, and so on. The political processes associated with the concept of dominant culture are recognizable in these exclusive groups too, and appear to serve the purpose of protecting communal values. In this sense, members are encouraged to invest in the group and to integrate their identity with that of the group conscience. According to Gubrium & Holstein (1999),

> There is extensive storytelling in these support groups, as there is in most. When participants are not conducting group business . . .they are telling stories. Some groups provide virtual narrative templates for storytelling that lead individual

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people, there is a multitude of labels that persons can choose from.

> stories to become quite formulaic. As if following a narrative map, the storyteller fits his or her experience to a well-known pattern that organizes the caregiving experience in particular terms…While one might argue that a discernible culture is in place and is supported by a nation-wide self-help organization, this culture is diversely articulated through local storytelling. Time and again, caregivers and others "compose" the culture of the disease experience as they convey and compare their experiences at group meetings. As such, the culture of the disease experience for caregivers is a living entity, whose shared themes and biographical nuances both reproduce and distinguish what ostensibly is common to all. (Gubrium & Holstein, 1999)

Consequently, according to Gubrium and Holstein (1999) cultural norms and values are internalized. It is in this regard that I use culture as a term representing value systems, with specific epistemological assumptions and rhetorical views. For example, if a committed AA member were to move to a community where there were no meetings, the person would still be an AA member via her or his commitment to honouring his or her own program. Culture, when conceptualized in this way, draws upon Foucault's post-structuralist concept of discourse—the analysis of statements associated with politically constructed organizations of "truth," and "discursive formations" or contradictory discourses. I see these discourses as the narrative evidence of competing cultures, from the generalized dominant culture of society or local communities, to the internalized cultures that sway our individual identity formation.

Labels

Much of the generally accepted nomenclature commonly used to describe people's relationship with alcohol is in fact claimed by different rhetorical cultures. For example, the term alcoholic, coined in the late 1880s (Valverde, 1998), is assumed in certain circles to mean a person who has a disease, and likewise that she or he is a candidate for the Alcoholics Anonymous fellowship. Other examples found in this work

include *alcohol misuse*, suggesting misbehaviour but not necessarily abnormality, and *alcohol abuse*, which suggests serious problems, which might infer indications of pathology. However, in my opinion, these two terms focus on behaviour and consequences with no epistemological inference. Terms like *dependency* and *alcoholism* are value-laden labels that do assume disease rhetoric, and *addiction* has been used so frequently in different theoretical frameworks that I consider the term value-loaded and epistemologically vague. Finding rhetorically neutral terms was difficult enough; but I wanted to honour people's self-concept in this research. Rather than attempting to coin new terminology, I use the less value-laden term "alcohol problems" to define the entire range of negative experiences and consequences of drinking. Similarly, rather than use current nomenclature that defines new categories (for example, "self-remitters"), I use the phrase "overcoming alcohol problems" to describe participants' purposes in this study. Although this term also could apply to AA members, without qualification I am using it specifically for participants in this study, and for others who would fit the criteria for this research.

After 20 years as a social worker / alcohol and drug counsellor in northern British Columbia, my practice has been greatly impacted, strangely enough, by political rhetoric. After earning a BSc in psychology, I found that cognitive behavioural approaches were not acceptable to the professional community or the support agencies in the town where I started my career, unless they were within the theoretical boundaries of the disease model[8] and the 12-step approach to treatment for alcoholics (Appendix A). I understood that the practical reasons for this policy precluded any consideration of other models or development of other resources / supports. Essentially, before alcohol and drug

counsellors were available,[9] the local community depended on Alcoholics Anonymous as the only support for people with alcohol problems. Later, as I earned my BSW and moved to a somewhat larger northern community, I found there was more room for a variety of approaches in a multi-staffed alcohol and drug counselling office. I found that, as a result, I had a front-row seat to the political turf wars between multiple recovery cultures. Polemic disputes occur on several levels. One concern is over the ethical dilemma of client self-determination versus a prescriptive disease model that assumes that "insanity" and "denial" (terms often used in 12-step literature) preclude the client's capacity to make healthy choices. Another level relates to policies and practice of harm reduction versus zero-tolerance and tough-love approaches. The conflict also highlights disputes about the context of expert knowledge (those with personal experience versus those without[10]). The fundamental issue is the debate over alcohol addiction as individual experiences of one truth, one journey, and one solution informed by pathologizing practice, versus a perspective of addiction as individual experiences with multiple knowledges, journeys, and many uncharted territories[11] where outsiders find themselves.

This debate reflects, from a cultural studies perspective, the influences of more dominant cultures and how these ideas seep into the community in which this study was conducted. Dominant ideas are sold through a market-driven deluge of television shows, magazines, music, and newspapers. This subtle or overt propaganda is disseminated through many modes and role models. For example, a key character in the award-

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[8] The disease concept of alcohol dependency is explored further in chapter 2.
[9] Alcohol and drug services have been available in British Columbia for more than 35 years (Greater Victoria Association on Alcoholism, 1980).
[10] This philosophical debate usually treats personal experience and academic / professional knowledge as mutually exclusive cultures of knowing. In my experience, this debate polarizes opinion and serves to restrain people from exploring all resources available to them.

winning, long-running ABC network television series *NYPD Blue*, detective Sipowicz (played by Dennis Franz), suffers loss of control over his drinking.[12] The character's capacities deteriorate until he surrenders his will, asks for help, and rejoins AA. In this series, Sipowicz also tries to sponsor[13] another department member. This plot depicts the classic American disease model view of anyone with a drinking problem. Many depictions of alcohol or drug problems as viewed from the disease / recovery culture are demonstrated in popular culture, from major motion pictures such as *Leaving Las Vegas* (Figgis, 1995), *Clean and Sober* (Howard, 1988), and *28 Days* (Thomas, Topping, & Grant, 2000), to television episodes, to themes and images pervasive in most forms of media. Marketers for brewers or distillers construct dream sequences of bikini or Clydesdale teams[14] on the air to remind the consumer that the good life happens with alcohol. The consumer's boring lifestyle is shaken, not stirred.[15] The capitalist prerogative to saturate markets for profit continues, neither acknowledging nor taking responsibility for the consequences. Whereas marketing discourse serves to popularize drinking, alcohol problems are marginalized, objectified, and relegated to the gaze[16] of medical discourse. To have a problem with alcohol is to be abnormal. The message is that

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[11] Korzybski said that "the map is not the territory" (Truan, 1993). Consequently, the uncharted is beyond the conception of the rhetoric commonly used to understand the experience of addiction.

[12] *NYPD Blue*'s third season, episode 65, "Closing Time," broadcast on May 14, 1996, written by David Mills and directed by David Rosenbloom (Kytasaari, 2003).

[13] A sponsor is essentially a mentor who is a 12-step fellowship member in good standing. As in other cultures, good standing can be difficult to assess, but fellowship practices do offer some general guidelines. For example, people who are of the same gender (a heterosexual assumption) as the sponsored person with two or more years of sobriety / "clean time" are usually considered reasonable candidates.

[14] Old Millwaukee Beer television ads in the early 1990s depicted vacationing men being rescued by the gorgeous female Swedish Bikini Team, with a generous supply of product. The message "It doesn't get better than this" associated sex and drinking with the pinnacle of the good life, but was rightly accused as "unfair, misleading and irresponsible" (Holst, 2003a). The Clydesdales have been popular mascots of the Anheuser-Busch Brewing Company in St. Louis, Missouri for approximately a century, and were introduced to television in 1951 (Holst, 2003b).

[15] Forgive the pun from the famous James Bond movie series.

if you join a fellowship, abstain, and toe the line, perhaps you will be redeemed, or at least viewed more acceptably, like detective Sipowitz. How does this polarized perspective serve the needs of persons who seek help? What is the role of the social worker? Does she help the client by honouring his preferences? Or does she help the client construct himself in the image promoted, expected, possibly required by the dominant culture? This seemingly trivial dispute has nevertheless embedded itself on many levels in the addiction field with some important implications for social work practitioners.

The field of addiction treatment has often been described as a multidisciplinary setting, with competing etiological assumptions and theoretical applications concerning addiction and therapy. Since the inception of the Alcoholics Anonymous fellowship in the 1930s, there has been significant progress in the development of therapeutic methods to assist individuals with alcohol- or drug-related dependencies (Baker, 1988; Berg & Reuss, 1998; Blum & Roman, 1987; Chang & Philips, 1993; Roberts, Ogborne, Leigh, & Adam, 1999a). Nevertheless, in North American culture the concepts of the disease model and 12-step program treatment dominate (Kaiser Foundation, 1997; Lender, 1979; Roberts et al., 1999b). The culture of the disease model and the 12 steps of Alcoholics Anonymous tend to predominate and marginalize alternative options in northern remote communities.

For many who overcome an addiction habit, personal identity relating to the process of recovery changes over time (Sommer, 1997). Others who face addiction and are adversely affected by the dominant practices of the "recovery industry" (Peele &

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[16] Michel Foucault used the gaze metaphor to describe how authoritarian views of a dominant culture are internalized by people, for the purpose of ensuring compliance (Filingham, 1993).

Brodsky, 1991) find alternative ways of healing. Whereas society often marginalizes the addicted, 12-step discourse often further marginalizes those who do not conform to the accepted etiological assumptions and resulting implications of the program (Granfield & Cloud, 1996; Kearney, 1998a; Peele & Brodsky, 1991). In spite of pressure toward conformity in the culture of recovery, there are those who have success in overcoming addiction in their own lives outside of a 12-step program or formal treatment (Anderson, 1994; Granfield & Cloud, 1996; Kearney, 1998a).

I have known several persons professionally who retired their identity as an alcoholic in recovery and developed what they believed to be a personally more fulfilling and healthier identity. In my private life I have met a number of people who managed to leave the 12-step community after years of membership and eventually began drinking moderately, responsibly, and successfully. These stories of outsiders who left the alcoholic-in-recovery identity may reflect a self-perception based on strength and capacity, turning away from a deficit identity. Some of these people tell stories about learning to accept love, and about taking responsibility not only for their potential worst, but for their best as well. These persons seem to have developed a maturity and insight that comes from years of personal work and growth. Ambivalence, gratitude, grief, and frustration about the years of commitment to their fellowship often punctuate their stories, along with the rationalization that they made use of the only resources available.

The narratives of the participants in this study reflect similar values. One participant described a journey of discovery for the love within himself he knew wasn't afforded him as a child. Others describe their families as their greatest strength, and that placing the family first affirmed all of the love, support, and incentive needed. Still others

found that stepping out of the culture of recovery was necessary to reclaim their creativity and find love. Other qualities included demonstrations of strength, commitment, compassion and consideration for others, and a potent determination to never again give up their right to decide how to view the problem, or the solution. Outsider recommendations invite reflection on what it means to offer a no-harm practice; I believe we do no harm whatsoever to our clients by identifying, amplifying, and celebrating their strengths and capacities.

The experiences of the participants in this study are rich and empowering, and they describe a struggle of overcoming biochemical, mental, social, and political adversity to build identities that are personally healthier and more meaningful. These stories offer great potential in a different capacity: as alternative descriptions that can inform us of inquiry methods and strategies for those who, for whatever reason, are unable succeed in the traditional methods of the medical model and 12-step approaches. Their experiences provide valuable insight into empowering ideas, themes, and strategies that can serve to inspire others and describe where and how dominant practices fail. The information described from the experiences of these people may have some interesting implications for social work practice. These insights may also have meaning outside of the boundary of discourse on alcohol problems and recovery, in that some of the participants' stories reflect a similar context of struggle experienced by others, such as people with drug problems or smoking and eating disorders.

CHAPTER TWO

LITERATURE REVIEW

> Our prevailing narratives provide the vocabulary that sets our realities. Our destinies are opened or closed in terms of the stories we construct to understand our experiences. (Goolishian, as cited in Friedman, 1993, p. v)

This study focuses on the impact of different rhetorical views on people's journeys of growth. Consequently I have organized this literature review around different cultures of rhetoric. I will start with the medical model and the perspective of Alcoholics Anonymous, as these frameworks have contributed to practices which participants in this study find oppressive. Consequently, the premise for this study is grounded on dilemmas relating to these approaches. Although the Minnesota Model could be summarized as merely the sum of medical and 12-step philosophy combined, I will review it because of some of the practice dilemmas I see in its application, especially in relationship with those who share similar needs and preferences to the study's participants. Then I will discuss other models commonly used in current addiction counselling practice in British Columbia, exploring the rhetorical assumptions of each model in comparison to the medical and 12-step frameworks. I then will review the research and other literature that impacted this study.

The Medical Model

In the United States, some of the oldest documents describing treatment of patients with alcohol problems were written by Benjamin Rush (1746–1813, physician and signer of the U.S. Constitution). Although Rush documented cases of spontaneous remission—patients who quit on their own (Granfield & Cloud, 1999), he promoted the

idea that alcohol addiction was "a palsy of the will" (Valverde, 1998; White, 1998). This perspective provided the basis for further research; by the 1850s asylums for inebriates had been established in the United States for the purpose of medical research and developing treatment procedures for those with alcohol problems (Lender, 1979; Valverde, 1997; White, 1998). Lender (1979) provides a chronological summary of the asylum period from the 1850s through the early twentieth century, and of the research at the time distinguishing different types of drinking patterns displayed by inebriates. The work from this period provided the basis for Jellinek's research and promotion of alcoholism as a disease in the 1950s (Jellinek, 1942, 1947). Lender also describes the development of a number of associations during this period, such as the American Association for the Study of Alcohol and Other Narcotics, who were eager to establish themselves as authorities of the profession. Lender (1979) states "the credence of the disease conception became largely associated with the prestige of the new society" (p. 372). In short, Lender describes the birth of the addiction recovery industry in the United States.

Jellinek, who described his disease model of alcoholism as a hypothesis (1960), was a member of Alcoholics Anonymous, and was generally credited as the key advocate responsible for the World Health Organization's acceptance of the disease model in the 1950s. The WHO abandoned the classification of alcoholism several years later; however, U.S. institutions such as the National Institute on Alcohol and Alcoholism (2001) continue to use it. Furthermore, other authorities such as the American Psychiatric Association (2000) and the Canadian Society of Addiction Medicine (2002) have adapted

criteria associated with alcoholism into more current guidelines for assessment and diagnosis (see Appendix B).

Essentially, the disease model presumes the following points:

1. Alcoholism is a fatal disease, that is, it is deadly, manifests predictable signs and symptoms, is diagnosable, has a predictable course (pathology), and is treatable.
2. It is incurable—at this time.
3. It is chronic; it lasts a lifetime.
4. It is progressive—the disease becomes progressively worse over time. (This implies that the lifestyle of an alcoholic who remains sober for many years, and who begins to drink again, will deteriorate at an accelerated pace until he or she is manifesting problems typical of what he or she would have been experiencing without the years of sobriety.)
5. The disease is characterized by loss of control over alcohol (and other depressant drugs). The "loss of control" term seems vague, but is often used for the purpose of detecting any risk, usually manifested in negative consequences, for example, drinking and driving, blackouts, fights, loss of relationships, loss of income, the withdrawal syndrome, and so on (see Appendix B).
6. Given the aforementioned points, the only treatment for alcoholism is abstinence, whereby the disease is considered in remission—a state that will require maintenance for the rest of the patient's life (Miller, 1999).

This model and its more current derivatives (see Appendix B) guide practices in health care in North America. For example, medical institutions specializing in addiction care are common (for instance, detoxification units in Canada) (Roberts et al., 1999b);

doctors and other clinicians are required to provide a diagnosis to secure payment for their services from the health care system.

There has been significant progress in addiction research and treatment since the 1950s. Research grounded in different epistemological approaches has provided more tools for effective assessment and treatment (Bandura, 1977; Berg & Miller, 1992; Marlatt, 1985; Peele & Brodsky, 1991; O'Hanlon, 1993; Prochaska, Norcross, & DiClemente, 1994; Roberts et al., 1999a). One indicator of these developments is the current diagnostic criteria for substance dependency as defined by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (2000). The *DSM-IV-TR* diagnostic criteria for substance dependence include specifiers describing the nature of a person's success over time in dealing with their dependency. These specifiers do not require abstinence in order to maintain a positive prognosis, that is, sustained full remission, but they do refer to the criteria for diagnosis: tolerance, withdrawal, drinking more than intended, unsuccessful attempts to cut down, and so on. In other words, these criteria assess the pathology of the disorder according to *consequences* of drinking, and not drinking itself (although the development of tolerance is another criterion). This is evidence of change in etiological and epistemological views from the disease model presented in the 1950s.

There are a number of arguments critiquing the *DSM-IV-TR* criteria specifically and the disease model in general. One argument against the *DSM-IV-TR* is that although some of the criteria are clinically measurable (for example, elevated resting heart rate for those in withdrawal), others are more subjective. A clinician's preference to explore the minimum evidence necessary for a diagnosis may not be in accordance with the

perspectives of the client, thus creating the basis for a "resistant client" phenomenon. Other arguments relate to the emphasis on consequences without considering other contextual factors in the client's life. For example, whereas a mother's inebriation while her children are in her care could be a significant indicator, the violence by her partner toward her, which she chooses to self-medicate with alcohol, may not considered a contributing factor.

Other arguments against the disease model question the client benefit derived from making a diagnosis of a condition that is considered incurable given that the referral (to AA) for treatment is outside the mandate of medical practice. Another general criticism of the medical model is its overly reductionist approach to the complex issue of addiction. For example, Valverde (1997) uses a deconstructive analysis to provide an excellent examination of the historical political implications of assessment / treatment distinctions relating to class and gender, as well as the construction of addiction / drug issues in western capitalist culture (Valverde, 1998). Others have employed deconstructive analysis (Fillingham, 1993; Foucault, 1973; Rabinow, 1984) to argue that the diagnostic process objectifies, classifies, and helps to subjugate people by honouring information in a file over the experiences of a person.

Alcoholics Anonymous and 12-Step Fellowships

Alcoholics Anonymous is a fellowship whose primary purpose is to help members stay sober, and to help other alcoholics. AA is the oldest and founding fellowship of what are commonly referred to as the 12-step programs. A list of the 12 steps is provided in Appendix A. Alcoholics Anonymous provides a highly accessible

support system (meetings are available in most communities in North America, and thousands of groups are located throughout the world) and a structured program (the steps). AA also has its own culture, attributable in part to its literature. Bill Wilson, cofounder of AA, had prior involvement with Buchman's Oxford movement (Apple, 2001; White, 1998), and borrowed a number of ideas from this group when he wrote *Alcoholics Anonymous*. Specific recruiting processes, a spiritual focus, and other practices were common to both groups. A good way to begin to understand the rhetoric and culture of AA is to read *Alcoholics Anonymous*; the fourth edition is now available. As in the second and third editions, however, the most often-used literature is the first section of the book, which is essentially the first edition without changes.

The first edition was published in 1939, for the purpose of spreading the AA philosophy to others (AA, 1976). This book began with Bill Wilson's narrative, "Bill's Story," then proceeded to describe the program and how it was applied, with chapters devoted to working the steps, working with others, agnostics, spouses and families, and employers. By keeping the first edition intact in each edition since, the fellowship has maintained consistency in its perspectives, guidelines, and culture over the years.

The essence of the program is based on three epistemological assumptions: that alcoholism is a deadly illness characterized by insanity, that recovery requires belief in a power greater than oneself, and that only an alcoholic can truly understand and help another alcoholic. I believe that AA fellowship culture assumes that members need to attend meetings for the remainder of their lives, with some regularity. While AA traditions ensure that the fellowship does not become involved in matters outside its mandate (AA, 1976), members have made significant investments, from supporting

recreational activities to political lobbying. In fact, Jellinek's research was underwritten by R. Brinkley Smithers, a private philanthropist and AA member who dedicated much of his life's work to grounding the philosophy of Alcoholics Anonymous in scientific research (White, 1998). In fact, Smithers and others (such as Thomas Pike, a board member of both the National Council on Alcoholism and the Rand Corporation in 1976) demonstrated their investment in political rhetoric over empirical research in their attempt to censure the 1976 and 1980 Rand reports. These reports found it common for alcoholics to resume non-problem drinking, a result that did not support the universal disease concept promoted by the AA fellowship (Peele, 2002).

Critics of Alcoholics Anonymous argue that emphasis on "keeping what isn't broken" has resulted in the fellowship's difficulty in embracing new developments in the field of addiction treatment. Others feel excluded by the program which hasn't significantly changed since the 1930s, reflecting the culture of predominantly white, privileged, middle- or upper-class male America at that time. A number of critical essays of personal experience are available on the Web site AA Deprogramming (Apple, 2001), highlighted by the ironic limitations of AA's doctrine to address the needs of abuse victims, or abusers who exploit other AA members.

An ongoing theme I have noted during this research is the description of AA as a quasi-religion. For example, AA members often refer to their primary guiding text, *Alcoholics Anonymous*, as their bible. AA rituals include opening meetings with literature from their text, and the passages of the text are treated as scripture, that is, as the purest artefacts available of "the way" that the program works. To question the ideas, language, or intentions of AA literature is to question one's own status as an AA member.

Conversations involving members' relationships with a higher power are inescapable at meetings. The culture of AA has a tautological feel: success is attributable to the program. Individual difficulties are indications of human error, but never attributable to the program rhetoric. There are a number of recommended rituals including daily prayer / meditation and a process of confessing character defects, "our wrongs," that is similar to rituals within the Roman Catholic church and other Christian denominations. The fellowship is an exclusive culture with its own traditions, rituals, scripture, and promises of salvation ("serenity") (AA, 1976; White, 1988).

Consequently, there have been concerns that incentive policies used to ensure that persons with alcohol problems are indoctrinated into AA are coercive in nature. Reed (2001) has provided an excellent critique of AA's role in Canada's corrections systems, clearly describing how the program's culture and rhetoric do not fit First Nations traditions and how many First Nations people view the program as a poor replacement for traditional healing rituals that, typically, continue to be denied.

Other client complaints I have noted include the fact that length of sobriety and knowledge of literature are used as criteria for authority in the groups, honouring the mandate of the program over other factors, such as personal responsibility. Finally, one's admission that he / she is an alcoholic (the method of introduction in meetings) is inferred to mean that one is a member for life.

The Minnesota Model

The philosophy of Alcoholics Anonymous and the disease model, as presented by Jellinek (1942, 1947, 1960; Jellinek , Popham, & Addiction Research Foundation of

Ontario, 1970), are linked. This relationship created a mandate that began to be applied in the 1940s in institutions for alcoholics throughout Minnesota, prior to Jellinek's published work. Essentially, institution policy mandated the disease model as the therapeutic frame and AA rhetoric as the treatment process. The practice of hiring AA members as counsellors was adopted. Jellinek's work, in combination with Smithers's effective lobbying, established the credibility of the disease model in addiction research by the 1970s (Peele, 2002). Consequently, the Minnesota Model became the dominant treatment model for many years (see Appendix C), and continues to be the model of choice for many institutions throughout North America (Kaiser Foundation & Addiction Services, 2001; Roberts et al., 1999b; White, 1998).

The Minnesota Model's assumption of a mandate from medical research while maintaining that only an alcoholic can truly understand another alcoholic has led to some potential dilemmas in practice. This model prioritizes 12-step culture over more clinical approaches to assessment and treatment. Consequently, dilemmas can arise about the separation of personal and professional practice, and about incorporating a model designed for a self-help context into a professional context, that is, vesting a personal, voluntary program with the authority to require rhetorical compliance (Reed, 2001). I also believe that the consequences of this dilemma impact clients, and potentially taxpayers. Many Canadian residential institutions using this model receive government funding—in other words, we are paying counsellors to indoctrinate clients using the disease model and to encourage clients to attend AA for the rest of their lives (Roberts et al., 1999b). While there is support for this approach, Health Canada and the Health Authorities in British Columbia have also explored other models in training and in policy

(Ministry of Health Services, 2002a, 2002b, 2002c; Roberts et al., 1999a; Tornsey et al., 2002). I will outline these later.[17]

Other Models for Addiction / Treatment

There has been a plethora of different therapeutic models, with a variety of epistemological assumptions, used to treat addictions. I chose to explore some of the more popular models used since the 1980s in this field in British Columbia.

Bio-Psycho-Social-Spiritual Model

The bio-psycho-socio-spiritual model has been adopted as a standard of assessment and treatment practice in British Columbia since 1999 (Ministry of Health Services, 2000a, 2000b, 2000c; Roberts et al., 1999a; Tornsey et al., 2002). This model was created on the assumption that alcohol problems impact clients physically, mentally, socially, and spiritually. Consequently, appropriate service ought to address these different areas. This model focuses on practical issues in a person's current life and is not invested in a particular etiological view—in other words, it can be incorporated into practically any other approach.

Social Learning Models

Social Learning approaches encompass a number of different methods incorporating cognitive-behavioural and behavioural theory. I am including the more

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[17] For more information on the history of treatment employing the disease concept and Alcoholics Anonymous, I recommend White's (1998) *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Valverde's (1998) *Diseases of the Will: Alcohol and the Dilemmas of Freedom* presents a historical and political critique of disease rhetoric.

specific therapies, such as Glasser's Reality Therapy (Glasser, 1984) and Ellis's Rational Emotive Therapy (Rational Recovery, 2001) in this category because I believe these models are grounded in Social Learning epistemology. Social Learning theory has been strongly advocated by clinicians in the field who oppose the disease model. The rhetorically distinguishing assumption of Social Learning theory is that people can change based on their strengths, capacity to learn alternative behaviours / activities, and training.

The bodies of research by Marlatt and Peele provide two excellent examples. Marlatt & Gordon (1985) wrote *Relapse Prevention*, which is often considered the definitive book on the application of Social Learning theory in addictions treatment. Marlatt provided a strong critique of the disease concept, a detailed model based on self-efficacy (Bandura, 1977), criteria for assessing risk, and guidelines for establishing effective treatment plans addressing all areas of a person's health. This book was written for clinicians. Peele, who has maintained a high, politically confrontational profile (Peele, 1999) also has provided a similar approach in his Life Process program (Peele & Brodsky, 1991).

A number of alternative mutual-support groups utilize Social Learning methods. For example, SMART (Self Management in Recovery Training) recovery groups employ a model addressing motivation, problem solving, coping strategies, and lifestyle balance (Gilman, 2002). Another support group, Rational Recovery, which was founded in 1986 by Jack and Lois Trimpey, employs Albert Ellis' Rational Emotive framework in a program called Addictive Voice Recognition Technique (Rational Recovery, 2001;

Trimpey, 1996). Information, support, and meetings are available for these groups via their Web sites.

Theories Focusing on Change

Initially, de Shazer developed Solution-Focused Therapy (SFT) from structural and strategic family systems applications (de Shazer, 1985), but with Berg's assistance, the method became adapted into a simple, practical, client-centred approach. *Working with the Problem Drinker* (Berg & Miller, 1992) and *Solutions Step by Step* (Berg & Reuss, 1998) are two examples of Solution-Focused applications for alcohol problems. Although this approach has sometimes been used in conjunction with disease model rhetoric, Solution-Focused method is based on significantly different epistemological assumptions. For example, SFT assumes that change is happening constantly in people's lives, that people are capable of creating better outcomes for themselves by focusing on solutions rather than problems, and that a little change can be significant. Essentially, Solution-Focused Therapy is a client-centred approach, which presumes that the client is the expert in her or his own life, and is capable of developing her or his own therapeutic goals and strategies for success.

Prochaska, Norcross, & DiClemente (1994) collaborated in the development of the Transtheoretical Model of change. This stage model focuses on effective assessment and service matching for clients according to their state of readiness to make changes. The goal of this approach is to ensure effective service to promote progress as a client moves from pre-contemplation, through contemplation, preparation, action, and

maintenance stages of change. This model can be incorporated into a number of approaches, and is relatively neutral in etiological stance.

Miller & Rollnick (1991) developed the Motivational Enhancement approach for working with people who are ambivalent about their alcohol use. Their process invites clients to assess their own relationship with alcohol and make their own decisions. The approach is both strategic and client-centred, with an emphasis on effective use of basic counselling skills. The authors critique and advocate against the use of pathologizing or "confrontation-of-denial" strategies that are systematically used in the Minnesota Model. Other authors have successfully used this approach in conjunction with other methods. For example, O'Hanlon (1993) has incorporated this approach and others into his own eclectic method called Possibility Therapy.

Theories of Resistance and Empowerment

A number of practices for assisting the dis-empowered developed out of the second wave of the feminist movement. Feminist therapy emerged—an eclectic approach that combined social resistance strategies with client-centred methods. The purpose of feminist therapies was to help people understand how they are being oppressed, and to develop and implement ways of empowering themselves and others (Van den Bergh, 1995; Reinharz, 1992; Saulnier, 1996). Consequently, feminist advocates have provided some of the strongest critiques of the 12-step programs, and of the pathologizing practices of the disease model (Apple, 2001). For example, one ethically controversial study compared evidence gathered in AA meetings with cult profiling information and concluded that the AA fellowship shared many rituals with cults (Alexander & Rollins,

1984). As another example, Anderson's (1994) critique of the disease model focuses on the notion of co-dependency. She argues that the term pathologizes attributes expected from women by society, and reframes selflessness as a deficit and a disease, which requires its own treatment (the Co-dependents Anonymous fellowship). A prolific forum for feminist and other critiques of the AA fellowship is available on the Web site AA Deprogramming (Apple, 2001). Apple (the pseudonym for the site's author) provides thoughtful analysis and reflections on her involvement in the program, exploring topics such as the program's difficulties in responding to gender issues, survivors of trauma, and predators in the meetings.

Women for Sobriety is a mutual-aid support group founded by Jean Kirkpatrick that provides a nurturing alternative to AA for women. This group nevertheless embraces the disease concept (Kirkpatrick, 1990; Women For Sobriety, 2002). Charlotte Kasl's (1992) 16-step Empowerment program has also garnered wide support as an alternative support group for (but not limited to) women (see Appendix D).

A second theory of resistance and empowerment, Narrative Therapy, has a number of similarities to feminist therapy. This approach is grounded in Foucault's process of examining power structures, and incorporates the metaphors of narrative (a textual focus on experience—history as biography) and social constructionism (that truth is subjective, and constantly negotiated). Narrative theory defines therapeutic process as a political act (Furman & Ahola, 1992). Elements of political analysis and deconstruction are incorporated into the therapeutic conversation for the purpose of externalizing internalized concepts that serve to limit, control, and marginalize the client. One of my principal consultants in my orientation to narrative ideas, Stephen Madigan, suggested

that the narrative therapeutic process is analogous to inciting clients to revolt against their issues and create the space for positive change. The view of therapy and research as a political act is shared by other traditions, such as feminist (Reinharz, 1992) and structural perspectives (Mullaly, 1997).

Some authors have demonstrated how narrative ideas can be used in conjunction with the disease model and 12-step culture (Hanninen & Koski-Jannes, 1999; Morrell, 1996; Rappaport, 1993). Diamond's *Narrative Means to Sober Ends* (2000) is an example of this; however, I found this work to be a disappointment, with few original ideas, especially when the title invites comparison with White & Epston's definitive work on the subject, *Narrative Means to Therapeutic Ends* (1990). Others have documented more original applications of narrative therapy to assist people overcoming alcohol problems. For example, Smith & Winslade (1997) explore young men's experiences using a "migrating identity" metaphor, to help them pioneer their own journey to a better lifestyle.

Harm Reduction

Harm reduction philosophy violates fundamental rhetorical assumptions of the disease model and AA philosophy. This perspective focuses on preventing consequences of problem behaviours, and protecting opportunities for further change in the future. For example, needle exchanges and safe injection sites help to control the spread of infectious diseases and increase safety for both drug users and the larger community. Marlatt (1998) has edited a book on this subject. Further information has also been made available by the

U.S.-based Harm Reduction Coalition (2003), which maintains a Web site (see Appendix E).

The Harm Reduction approach has been considered controversial, especially in cultures where the disease concept has been promoted, such as in some First Nations communities. Alcohol was used as a tool of colonization, subjugation, and genocide of aboriginal nations in countries throughout the British empire, including Canada (York, 1990). Consequently, when communities such as Alkali Lake in British Columbia began to overcome devastating alcohol problems by starting Alcoholics Anonymous groups and referring people to residential treatment centres, there was considerable impetus to incorporate the Minnesota Model into First Nations culture. Typical examples ranged from combining disease model concepts with the medicine wheel to developing residential treatment centres, where cultural practices of First Nations tradition were combined with disease rhetoric (Leland, 1976; Lowery, 1998). Consequently, approaches that provided any tolerance for alcohol were highly suspect for First Nations communities (Daisy, Thomas, & Worley, 1998). Nevertheless, Stanton Peele has been asked to consult with First Nations communities in Canada, out of concern that the disease model, and 12-step rhetoric, does not harmonize with First Nations culture as hoped. Peele (2003) argues that these communities continue to suffer from addiction issues that have not been effectively addressed using the Minnesota Model. Consequently, these communities are looking for solutions, possibly including solutions based on Harm Reduction philosophy.

Methadone support groups are an example of a mutual-aid system that applies Harm Reduction principles. I started one of the first methadone support groups in Prince George, British Columbia, and I believe it is still running, with the support of a

facilitator. This group was developed to provide a social support opportunity for people prescribed methadone to help them resolve their narcotic addiction, who would not be welcome to reveal their status and experiences in abstinence-focused groups.

Clinical Studies

Clinical research exploring the effectiveness of different therapeutic methods, including the phenomenon of quitting substance use without treatment, has been conducted since the "disease versus habit" debates of the 1970s (Marlatt & Gordon, 1985; Peele, 1989, 2002). More than a dozen studies are available since the 1980s (Sobell et al., 2000), most of which are quantitative. One of the most famous and referenced examples in the United States was Project MATCH (Glasser et al., 1999), an eight-year, multi-site study of how patients responded to different treatment approaches designed to help them recover from alcohol problems. This nationwide U.S. clinical trial involved 1726 patients, 25 senior investigators, 80 therapists, and many more staff, at over 30 participating institutions and treatment agencies. This was the largest experimental trial of psychotherapies ever undertaken to date. After assessing subjects regarding 10 different variables, each subject was assigned to one of three therapeutic groups: 12-step facilitation (promoting and referring to AA—12 sessions), cognitive behavioural therapy (12 sessions), and motivational enhancement therapy (4 sessions). Follow-up continued for one year after treatment.

The results determined that, generally, treatment matching had little long-term impact, contrary to several of the study's hypotheses. However, it is interesting to note that the result criteria used to demonstrate the study's success (number of days of

abstinence in a month and number of drinks consumed per drinking day) embrace a Harm Reduction perspective. In comparison, the majority of clinical studies have categorized any alcohol use as relapse and failure (Sobell et al., 2000). Essentially, Project MATCH used abstinence as the goal for subjects for all of the therapeutic interventions, but used Harm Reduction philosophy (Harm Reduction Coalition, 2003; Marlatt, 1998) to reinterpret success as the degree of progression along a continuum toward the goal. While I believe that most professionals would agree that the results demonstrate therapeutic benefit, I find it ironic that Project MATCH has been quoted by professionals as evidence that the disease model and the 12-step fellowships are the therapy of choice.

There have been a number of qualitative studies exploring the experiences of persons overcoming addiction (Bannerman, 2000; Brady, 1993; Brecher & Friedman, 1993; Brudnell, 1996; Copeland, 1995; Crowley, 1999; Denzin, 1993; Granfield & Cloud, 1996; Hammersley & Ditton, 1994; Kearney, 1996, 1997, 1998a, 1998b; Kearney, Murphy, Irwin, & Rosenbaum, 1995; Keith, 2001; Swatson & O'Callaghan, 1999). Of these, I was especially interested in two studies.

Kearney has devoted much of her research to women's experience, and to the development of grounded theory (Kearney, 1996, 1997, 1998a, 1998b; Kearney et al., 1995). In her work *Truthful Self-Nurturing: A Grounded Formal Theory of Women's Addiction Recovery* (1998), Kearney analysed 10 studies of women's addiction and recovery from 1985 through 1996, with sample sizes ranging from 6 through 35, for a total number of 217 subjects. Her research described the subjects' process of developing a more honest understanding of themselves via simultaneous effort toward healthful self-care and positive relationships. The process begins with a painful shift in awareness,

accepting "self-destructive self-nurturing" activities as being more painful than helpful. Kearney found that the choice to seek formal treatment correlated with women's socio-cultural milieu. For example, women tended to do better in programs that met their needs (e.g., lesbian women had several problems with AA culture), and women with less addictive incapacitation and more social skills and personal resources tended not to seek treatment. She also found that women tended to proceed through three phases: abstinence, followed by self-care, and broadening into connections with others. Kearney found a number of notable points in each phase. For example, self-care often correlated with seeking professional help, involved honest self-appraisals and responsible self-nurturing, and resulted in increased self-esteem. Kearney provides an example of alternative descriptions of women's experience with overcoming addiction in their lives.

Granfield & Cloud's study *The Elephant That No One Sees: Natural Recovery Among Middle-Class Addicts* (1996) was the research that most influenced my own thesis research. Their study involved interviews with 46 addicts and alcoholics who terminated their relationship with addictive substances without treatment or an ongoing commitment to 12-step programs. The study involved a two-stage design. Initially 25 interviews explored three areas: successful strategies, perceptions of self relative to former use, and attitudes concerning treatment (i.e., counselling and/or fellowship groups). The next stage involved unstructured interviews regarding experiences within the areas of the first stage, to gather more information for their thematic analysis. Specific criteria were set for screening subjects, for example, abstinent for at least a year, with specific addiction phenomena within personal experience (cravings, extended use, and related problems). Philosophical assumptions inherent in the research related to concepts regarding identity;

if an "addict identity" is acquired within the context of recovery resources, then those with little contact would have a different self-concept. The researchers found that subjects generally eschewed the addict identity, and had developed identities congruent with contemporary roles (Granfield & Cloud, 1996). The researchers also explored other queries, such as the reasons that subjects avoided treatment resources. They found that respondents either did not want these resources (they had complaints about the programs, such as the denial concept within the disease rhetoric), or did not believe they needed these programs (they had a sense of personal capacity and ability, in contrast to the deficit focus of the disease found in 12-step rhetoric). Granfield & Cloud grounded their perspective in a narrative framework. They recommended further research to substantiate their findings and related conclusions. These researchers later wrote a book based on their study, aimed at a less clinical audience, called *Coming Clean: Overcoming Addiction Without Treatment* (Granfield & Cloud, 1999).

I found no studies in my research that defined controlled, non-problem alcohol use by former problem drinkers as a successful outcome; in the literature, alcohol use was equated to relapse. This indicates the political controversy inherent in this topic. Controlled non-problem drinking is, by AA's definition, impossible for an alcoholic. That no research has examined this outcome of controlled non-problem drinking is indicative of how widely the AA and disease rhetoric has been adopted, either explicitly or implicitly. Meanwhile, the experiences of people who formerly had alcohol problems, and their reclamation of the capacity to manage their use of alcohol, has gone unstudied.

Other Literature Pertinent to this Study

Kearney's (1998) and especially Granfield & Cloud's (1996; 1999) work provide examples of research frameworks that reflect the context of individual experiences. Another road to understanding theories of meaning has also influenced my thinking. In researching of the construction of meaning, I initially began to explore Frankl's logotherapeutic model (Das, 1998; Frankl, 1963; Guttmann, 1996; Truan, 1993). Frankl employed a psychodynamic framework to explore how people create the meaning in their lives. I found Crumbaugh, Wood, & Wood's (1980) book, *Logotherapy: New Help for Problem Drinkers*, which I believe is the only book applying logotherapy to alcohol problems, to be somewhat academic and formulaic; many examples used in the book are poor analogies to addiction experience. While the work explores the subject theoretically, the authors do not directly address the process of constructing spirituality as applied within 12-step rhetoric (higher power, wanting what others in the program have, serenity, and so on). Nevertheless, Frankl's work provided a bridge between historical practices (psychoanalytic framework) and more postmodern applications in therapy, such as narrative therapy and collaborative language systems (Anderson, 1997, 2000; Gergen 1998).

Another lens that I used in my study is that of cultural studies along with its focus on the metaphors and symbols of culture. As mentioned earlier, the cultural studies discipline has grounded and provided significant contributions to postmodern perspectives in therapy (Gergen, 1995; Gergen, Massey, Bogazici, & Misra, 2001). Key ideas of this approach include transforming personal identity and mediating identity in relation to cultural environments (Alasuutari, 1992, 1996; Brodie & Redfield, 2002;

Brooker, 1999; Gergen, 1997, 2000; Kvale, 1992; Peele, 1985, 1990; Rappaport, 1993; White, 1997). Denzin's (1993) study is an example of identity transformation by people with alcohol problems. After providing a conceptual background of different addiction-related theories, including Bateson's theory of addiction, Denzin develops theoretical perspectives of alcoholism and describes the thoughts that characterize the alcoholic identity, or "alcoholic self." He also describes how these thoughts change in the "recovering alcoholic self."

As with all research, it is impossible to provide an exhaustive literature review. This overview generally describes the influences that have contributed to this study.

Focus of the Study

The research question I developed for this study is, *How do the experiences and needs of those overcoming addiction without the 12-step / disease model culture impact social work practice?*

The objectives for this study were

1. To describe the experiences, issues, decisions, and outcomes of those who go their own way to overcome the influence of addiction in their lives
2. To identify the contributing factors that restrain people from using the medical model and 12-step approaches (henceforth referred to as the recovery approach)
3. To describe the needs, preferences, and choices of people who decide to deal with an addiction problem outside of the recovery culture
4. To summarize the implications of this experience for social work practitioners, and for my own future professional praxis.

Current medical definitions of substance dependency (American Psychiatric Association, 2000; American Society of Addiction Medicine, 2001; Canadian Association of Addiction Medicine, 2002) do not include age, gender, or other information as screening parameters. The 12-step literature also suggests that there are no demographic differences in its membership compared to the general population (AA, 1976, p. xx). Consequently, I inferred there was no theoretical basis that could be used to identify exceptional demographic parameters for this study. I did not set parameters beyond the criteria within the research question; I sought out adults who had overcome serious alcohol problems without adhering to the practice of the recovery culture as prospective participants. The focus of the research is on the experiences of the participants and the co-construction of meaning generated from their experiences.

CHAPTER THREE

RESEARCH METHODOLOGY AND DESIGN

> We'll call it an oral herstory, oral herstory and history, through multi-method narrative, [smile] and uh, you'll find your group through snowball sample. There we go! We'll call it a snowball sample, and then you can stick anything in there you need, because snowballs have got all kinds of dirt and dog doo in there… (Transken, 2002)

Theoretical Orientation to the Research

My theoretical views regarding this study are grounded primarily in my experience in the field. I have no personal history involving alcohol problems, and I have seen clinicians use a variety of therapeutic approaches effectively to help clients resolve their drinking issues. Consequently, I believe that there are a variety of effective approaches for assisting people who wish to overcome drinking problems. My view of therapy is distinctly postmodern in that I believe that, for the purpose of counselling, reality is constructed, subjective, and dependent upon experience and context (Furman & Ahola, 1992). Consequently, I believe in client-centred practice, which honours the client's needs, abilities, and preferences. I have developed my repertoire of therapeutic approaches based on client-centred practice; for example, I like to use narrative and solution-focused therapies (discussed in chapter 2) because these frameworks assume people have the capacity to be the authority in their own lives, create their own goals, and author their own solutions.

I liken my professional relationship and work with clients to a researcher approaching qualitative inquiry. My role is to help clients by describing and reflecting experiences in a manner that validates and resonates for them. This process can be

empowering, and promotes positive change, as defined by each person. Consequently, I use a stance that eschews deficit-based epistemological rhetoric, preferring rather to discuss and co-construct meaning with clients in our sessions. In other words, I like to employ a social constructionist approach to therapy. Anderson's (1997) work has been an important influence in my theoretical stance; she grounds her collaborative language system approach in the epistemology of social constructionism, encouraging the therapist's theoretical transparency and openness toward negotiating and co-constructing meaning with people.

I was introduced to cultural studies during the development of my proposal for this research. I like to use the concept of culture as a way of respecting different epistemological and rhetorical views that inform individuals' self-concepts and drive various practices in helping people overcome addiction problems. This application of the concept of culture is similar to narrative and other postmodern approaches, using aesthetic and rhetorical criteria in lieu of positivist methods that assume knowledge represents an objective reality, or "truth" (Botella, 2000).

Research Design

I conducted an interview study with seven participants, using a flexibly structured interview process in order to ensure participant experiences would be documented in their richest detail, in relation to the objectives of this research. The design was intended to invite participants into a "co-authorship" relationship, sharing power and insights. This "co-authorship" function was supported through a member-checking follow-up discussing and negotiating the results of a retrospective analysis of problem severity and

a thematic analysis. The "co-authorship" intention of this research is demonstrated through the use of participant quotation as much as possible to ensure that experiences, theoretical developments, arguments, and other insights could be credited to each of the participants. The use of quotation would also serve to distinguish my voice in the research from theirs - enhancing reflexivity, as well as the credibility and transferability of the participants' experiences.

Qualitative Approach

My research question focuses on the experiences of persons. I sought to represent people's everyday experiences, their personal interpretations, and their stories about experience. Mason (1996) provides an outline reflecting the requirements of a study using this focus. Honouring people's contexts requires research that is strategically and rigorously conducted, yet flexible enough to reflect participants' contexts. My social constructionist view honours the contextual aspects of the research; experiences are negotiated, creating new perspectives regarding personal experience. Consequently, the research was conducted in a manner that recognizes political and ethical processes involved. The research has provided an opportunity for my self-scrutiny, or active reflexivity.

My research question includes a mandate to explore explanations to rhetorical dilemmas, and the reason persons chose to eschew certain prescriptive models and practices that interpret their experience. These considerations, which involve the process of exploring the "what" and "how" of participant experiences, clearly favour a qualitative process of inquiry. A qualitative design also provides an opportunity to honour

participants' authentic voices, which is crucial to my purpose of reflecting experiences that are uncommon in addiction research and rhetoric.

Researcher Role

My choice of qualitative design allows for my personal perspective in the work, providing that my influence is recognized and made visible (Creswell, 1998). Consistent effort was required to ensure my self-awareness, personal impressions, observations, and other experiences were visibly separate from those of the participants.

Interview Study

There are a number of classic traditions in the process of conducting qualitative research, each of which is founded on a number of epistemological assumptions, with specific methodological prescriptions (Mason, 1996). Rather than follow a prescriptive method within these traditions, I designed my interview study around the theoretical orientation that I had developed through my professional experience as a social worker / addictions counsellor.

The interview is an effective and efficient method of documenting the experiences of persons whose voices have been silenced by more socially dominant discourse. Although other artefacts or documentation may be available that reflect participant experiences (for example, journal entries, artistic expression in poetry and song, pictures, and other meaningful evidence), I believe that the interview provides the most consistent method of gathering participants' meanings.

Sampling

Participant selection for this study involved a non-probability sampling method. I made this choice for several reasons. First, non-probability sampling is the preferred method of selection in a qualitative inquiry (Mason, 1996). Second, I had no means of ensuring that a sample for this study would truly be a random one. Finally, I chose a relatively small number of participants for my study; consequently participant experiences could not be considered representative of a larger population, in any case.

Participants were recruited through the snowball method. This is an interactive sampling process whereby participants led me to more prospective participants, who had similar experiences within the scope of the research (Monette, Sullivan, & DeJong, 1986). I began the selection process by soliciting interest among five persons I know whose experiences fit within the scope of this study. I was willing to accept these persons as participants, and also followed up with other prospective participants they recommended. If no participants had been recruited in this manner, I would have placed an advertisement in the local paper, and continued the snowball selection process with respondents.

Data Collection

Data for this study were collected in several ways: by face-to-face conversation, by telephone, and by email and other written correspondence. Oral conversations were recorded and transcribed into written text.

Interviews

The purpose of these interviews was to acquire the personal contexts, experiences, and perspectives of the participants in reference to my research question and objectives. I developed a set of questions to guide the interview process (see Appendix F).

In order to provide an opportunity to gather richer descriptions, each participant received the list of questions when they consented to participate, whereupon we scheduled a date for the interview. Consequently, each person had time to reflect on his or her responses. In the interviews, I used the standard questions as a general guide, and presented them in a flexible rather than rigidly structured manner in order to honour participant experiences and meaning. When the questions had been answered to the mutual satisfaction of the participant and researcher, the interview was complete.

Database

Interviews were stored as written documents, and gathered into an archive organized according to the information provided by each participant. This archive provided the database for the data analysis.

Data Analysis

Data analysis in qualitative research is an inductive process in which the researcher organizes information from a relatively small number of subjects, with many non-controlled variables (Creswell, 1998, p. 16). My main purpose in analyzing participant narratives was to ensure that my descriptions of participant experience honoured intended meanings and contexts, while addressing the objectives of this study.

However, I felt it was also my responsibility to present participant experience in a manner that acknowledged, at least to some degree, the participants' histories of serious alcohol problems. Hence, an analysis of problem severity (that respected participant preferences) was important in addition to a thematic analysis.

Retrospective Analysis of Problem Severity

I documented, through personal review of interview transcripts, the extent of alcohol-related problems apparent in each participant's narrative. My purpose for this analysis was to clearly describe, or qualify (a term often used in 12-step fellowships where a person describes the extent of their problems in order to demonstrate they belong), the serious nature of the participants' alcohol problems. I developed the units of measure for this analysis by adapting criteria from the *DSM-IV-TR*, which is widely accepted in addiction assessment discourse; indeed, it is the most cited reference for emotional and mental health problems in North America. I did not use the specific substance dependence criteria from the *DSM-IV-TR*, to dispel any assumption that the participants in this study could be diagnosed as substance dependent. The specific criteria I used are provided in Table 1. This analysis was limited to the presence of evidence within each participant's narrative that satisfied each of the adapted criteria.

Thematic Analysis

I reviewed my database to ensure that the information was within the scope of the research question, and supported the objectives of this study. I strove to allow participants' authentic voices to be heard through quotation, in order to limit intrusion or

interpretation of participant experience. A cross-sectional analysis (Mason, 1996, pp. 112–128) was used to explore patterns and commonalties between participant narratives, for the purpose of organizing participant experiences in a manner that highlights common concerns, preferences, and experiences. A non-cross-sectional analysis (Mason, 1996, pp. 128–133) was used to develop descriptions situating participant narratives and meanings within the context of their living experience, and to describe the significant points within a participant's experience.

It was not my intention to provide an exhaustive, complete analysis of participant narratives. According to the social constructionist view that meaning is a dynamic, ongoing negotiation within discourse, the notion of completion is an unobtainable goal. I ended the analysis development when the information from each participant had been thoroughly reviewed according to the four criteria described in this section. Furthermore, I chose not to overly interpret participant experiences through the thematic analysis, preferring instead to use quotation from the participants to allow their direct input to discourse with the reader. I believe that this decision supports the integrity of the social constructionist process, the wisdom of the participants, and the imagination and critical judgement of the audience.

Ethical Considerations

All issues regarding ethical practice and confidentiality have followed the policies and protocols of the UNBC Research Board and the British Columbia Association of Social Workers Code of Ethics (British Columbia Association of Social Workers, 1999).

Any discrepancies were resolved in consultation and collaboration with academic supervisors and the participants of the study.

Confidentiality

Confidentiality is important to ensure participants feel secure in offering their authentic voices. Several methods were used to ensure confidentiality. Participants were invited to consider altering their names and other identifying information prior to interview recording. There was no documentation linking narratives with actual identities for participants who choose this route. Participants' names were removed, and they were addressed as "interviewees" when interview tapes were transcribed. Other identifying information was altered at this time to protect identities with minimal effect on participant narratives. Finally, I used a pseudonym for each of the participants who did not choose to alter her or his identity. The purpose of this final step was to ensure that each participant's information could be properly sorted, while maintaining anonymity.

Confidentiality also was maintained by appropriate security measures. All documents have been kept secure, as outlined in the information and consent form (Appendix G). I used a double lock security policy, for example, storing the documents in a locked briefcase, and locked in my home or in the trunk of my vehicle. Tapes have been kept secure in a similar manner, and will be destroyed after the successful defence of this research.

Informed Consent

Each prospective participant received a "Research Information and Consent to Participate" form (see Appendix G) which provides a summary of the purpose and process of the research, methods of security / confidentiality, and participant rights. I ensured each person understood his or her rights, and I answered any questions before accepting the signed forms.

Safety and Well-Being of Participants

Interviews were scheduled in consideration of participant preferences to ensure minimal disruption. I left time after the completion of each interview to offer an opportunity to debrief, and, if appropriate, a referral for counselling.

Ethics Committee Approval

The proposal for this research was approved by the UNBC ethics committee on July 4, 2002 (see Appendix H).

Researcher Perspective and Reflexivity

My everyday life, theoretical perspective, and personal views have significantly influenced conversations and co-constructions of meaning with participants, thematic analysis, discussion of results, and recommendations. For example, the construction of the transcript for recorded interviews involved my decisions about the use of punctuation and grammar; I was an editor of sorts for the participant narratives. I have relied heavily on participant quotation for this research; consequently, I needed to employ some

editorial license. Specifically, I removed the artefacts of oral conversation that render literal transcriptions practically unintelligible, the use of "uh," "ah," and many "false-start" sentences that make literal transcriptions difficult to read. I edited transcriptions to accurately reflect train of thought as the key criterion.

For the reader's benefit, I am a Caucasian man in my mid-forties; my friends tell me that I have a pleasant demeanour, and that they view me as an intellectual. I'm a professional social worker with about 20 years of experience as an outpatient alcohol and drug counsellor in northern British Columbia. I am currently working with a multi-disciplinary team providing multiple therapeutic services to families designated as "high risk" by the Ministry of Children and Family Development. I am currently single with no children, and occupy my leisure hours reading and studying, playing music in a band (just for fun), and socializing. I have no personal history of alcohol or drug dependency, but have enough experience to know that I dislike feeling drugged. I had an uncle who died of alcoholism years ago. I have been dealing with a weight problem for most of my life—but I do not consider it analogous to alcohol or drug addiction experience.

Rigour and Generalizability

The contributions of this study, to theory or practice, are dependent upon the degree of rigour in the research process. This qualitative study is designed in consideration of possible theoretical generalization, that is, the extent to which findings create a conceptual or experiential resonance for the reader, reflecting stories of others with experiences similar to those of the participants (Mason, 1996). I have attempted to ensure rigour for this research process in several ways. The social constructionist process

requires clarification and elaboration of meaning in participant interviews; this will ensure that participant narratives are rich in data relating to the research question. Frequent quotations from participant narratives have been used to enhance the credibility of this study. This use of quotation ensures that data and corresponding themes and issues effectively describe participant experience and are easily recognizable by the participants or others with similar experiences. Member-checking, where participants are repeatedly involved in the research, such as further questions or thematic analysis, also assisted the credibility of the process. The degree of detail, including previous experiences the researcher had with some participants and important changes in participant lives after the interview, will be provided in consideration of the transferability and dependability of the findings. I will keep information for the purpose of an audit, such as signed consents, transcriptions, other correspondence, and artefacts of the process used in the development of the thematic analysis, to address confirmability of the research.

CHAPTER FOUR

DATA COLLECTION PROCESS AND ANALYSIS RESULTS

> A part of me said, "It's time to do this on your own." Stepping out of this shell of a community I had around me, I stepped into the real world. (Joe)

At the end of the summer of 2002, the data were collected, and I had the opportunity to reflect on the process so far. While finding participants for this research was somewhat easier than expected, the "how" part of this process was certainly different than planned. I was reminded about some potential risks concerning advertising, anticipating a variety of responses[18] that might have required a chapter entitled "Bravery," or "The Experience of Soliciting Unpopular Requests." Fortunately, in the course of discussing the development of my research topic and proposal, I had a number of people volunteer to participate. I received half a dozen invitations in this manner, and was confident that I might have enough interest, with using a snowball sampling approach, to fill my quota of interviews. There were, in the end, seven participants. Three of the participants for this research were from the half-dozen prospects mentioned. Two consultants who assisted me in the development of my proposal referred three other persons to me. The interviews from these six persons were audiotaped, five during face-

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[18] During the development of the proposal for this research, I had the pleasure of discussing the topic with many people who were in the field of addiction treatment, and often who were personally in recovery. For example, one person (who referred me to a prospective participant), proud of her membership in Narcotics Anonymous, declared, "Your research scares me to death." Two other persons, upon understanding that I had several interviews of people who had left after a decade each in 12-step fellowships and successfully resumed moderate drinking, each replied, "Sounds like something that you wouldn't want to tell too many people." I found that I was anticipating judgmental responses to the topic I chose, witnessing Foucault's "internalizing discourses" idea (as cited in Fillingham, 1993) in my head: "Why don't you just keep this to yourself?" My fertile imagination began to play with the idea of bags of hate mail and warnings that I was "killing newcomers" in response to my advertisement soliciting those who overcame alcohol problems and

to-face interviews, and one by phone. The phone interview participant lived in a distant community, so we agreed to conduct an audiotaped phone conversation. The seventh participant volunteered her story at the last minute and sent me her written narrative via email. In retrospect, and given my own professional background of engaging with people who have a troubled relationship with alcohol, I believe I could have found *many* more outsider interviewees who would have shared their divergent success stories.

The interviewing process was completed within two months, but the transcription process took longer. I initially hired a bonded transcriber who was recommended by a fellow graduate student. This person began the process, but was unable to complete it for personal reasons unrelated to this work. A bonded acquaintance offered to help, but had to leave town shortly after. I personally transcribed five of the seven interviews.

The process of thematic analysis for this research (my first effort) proved to be a daunting task. I initially and naively wanted to approach this process from a number of angles. I considered employing a purely inductive, grounded approach, developing coding and generating themes strictly from the transcripts of the participants' stories themselves. But I also wanted to ensure that the categories fit within my objectives for the research as defined by the research question. I also wanted to recognize the conceptual frameworks developed by other researchers for comparison (Granfield & Cloud, 1999). The result was a maddening prescription for confusion with too many interrelated perspectives influencing each other and constantly changing the frame I was already using. I became caught in trying to perform cross-sectional and non–cross-sectional analyses, inductive theme generation, and deductive grounding of different

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who do not see themselves as having a disease. As a result, I chose to use this avenue of soliciting participants as a last resort, which I ultimately didn't have to do.

models, all at the same time. The more I invested in this process, the more I found I was focusing on operationally defining experiences, reducing narratives to codes that could in turn generate themes, which had little to do with honouring the organic experiences of the people who had considerately volunteered their stories in the first place. Later I learned that my experience was not uncommon among qualitative researchers.

In desperation I abandoned the umpteen document screens on my computer for a day of play with crayons and flip-chart paper, focusing on mapping my chaos. This process, combined with the initial cross-sectional analysis work, helped me develop a generalized social constructionist–culture identity model to help organize the themes I had inferred from the participants' stories. This model is described in detail in the section titled "Social Construction, Identity, and Culture: A Sketchy Model" (p 67).

The nature of the model I employed created yet another dilemma for me. I had received heartfelt narratives from people in response to my interview questions. But the thematic analysis developed directly from the transcriptions of the participants' stories, inferences that led to the creation of codes and eventual themes, were of my creation. It seemed to me that this process, for which I employed a social constructionist view of negotiating meaning (Blum & Roman, 1987; Botella, 2000; Freedman & Coombs, 1996; Gergen, 1995) required further discussion with the participants in order to ensure the thematic framework validated their experience. I attempted to contact all seven of the participants, and provided each of them with a copy of their transcribed interview and a draft of the thematic framework I had developed. Six of the participants responded, and each indicated they believed the model I used accurately reflected her or his personal experience and perspectives. I was able to have a face-to-face discussion with four of the

seven participants. The three remaining people lived in distant communities. I sent them each a copy of their transcribed interview and a draft of the thematic framework with a cover letter that asked them, "Does this work for you?" (see Appendix I). Of these, two supported the framework, and the third person did not respond to my package nor to several phone messages. Since this person had been provided several means to contact me, had been briefed prior to signing the consent to participate, and had been informed of my timeline, I assumed that her silence did not constitute her withdrawal as a participant. She will receive a copy of the finished thesis as mutually agreed.

Although this approach deviated somewhat from the original plan, this last phase reinforced two important ideas. First, the process helped to ensure that the research method, thematic analysis, framework, and discussion were more integrated. Second, the process reflected the underlying intention of the work; it helped to ensure that these persons' voices, their stories, were honoured.

At this stage, I conducted one of the most controversial parts of the research, a retrospective analysis for the purpose of demonstrating the extent of alcohol problems experienced by the participants. The reason for this process is purely political; addiction service professionals and people in recovery tend to take epistemological perspectives very seriously. The disease epistemological stance would allow only two explanations: that these persons couldn't be *real* alcoholics with serious alcohol problems, or that the participants in this study, by no longer abstaining from alcohol, had begun the pathological descent into active alcoholism. These perspectives reflect the tautology of AA and its application of the medical model. As one of the participants commented, "There's a piece to that writing in the book, 'This program does not fit for everyone.

There are those who are constitutionally incapable of being honest.'[19] So this gets back to that idea about closed systems and totalizing practices" (John).

I felt that a retrospective review was in order, in order to provide evidence that all of the participants had experienced serious alcohol problems. I used criteria adapted from the *DSM-IV-TR* (see chapter 3). I approached this analysis from the perspective of identifying the presence of the factors outlined in the participant narratives. Specific information on the criteria used and the results are presented in Table 1, which provides a summary of participants' alcohol problems at the most serious point in their history.

[19] John was paraphrasing, referring to the quote without directly reciting from the text of *Alcoholics Anonymous* (AA, 1976).

Table 1 **Retrospective Analysis of Participant Narratives for Indicators of Alcohol Problems**

Indicators of Serious Alcohol Problems[20]	PARTICIPANTS						
	Joe	George	Gina	Claire	John	Judy	Beth
(1) Tolerance: a need to drink substantially more to experience euphoria	*	*		*	*	*	*
(2) Withdrawal: after slowing or stopping after a long period of drinking, the following occurred:			[21]	[22]	[23]		
(a) *"Hair of the dog": drink or drug to avoid sickness*				*	*		
(b) Increased shakiness	*				**	*	
(c) Nausea or vomiting						*	
(d) Seeing, hearing, or feeling things that were not really there					*	*	
(e) Anxious, frightened, worried without a direct threat	*	*			[24]		*
(f) Seizures					*		
(3) Drinking more than intended—loss of predictability regarding drinking				*	**	*	
(4) Failed attempts to control the drinking							*
(5) Much time is devoted to alcohol-related behaviour	*	*	*	*	*	*	
(6) Significant events or responsibilities are sacrificed because of drinking	*		*	*	*		
(7) Continued to drink, knowing that it was a problem	*	*	*		*	*	*

Of the six persons with audiotaped interviews, information in each of their detailed transcripts revealed a fairly broad range of alcohol-related problems, ranging from avoiding certain events because of drinking to withdrawal seizures. On December 1,

[20] These risk factors have been adapted from criteria in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*).
[21] Treated for withdrawal risk reduction / prevention by an attending physician in a hospital.
[22] Spent 22 days in a residential detoxification facility.
* There was evidence that this phenomenon was present in the participant's narrative at least once.
** There was evidence that this phenomenon was present in the participant's narrative, and that it had been present within the previous 12 months.
[23] Initially underwent several detox stays and completed residential treatment.
[24] John indicated there was some indication of anxiety, but that this may not be completely explained by his drinking.

2002, the seventh participant sent me her responses to the risk areas according to her experience. Beth wrote,

> My response is neutral or rather supportive—I think that it makes sense for you and your readers (including critics—as with any fine piece, there will be many) to know exactly where your interviewees are coming from in terms of the system's requirements of dependency.
>
> My alcohol use did not have a huge effect on me physically and in terms of interfering with commitments. I tried to get to things that needed doing first and also build in some recovery time after drinking—not that I suffered physically or got sick. I just felt depressed, tired, blah, and unmotivated to do any more than lie around and watch movies. I believe the intent behind pouring alcohol down my throat was the real problem, not the alcohol itself.
>
> In some ways the questions are difficult to answer with a yes or no. For example, in number 5 [much time devoted to alcohol-related behaviour] I said no, but it would take a good day to (read above), so I don't know. I was never really sick, but I sure felt that I had let a deep part of myself down; I also felt like I had let my parents down and that made me feel sick.
>
> I answered yes to number 7 [continued to drink, knowing that it was a problem], because I knew in my heart that I was not living up to my true potential and on a more practical, measurable note—I would drink while on anti-depressants (was advised not to use alcohol on this medication). I remember passing out in the bathtub one night because I was on medication and was drinking vodka straight from the bottle.

Beth's answers indicate that she had, at one point during her relationship with alcohol, several problems she deemed personally significant.

Table 1 demonstrates that the participants in this study have all experienced serious alcohol problems. However, this process was controversial for the participants. Beth provided some feedback regarding this analysis which I believed reflected a common concern participants had, over a process which involved potentially pathologizing practices:

> You know, Jeff, talking about this stuff has brought up a lot of old feelings. When I was working on my degree and had a practicum at [residential treatment centre], there was a behind-the-scene conflict about how we try and assess / diagnose people in terms of the level of dependency / damage done by alcohol. There is a definite need especially when detox referrals are involved, but the same scale [*DSM-IV-TR*] does not so neatly fit with people like me. People like me want to

> make changes in their life; they know they are missing the mark and that AA does not help them. I have never mentioned my bottom in AA meetings as it would seem so insignificant to the culture there—there would be a whole batch of stories that would make that seem like nothing. Yet the experience was enough to shock me. Mountains to one, pebbles to another. Personal frame of reference needs to count for something.
>
> The criteria, like other mental health assessment tools, need to take into account cultural, identity, and spiritual (including personal values) aspects of the person being tested. I once had a friend in class practice a new mental health assessment tool on me. I asked her before I filled it out, "Do you want me to answer like a client—like how I think it should be done, or do you want me to answer honestly (including spiritual experiences)?" She smiled and told me to answer honestly. So I did. My diagnosis? Schizoid and dependent. Was she ever shocked! How could her test say this? She had no clue as she thought that I was pretty functional. I smiled back and told her that her test is designed for one culture group and that she told me to be completely honest. The results would have been different if I was answering like I thought I should be (according to the culture behind the test design). How true is that? Do I really need to be walking around with those labels? (Beth)

It is vital that the reader understand at this point that I am not a certified diagnostician, nor did I approach this analysis from a completely neutral and objective position. Moreover, there are obvious weaknesses in retrospective self-reports, particularly concerning descriptions of character blemishes, and especially regarding recollection of events over a decade old. It was my intention that this exercise would provide evidence to caution any assumptions trivializing the impact of participant histories with alcohol.

The Participants: An Introduction

Judy[25]

Judy was the last person I interviewed. A Caucasian woman in her mid-forties, she is happily married without children, but she enjoys children, creativity, and music in

her life. She lives in a suburb of a large urban community in southern British Columbia, works full-time, and loves her job, her home, and her life.

I believe that Judy's story deserves some detail; I like to think of Judy as one of the first people who introduced me to the phenomenon of folks who reclaim their identity beyond the predominant description of "alcoholic in recovery." In retrospect, it seems that Judy told me my first paragraphs of outsider story. Consequently, her voice has been significant in this research and has contributed to my decision to choose this topic for this work. She was never a client, but more of a friendly acquaintance, whose story grew in importance as I racked up experience in alcohol / drug counselling. The following is an excerpt from a rant journal[26] (field notes) I created, relating my story in context with Judy's:

> I've spent very little time with Judy; three occasions in the last dozen years or so. Over ten years ago I decided to learn about a new approach in therapy that spoke about postmodernism and narrative and about honouring client stories. I went to Vancouver and stayed with my sister while attending a couple of intensive training weeks at Yaletown Family Therapy[27] with Steve Madigan (and Ian Law, Colin Saunders, and others). It was very exciting, and I became inspired about the possibilities of applying these ideas in my work with clients.
>
> My sister's roommate's name was Judy. During my stay I couldn't help but notice Judy's beautifully handmade stringed musical instruments hanging on the wall in the apartment. I tried to invite her to join in when I practised on the guitar I brought with me; she remained somewhat distant. My sister suggested that Judy was under some stress at the time. The day before I left, Judy spoke with me; we began to discuss some of the problems she was trying to deal with. I invited her to consider talking to Steve Madigan. I gave her Steve's card. The next day I thanked sis and left to begin using some new tools in my work.

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[25] This name and all others are pseudonyms. Other information, such as demographic clues, may have been altered to protect the anonymity of the participant while maintaining the context and meaning of the narrative.

[26] I titled this very personal and unpublished journal "Warning: Bitter Little Man's Thoughts." It is a repository for unbridled creative thought and exploration of what I believe to be the political quagmire of the addictions field (Talbot, 2002). This journal should also be considered as my journalistic notes from the field.

[27] Suite 207, 1168 Hamilton Street, Vancouver, BC V6B 2S2.

> It was a year later when Judy phoned me and asked for some advice. Steve had asked her whom, in her cheering section, she'd feel comfortable talking to about a decision. She was contemplating retiring from her career as an alcoholic in recovery. She explained that once upon a time she had a full-blown alcohol addiction, and decided to join AA. She tried hard, and became known as Miss AA in her circle. But she was always running from fear. She was afraid that if she allowed fun into her life, she would relapse and that would be terrible, i.e. jails, hospitals, death. No fun, no creativity, work the program, that was her recipe, one day at a time, each and every day. She said she'd done this for 10 years, and it had been that long since she'd played her mandolins. Every time she moved, she hung her beloved instruments on the wall in a place that would do justice for her love of creating songs, then watched them gather dust. I suggested that perhaps it was time for her to reclaim her life, and her music.
>
> Three years later my sister let me know that Judy now had the occasional drink, that she had a job involving music in Vancouver, that she was in love, that she was writing and performing her songs at different venues, and was inspiring others in their creativity. Last time I saw Judy was at my sister's wedding. She looked great, with her glass of wine, and her fiancé. That was seven years ago.

Judy provided more personal insights during the interview. She was born in eastern Canada; her father worked in the criminal justice system. Judy's family had a number of problems as she was growing up, including her father's heavy drinking. Prior to her parents' break-up, she left high school prematurely and hitchhiked to British Columbia with a friend.

> I wasn't terribly prepared for reality, and I think not having the family support, and being out there as a young person, searching, I looked in the wrong places out of ignorance; not knowing what to do. Finally I went to a psychiatrist in [the community] where I lived. She referred me to AA. Off I went. I certainly stopped drinking, and hung around very faithfully for the first five years of my not drinking. (Judy)

She also attended Adult Children of Alcoholics (ACOA) fellowship meetings, "...but I didn't bond with anyone in ACOA like I had in my time in AA." She eventually left the program for a number of reasons:

> To give AA their due I learned some good things there... Well I felt pretty good, because AA taught me that I'm a loser, I can't do it on my own. ...I bought into this belief that everything that I was, was because of alcohol. So I was basing my

> life and who I believed I was on my supposed greatest weakness. Now that's tough. How do you ever get ahead?
>
> Not being comfortable as a single woman, in the prime of her life, going out to bars—you're not supposed to do that. Like, jeeps, you know? I'm a very social person, and I was missing a lot. And that's why I was so lonely and perhaps overly dependent on my AA family as it were. So when I made the decision [to leave the fellowship], I thought, is AA right, and I'm just kidding myself? That I'll go back and I'll be worse than when I started, like they said? No, that wasn't the case. And 10 years later I'm still not worse...because I learned how to manage my drinking. And it can be done. (Judy)

Joe

Joe is one of the participants who initially shared conversations with me in preparation for this research, and who later volunteered his story in an interview. I summarized my impressions of the man in my rant journal as well:

> Joe is the son of an alcoholic railroader, passionate rebel with a cause. Joe saw some violence growing up, and had a hell of a time with all the standard questions kids ask themselves in those situations. Joe kicked out into life on his own in his late teens, earned his class one and air brake tickets and was driving Macks and cab-overs at 21. And drinking. Maybe it was to drown his anger, or a convenient way of turning it against himself. There's lots of speculation, because he got into AA, then ACOA. There's always a lot of speculation in those rooms.
>
> That's where I met him. The reason I saw him in those ACOA meetings is because Joe knew there was more work he wanted to do, rather than surrender his will to a higher power and stay sober. I think initially Joe's work was about forgiveness and acceptance. For his family, and anyone else, but especially for himself. Joe has within him a beautiful and courageous wandering spirit, trying to find a home.
>
> Joe stopped going to the meetings so regularly. He felt that he still needed the meetings, but his tolerance of the hypocrisy was rapidly disappearing. The key turning points involved the falling out of his closest friends in the programs. One was an "offender" in recovery, who began to have too many secrets, and projected way too much of his stuff onto others. Another friend took pride in her reputation as one of the role models in AA, but took more pride in the attention she received in the rooms and her conquests of married men in the program. The last straw related to another close friend and mentor. Joe and this man had a lot in common: both were in recovery, dealing with anger and judgmental attitudes, and both were committed to their partners. After seeing his friend living a lie that profoundly affected the family, Joe never spoke to him again. Or attended another 12-step meeting.

> Joe did a lot of personal work, and a lot of grieving. And a lot of searching for meaning in his life. He realized that he had stayed in the program *way* too long, out of his need to belong. He turned to other opportunities. Joe's music has always been one of his ways of letting his soul create, and his love for music provided the momentum to find other musicians. Which of course led to the invitations and having the occasional drink or joint. Which led to more.
>
> Joe has struggled with social use of alcohol and cannabis. In my opinion, it's because many of the folks he's associated with often weren't social users. But in the last year Joe has managed his use of alcohol, and quit pot. The reason for his commitment isn't about fear. It isn't about relapse and going to hell in a hand-basket. It's about taking good care of himself. He doesn't abuse his body anymore or do things that can sabotage his relationships, because he knows he and his partner deserve better. He's done enough work about forgiveness and acceptance in his own life to take the next step. The focus isn't disease or fear in Joe's life; it's about love.

Joe describes himself as a social drinker now. Joe is a Caucasian man in his late thirties, living with his partner in a rural suburb in a northern community in British Columbia, working full-time. He continues to play his music with friends, but has set some clear guidelines regarding his alcohol use; he has recently prepared to quit tobacco again. Joe stated:

> When you are physically addicted to something—I have an addiction to nicotine, and I know what my body does when I go off nicotine. That is some real wild, freaky stuff. How come they don't have a 12-step group for smokers? [laughter] Really? You know it's the hardest drug in the world to get off; I go to these fucking meetings and they're sitting there slamming back the caffeine, sucking on cigarettes [chuckle], and they're trying to tell me that they've got it all together.
>
> So, that's what happened for me in the end of it all; I couldn't buy the hypocrisy anymore. I'm sitting there, non-smoker, non-drinker—at even one point I quit coffee. You know, I quit drinking coffee, and I eliminated it from my diet for some health reasons. I had some tendonitis—I was trying to get a cure from that—that's a diagnosable disease, tendonitis. Overuse, physical repetitiveness, you could have all kinds of acronyms for that, and that's diagnosable. Broken leg's diagnosable. I wish they could have had a diagnosis for my broken heart but that was the problem. That was, the pain and anxiety of growing up in that household, that's why I drank.
>
> I don't buy any of the rhetoric of AA anymore. I've heard it said in meetings "take what you need and leave the rest." I've done that, there are some good things about AA, but I don't need the program anymore. I have no doubt in my mind, I am one of the strongest people that I know. This sounds braggart but I

> firmly believe this. It is this strength that I rely on to guide me when I choose to drink. (Joe)

Joe continues to challenge himself, and is preparing to attend a therapeutic retreat next year. Joe was generous, creative, and reflective in his interview, which lasted over three hours; he contributed significantly to the foundation of the themes explored in this work. Joe definitely was the metaphor writer, and shared great insight on many topics, especially about emotional healing, and what he believed professional practitioners need to know.

Claire

Claire is a Caucasian woman in her early thirties, happily living with a man in her life and her children in a suburb of a community near the Sunshine Coast of British Columbia. I was referred to Claire by a mutual acquaintance while stopping briefly in the community during a summer vacation. I spoke to her on the phone one morning, and had the interview with her in her home the same evening. Claire's insights were especially valuable. After reaching a point where she sold her soul to drugs and alcohol in her teens, she went through detoxification, residential treatment, and follow-up outpatient counselling as a youth:

> I mean when I first started drinking I remember stealing from my parents' alcohol and getting drunk off a couple of drinks. To actually being able to sit down and drink, and drinking in the morning, God, I forgot about that. Yeah, I remember that near the end, actually, because people I hung out with were a lot older than me and so they were a little ahead of the game in their addiction… I would rip off my work to get money so I could go to the bar. Yeah, I'd do whatever I needed to do so I could party and back then it was mostly alcohol. Yeah, insanity. Of course I knew it, I was raised to know it.
>
> Detox back then…now, five to seven days; I don't know in your area, but in this area that's an average. But yet 22 days. [pause] Yeah, and then I went to

> treatment and I did the whole system of care…abstinence, total abstinence, 12-step models, that's where I was introduced to it. (Claire)

She achieved 13 years' abstinence from all mood-altering substances as a member of a 12-step fellowship. During this time, Claire continued her education, and now has years of experience in her own career as an alcohol and drug counsellor. Her story details great deliberation and insights, benefits and costs as she gradually prepared herself for her experiment and eventual success for two years as a controlled drinker. She still attends 12-step birthday celebrations and associates with members in the program to this day, but she is especially careful about her story:

> To this day I'm very careful whom I discuss this with because I don't want people to believe they can be a social drinker. I do not believe that everyone can do that. My standard line to friends, like I'm not talking about work here, is, "When you clean up at eighteen, when you have my family, when you do the treatment and the counselling that I've done, and you get thirteen years clean, then come and talk to me about it.
>
> I don't consider myself to have clean time anymore, because I respect the program and their beliefs…there's a lot of people that are watching. (Claire)

Claire continues to work her program but now uses a 16-step empowerment model in her life (Kasl 1992):

> It's not like I just dumped the steps. I believe in a program, I mean I just didn't clean up and become healthy. There were lots of other areas that I, you know, transferred addictions to. So I don't believe addiction is about using. It's about a number of things. It's about running, it's about not facing reality. It's about fear. It's about pain. A lot of different things for different people. It's about behaviour and when you work on those, my belief, then maybe I might be able to be okay in terms of using, in terms of life. (Claire)

Claire's outsider insights enriched this study immensely, especially regarding the process of deliberation toward the experiment of moderate drinking and informed recommendations from professional experience in the field.

Beth

Fate would have it that after the interviews and my thematic analysis, my friend Beth contacted me to catch up on news and to ask a favour. She had consulted with me years ago regarding the research when I was contemplating my topic during my first courses. I spoke to her about narrative ideas and recovery stories at the time, and she replied, "Alcohol is like a beautiful lover and a bad companion, who you have to let go of..."[28] I knew then that her ideas would be of great value to this research. When she called and I told Beth about the thesis, she wanted to participate, and was rather insistent. She offered to answer my questions via email, eliminating the transcription process. When I read her first line, I knew that Beth's contribution was a gift, "Alcohol is a weary old friend, available at short notice to distract me from my spiritual focus."

Beth also sent me the following brief summary of her background for the benefit of the reader:

> Beth is a Caucasian woman in her early thirties who grew up in Kelowna, BC. There were no signs of alcohol problems in the home; however, several relatives living outside the home experienced difficulties with alcohol (e.g., DWI's, embarrassing scenes at family gatherings) when Beth was a child.
>
> Both parents had white-collar jobs and childcare was arranged outside the home in the morning and after school. Beth and her younger sister Samantha received care in several different homes during a five-year period. In one of the homes, the caregiver sexually and emotionally abused Beth who was six years old and her sister Samantha who was four years old. This continued for a year until her parents found her another home.
>
> Childcare outside in other people's homes stopped a couple of years later when Beth's maternal grandmother began to reside in the home.
>
> In her early teens, Beth developed an eating disorder and her sister discovered rage. Without warning, Samantha would have fits of yelling in attempt to intimidate the other family members to her point of view.
>
> A variety of "helpers" (ministers, counsellors, social workers) were consulted in the hope that this middle-class, stable family would get back on track. It was recommended that Samantha reside in a group home for three months, which could provide the rest of the family with some breathing space.

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[28] I'm paraphrasing Beth to the best of my recollection. This conversation took place in 1999 or earlier.

Beth began to date and use alcohol and drugs to gain some control and independence over the family situation.

Beth completed high school and went to college. Her drinking continued and she was treated for clinical depression. She was introduced to AA and began to look at her own substance use. Beth worked the 12 steps and did the things that other people told her to do to look after herself.

Beth moved away from home and married an alcoholic/drug addict in recovery who was in and out of 12-step groups. The marriage, full of emotional and sexual abuse ended three years later. Beth continued to find a place in AA and began working on sexual abuse issues with a counsellor.

Beth would have periods of sobriety lasting approximately three years and would go out, drink, and then renew her commitment to staying away from alcohol. Beth began to feel that AA was limiting her growth as most meeting topics are structured around alcohol/drinking/not drinking. *"...the stories were safe for people, that by telling a drunkalogue they could continue to experience the high of getting drunk without getting drunk...I did not want to give alcohol any more energy!"*[29]

The meetings and overall culture of AA was recreating the abuse in her life—*"I would be speaking...and some guy would be looking at my crotch and then ask for my phone number after the meeting."*

She decided to leave AA and a year later began to introduce alcohol back in to her life. Despite the warnings from AA members, Beth did not plunge into the depths of alcoholism. *"I used to think I failed AA; I now think that AA failed me. When I use alcohol now, it is with honesty and I use it in a manner that will not hurt myself or my relationships with others."*

Beth knows who she is today and has broken out of the helper-imposed identity of "alcoholic," "addict," "survivor," "depressed." Her story provides a glimpse of the process of going beyond the traditional system of care for the alcoholic. (Beth)

John

John is a Caucasian man in his late forties, recently separated from a woman with whom he shared a common-law relationship for over six years. John's children have grown and left home; he and his pet dog live in a trailer in a rural suburb of a northern community in British Columbia. John grew up in a small northern remote community in British Columbia; he identified his father, brother and others in his family as having

[29] Quotation marks and italics are Beth's.

severe alcohol problems. He had developed his own alcohol and drug problem by the time he was a youth, and his life deteriorated:

> I ended up drinking myself out of a number of jobs, of a marriage, ended up with absolutely nothing… by the end I would drink with my cronies, and after a couple of days we would keep drinking because we were scared to stop. Because we knew what was coming… you'd drink for ten days and then you'd really go into trouble. I started to have seizures [pause] from alcohol. I still have great, big marks across my chest here from ruptures, from seizing. Um, I was actually very lucky I didn't die. (John)

John's recovery took several attempts involving residential treatment but he eventually gained over 10 years of abstinence from alcohol and drugs while attending 12-step fellowships. He moved to a different community, continued his education, and changed careers, and began to offer support for others who suffered alcohol-related problems. John stopped going to meetings, and eventually began to experiment successfully with moderate drinking, due in part to a new relationship with a woman who drank socially.

Recently, after their separation, John began to re-evaluate his drinking, after he had crossed the line regarding his own limits:

> I'd have to describe my relationship with alcohol today as tenuous. I've been on my own now for six months… and it's gotten way too much; what I class as danger drinking—I'd sit at home and drink by myself. I don't go out, I don't socialize, so it's not about a social thing. I've had to re-evaluate some of my perceptions [pause] and come to make some decisions about that. Because some of the markers that I set up for myself, I've actually crossed one of them. Two things I classed as warning signs—one was drinking and driving, right? Which I've done a couple of times. To go and get more liquor or to go and get cigarettes. I don't drive around. But that's still a rationalization. The other one was cravings…. (John)

When I spoke with John recently to discuss the research, he had reclaimed a controlled, limited involvement with alcohol, resumed a hobby he had wanted to develop for years, and had made significant progress developing his social life, all on his own.

John demonstrated great insight, personal reflection, and thought-provoking perspectives during the interview, toward the deconstruction of traditional disease rhetoric and 12-step culture and especially about spirituality in his life:

> One of my spiritual experiences when my dad died gave me an idea. I made it over to see him before he went into a coma and we were talking and everything was fine. I went away for dinner and I come back and he was in a coma. So I prayed for him cause I knew he couldn't—and so I prayed over him. And it was like a voice began talking to me and what it said was "It does not matter what man has done. The fact that he's killed people in the war, the fact that he was violent against his wife, the fact that he's a chronic alcoholic and a violent man. Everybody goes to the same place." …It was an extremely spiritual marker for me because then I knew regardless of what I've done I go there too. We all do…. (John)

George

I was referred to George through a family member who offered to proofread my research proposal for ethics approval. George is a Caucasian man in his mid-thirties, living with his common-law spouse in a rural neighbourhood of a northern community in British Columbia. He and his partner have been foster parents for years, and are currently caring for children in their extended family.

George's interview was relatively brief, but his narrative was succinct and descriptive; the essential summary of his story about overcoming the influence of alcohol and drugs in his life. George grew up in a home where his mother and father had alcohol and drug problems. He touched on his own ordeal with his own substance abuse. Clean from alcohol and drugs for several years now, George's story is different from the others mentioned so far, in that he never chose to involve himself in 12-step fellowships or supports other than his immediate family.

George's humour and compassion was clearly evident when he was encouraged to attend AA by his first wife, against his personal preference:

> As a young kid I went to Ala-Teen, you know? I didn't like it. I didn't like the atmosphere of having to share skeletons out of my closet to total strangers even as a young teenager. I didn't enjoy it; it made me uncomfortable.
>
> So I was with my first wife. She asked me to go to a meeting; she said, "You have a problem, go to a meeting." I sat there and said, "This is boring." …I could not sit there and listen to these people step up to the podium one by one, and tell me that their lives are shittier than mine, you know what I mean? It's not helping me; all I'm doing is going, "Holy Christ do I ever feel sorry for that person, like I need a beer!" Like, "If I have to sit through another one of these things…" It was really weird because you're going, "I should take that person down for a cold one." (George)

George's narrative was very refreshing to me, devoid of the language, concepts, and influence from addiction rhetoric contained within the participant stories discussed so far. What remains is the essential context of what makes his life worthwhile today, a clarity I referred to as Zen-like, where his courage and effort are all the more evident.

Gina

The same person who invited me to speak with George also referred me to Gina. Gina is a First Nations woman in her late fifties who recently quit drinking on her own for medical reasons. Her home is located in a small community in central British Columbia, but she is currently staying with relatives while she recuperates from her surgery and regains her health. Her manner was irresistible, and her wry wit made the interview most enjoyable, and certainly the most humorous. Gina's career has spanned many years, with a background in nursing and a manager position from which she is currently on leave. Gina was aware of the consequences of alcohol addiction, but clearly indicated that she did not believe she suffered any risks of dependency. In my opinion, of

all of the participants, Gina was perhaps the most patient with the line of inquiry that gathered information about the consequences of alcohol consumption. Gina preferred the more positive narrative, and spoke about the good things she enjoyed about her drinking:

> Oh I had a helluva good time! And I never drank when I was unhappy, but there were very few times that I was unhappy. I was a happy drunk. I thought sociability is sociability, and alcohol is a part of it. And that's the way my friends thought, that's how we got along so well and drank so many years together.
>
> I always had friends. I would always get involved in different activities and I'd always found people who didn't drink were boring. I played darts, and I joined the Legion bowling league, bowl, and slow pitch. There was always a party after.
>
> I know there were times at work, when they used to watch me, because they knew I was a heavy drinker, and if I drank wine, well you could smell it on your breath the next morning… So I started playing a game with them, because one of my union brothers was ratting on me all the time. I had fun with this, though. I'd come in real happy, and the truckers would all be sitting around there; I'd be telling jokes and laughing. So they'd come and talk to me, and I'd go like this [puts a hand close to her mouth, and mumbles words], "Good morning [name]," keep my mouth covered, and look away. I'd keep looking up. And so next thing you know the boss is right there in the [work site], checking me. And he'd say, "So, what are you going to do today?" I said, "I came here to work." And he's sniffing away there [laughter]. I got to love playing games like that. (Gina)

Gina's outsider story also reflected her own essential motives for remaining sober in a manner very similar to George's story. Gina gracefully refused invitations for counselling or support groups, preferring to be with family. Her commitment to remain sober has seemingly strengthened in step with her health, but her experience recovering from coma and near death has given her great resolve:

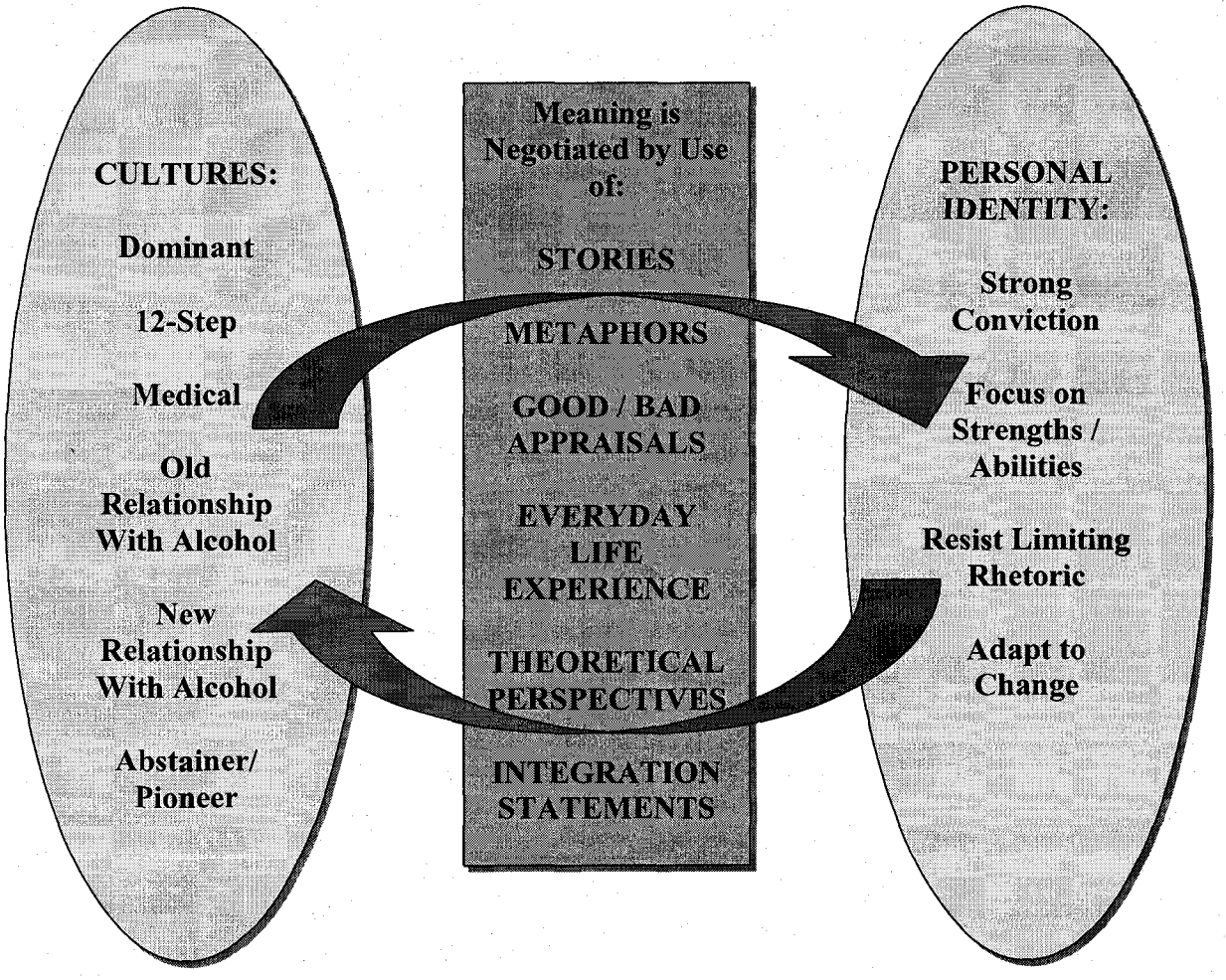
> I knew I had something to look forward to. I guess that's why I didn't die. But I was sort of critical there for a long time… Take each day as it comes. I can't see myself ever drinking again. It's gone, you know? It's just one of those things that happens in your life… I was talking to [name] looking after my car, and my trailer, and he says to me, "So good, you can help me stop when you come back." And I said, "No, you've got to help yourself, you say, 'I'm not going to drink anymore.' That's all you have to say. Don't taper off like we used to [laughter]. Don't quit for three days, and think that you're perfect. I think you've got to do it. It has to come from you. You have to want to." (Gina)

Social Construction, Identity, and Culture: A Sketchy Model

It is difficult to adequately describe the interplay between concepts such as social construction, identity, and culture, using a static model. Nevertheless, I have attempted to provide the reader with a map of the model I developed for the purpose of organizing information from participants' narratives in Figure 1:

Figure 1:

A Model of Social Construction, Identity and Culture



The model I developed is somewhat simplistic; however, my attempts to map all of the factors in more detail resulted in very complicated figures that were practically

impossible to understand. I began with the social construction concept, mapping the process of negotiating meaning through discourse. Within the social construction process, each interview had moments when the participant was her or his own narrator. Consequently, each story was grounded by descriptions of self, the "I," a dynamic focal point that I referred to as personal identity. The participants' conversations reflect their present sense of identity, situated in the present, in context to their story and their visions for the future. Their narratives include stories of their experience with different alcohol-related environments, which I have argued can be considered as cultures. Different rhetorical frameworks, described in chapter 2, also inform the discourse according to each model's view of people attempting to overcome alcohol problems. I chose to describe these different perspectives as cultures as well. For example, all participants spoke about living in modern society, which I refer to as the dominant culture (Fillingham, 1993; Rabinow, 1984), and about their "old relationship with alcohol," which involved other people, rituals, practices, and meaningful experiences. Whereas some participants speak of a new life without alcohol, others speak about entering the fellowship of Alcoholics Anonymous or other 12-step programs and later reclaiming their ability to drink responsibly. Each of these situations involves other people, specific rituals, practices, and meaningful experiences. Viewing these different milieus as cultures has been accepted practice (Alasuutari, 1996).

Participant narratives provided information that suggested some similar experiences. I have categorized experiences relating to personal development and self-concept, such as "strong conviction" and "personal identity." Other experiences that related to environment and lifestyle I depicted as "other cultures." Consequently,

personal experiences outside of the aforementioned cultures, such as the 12-step fellowship, could be recognized as contributing factors in the mediation of identity.

Although the participants' narratives resemble a generally linear storyline, each person's current identity has been cumulatively impacted by their experience within each of these cultures. Each of these cultures' perspectives relating to a person's current relationship with alcohol, whether abstinence or responsible use, is a mediating factor in the person's self-concept and their identity as they adapted to a new lifestyle. Consequently, there is an ongoing relationship between personal self-concept and different cultures, proportional to the person's experience, where meaning and consequent identity integration are constantly negotiated.

For the purpose of this model and the analysis, I considered the tools used in the mediation and expression of culture and concepts of personal identity. Common methods I noted included story, metaphor, good or bad appraisals, description of everyday life, theoretical view and development, and the integrating statements.

Stories

Each participant's narrative is a story in itself, and within each narrative are many stories that help to situate the person in his or her context, relating to the surrounding culture that he or she was immersed in. These stories are the allegories that inform the listener about the significance and the meaning attached by the teller. They are the building blocks of these people's messages—their most vital tool in communicating their experience. Consequently, participant stories have been constructed in a manner specific to this research, and would have been constructed differently in another situation.

Metaphors Reflecting Culture

The use of metaphor, a figure of speech where one word or phrase is used to imaginatively but not literally replace another, has been a significant and long-standing tool of qualitative research (Gubrium & Holstein, 1999). In recovery culture, one can expect to find a rich and seemingly endless number of metaphors (or codes and ways of decoding cultural insiders' constellations of meanings). Each one is essentially a story unto itself; perhaps it is an allegory with a moral or an in-your-face political message. These metaphors are the shorthand of the political rhetoric of recovery, which involves major transformations, such as the emergence of a new identity, or profound shifts in the perceptions and practices of everyday life. These metaphors can describe experience across cultures, such as Joe's:

> Like my AA buddy, who is hard-ass, hard-core AA, has no concept of his motives, although he's learning. I can't help but love the guy. But we have another connection. We met in school, when I was making a career change. We have a bond that is from being in another trench. From being in the school trench… (Joe)

Or the recovery metaphors can be cloistered within a culture, closed and cryptic, such as "A friend of Bill's,"[30] "I took the pledge," "disease," "cunning, baffling, and powerful…" "the word of recovery." Such metaphors mark insiders to each other, and exclude those who are outside of the culture of AA. Other metaphors can also provide a powerful indicator about how the teller views his relationship with the problem, the culture, or another relationship, such as, "I was firmly captured and imprisoned by the alcohol"(John).

Good / Bad Appraisals

Appraisals are a significant part of the process of moving from one culture to the next. They can provide a method of preparation for migration,[31] grounded in a number of practical models assessing change, such as motivational enhancement (Miller & Rollnick, 1991) and the transtheoretical model (Prochaska et al., 1994). Participant stories tend to indicate the level of commitment a person has in a culture by the preponderance of positive appraisals about the culture, relating to her or his identity. Judy spoke about AA, and stated:

> There's no doubt it helped me, there's no doubt about that. It gave me people to be with that were trying to stay sober too, which is what I needed and they supported me. And I think that's AA's absolute biggest asset: people caring. And it put me on some paths that I wouldn't have explored if I hadn't been there, like spirituality. (Judy)

Stories reflecting outsiders' ambivalence tend to include more of a balance of good and bad appraisals for different cultures. John gave a poignant example during a moment of reflection:

> It makes me think back to that old story about AA, "once an alcoholic, always an alcoholic," right? And I dismissed that, at one point. But I need to know under new evidence, re-evaluate... Because I certainly don't want to be going back to where I came from. But saying that, that little voice of alcohol pops up and says "maybe." (John)

Exit stories tend to reflect a shift of appraisals, with the bad ones describing the culture being left behind, and the more positive stories describing the culture they are moving to. These positive appraisals often incorporate powerful reflections of personal strengths and identity. Joe provides another excellent example:

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[30] In reference to Bill Wilson, one of the founders of Alcoholics Anonymous.

[31] The term *migration* is being used in a generally similar context to Smith & Winslade's (1997) "migration of identity" work, where leaving one place and moving to another, preferred place (lifestyle, quality of relationship, etc.) is visualized and therapeutically mapped.

> I stepped off into the world. I couldn't stand the hypocrisy. And you know what? At some point someone came along and said to me, "Well, you know, these [meetings] are great, but you get healthy here, and then you move on." And it was a seed that they planted in my head. It was just a thought, just an idea. It sat there, and suddenly I realized that I can't stay here forever. (Joe)

Participants who have settled into a new, possibly outsider identity over time may begin to use positive appraisals about former cultures, in proportion to the number of ideas from the culture they have been able to incorporate into their new identity. These appraisals are indicators reflecting the negotiation of meaning between cultures and personal identity. Judy reflected:

> And you know, to give AA their due I learned some good things there, too. Like ways to deal with fear, and just all the things life brings at you…the "one day at a time," that's good advice for anyone. (Judy)

Everyday Life Experience

Everyday life experience is the common ground between personal experience, social and cultural context, and theoretical perspectives (Alasuutari, 1992). These are the parts of a person's narrative that provide the witness with a window to life at that time, and provide an illustration of how different cultures and political views look and feel as normal, everyday experience (Healy-Ogden, 2001). John provided a poignant picture of living in a world of hopelessness:

> I tried suicide…because to me at the end I termed it being between the proverbial rock and a hard place. I took the gun out, I loaded it, I stuck it in my mouth…and I couldn't pull the Goddamn trigger. I was scared of living and I was scared of dying and I had nowhere to go… For me, even when I wasn't drinking, I could be out on a beautiful sunny day like this walking down the road and it would actually look grey. It was just dull. And that was my whole affect, right? I know, my first sponsor, he said he used to watch me walk by and I never looked up. I was watching my feet, walking down the road… (John)

I believe that the medical model, in comparison, tends to minimize the everyday life context, reducing phenomena to pathological criteria.

Theoretical Perspectives / Developments

As a person migrates from one culture to another, explanations become a natural part of integrating the process. It is noteworthy to consider the migrating person's explanations from the perspective of the different cultures she or he is negotiating. These explanations are the core of the social construction process. This is where political rhetoric crashes into personal reality and anecdotal truth. For example, George described his personal model of addiction as, "I believe it's a mental thing, not a physical thing, in that sense. I figure that if it's mental then you have control over that, as a person." George's theory is his practical explanation of his success in abstaining without help. If the reader reflects on his perspective in contrast with the messages of the AA fellowship, the implications of rhetoric on the person's identity and attributions of success become more apparent. Other statements that exemplify participants' outsider theoretical views include "The pain and anxiety of growing up in that household, that's why I drank," (Joe); "Alcohol, it isn't the substance that's the problem, it's the user" (Joe); "It's about a number of things. It's about running, it's about not facing reality. It's about fear. It's about pain" (Claire).

Integration Statements

Integration statements are affirmations regarding self-concept in relation to cultural influence. These are the statements that reflect upon what a person's story is

telling her or him about who she or he is as a person. Many stories end with integration statements, whether these stories are allegorical or about the living journey itself. Integration statements are often reflective potent descriptions, with a focus on what is and leaving behind what isn't. These statements can also reflect fundamental understandings about need, hope, and acceptance, and can be spiritual affirmations: "Let's say I *was* an alcoholic" (George); "I'm one of the strongest people I know" (Joe); "The choice I made I feel great with," and "I didn't make this decision thinking everybody was going to accept it. I didn't make it for them, I made it for me" (Claire).

I have identified and described these different processes of negotiating and expressing meaning as if they were mutually exclusive; obviously this is not the case. These processes are more than the sum of their parts, and they are interconnected; it would be unlikely to have integrating statements without inferring some theoretical view, good or bad appraisals locating self-concept in relation to political rhetoric, or without the use of metaphor. Wrapping the entire context of a person's identity and journey into the label "story" seems to trivialize the person's experience and meaning. A story is just one description of the complexity of one's experience. It is the profound nature of the experience that makes these stories so rich and provocative.

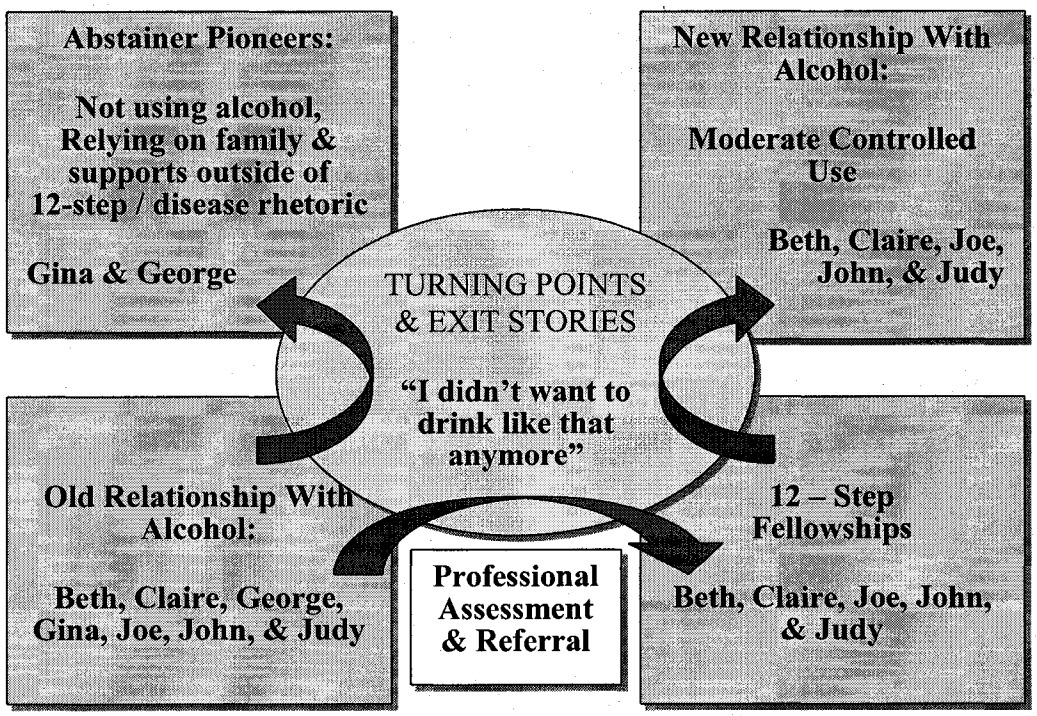
Culture

Each participant story of experience reflects more than one culture, and some reflect the influences of more cultures than are within the scope of this study, including cultures of race, career (for example, families of railroaders), or gender. The process of

describing the different cultures in the participant stories resembles a general map of the journeys the participants took, represented in Figure 2:

Figure 2:

Map of Participant Journeys Through Different Cultures and Identities



Consequently, the following description may imply an archetypal journey worthy of Ulysses' narration. However, "the map is not the territory." Although the description of the different cultures is offered sequentially as a general narrative roughly similar to these participants' experiences, this framework should not be considered as a grand story but rather as a reflection of each participant's identity development in relation to the impact of different cultures over time. Each participant took her or his own journey toward a better identity. Participants' stories all addressed one common context,

however: that of life as a drinker prior to their journey of change. I termed this context the "old relationship with alcohol."

"Old Relationship With Alcohol" Culture

This culture is about life in the old drinking days. This was often where the story began regarding the participants' narratives, the common ground for the source of theoretical explanation and the starting point where they used good and bad appraisals to compare different cultures. This is the culture that every participant has left. Consequently, the descriptions of this common culture bear the imprint of all other cultures and theoretical interpretations within the participant's experience, evident in the metaphors and other processes. Here is some of the best evidence that personal views of experience change over time, and of how history is rewritten. It is interesting to note that in spite of this culture's reputation of being "problem-saturated"[32] and attributed with every reason for beginning the journey of change, good appraisals live here too. There are many rituals of belonging and status in this culture.

Stories reflect family-of-origin issues and situating alcohol's first influences in the narrator's life (often through a parent); they reflect patterns and consequences of drinking and the good and bad times. Metaphors are very rich and loaded with the values of current perspectives, from "selling my soul" (Claire) to being "the life of the party" (Gina). Good and bad appraisals participants described include having status and fun, often with a terrible price. John describes what he thought in his youth was a payoff:

> When I was younger, especially with the drugs, I had status. When I think back on it I really played an image and a role in my little town 'cause everyone thought I

[32] A term coined in narrative practice describing the totalizing negative perception of a problem controlling a person's life (White & Epston, 1990).

> was dealing dope to little school kids and everything else. I wasn't, but they thought I was, so I had this image as a bad boy. (John)

Descriptions of everyday life experience were sometimes innocuous. Gina described how she liked to drink: "I always liked vodka. Not that I'd drink it straight...and I always measured it."

Other times descriptions provide a strange sensation of adapting; the experience of normalizing the abnormal. John described life with his drinking buddies: "After a couple of days we would keep drinking because we were scared to stop—we knew what was coming." Other stories about everyday life reflected a deep sadness and longing. George described some low points:

> Like I tried to commit suicide twice in my life, both times was alcohol-related, and once was in lock-up of the [community jail] cells, right? Now, that was at a young age, I was under 20 when it happened; under 20 and trying to commit suicide, you know? Being an alcoholic drunk, I should have known then, or somebody should have spotted that, don't you think? You know, the cops—they just [long pause] let me out the next morning like nothing happened. I betcha I wasn't even 18. I was [pause] probably abusive, [pause] both physically and verbally, doing things like driving around drunk with my father in the vehicle. Lots [pause] of little things. [pause] I can remember growing up with this guy from town here, and we'd get up after a big drunk and he would have a big fat lip or a black eye, "What the hell happened to you?" Don't remember... And it eats me up. I feel guilty about it.... (George)

Theoretical perspectives relating to the old relationship with alcohol reflect the more epistemological views regarding the cause of problem drinking. Joe believes the primary cause of his heavy drinking was that "I grew up in an oppressive environment, rife with sexual, physical, and alcohol abuse!"; whereas Judy theorized, "I think that definitely there is a chemistry difference between people with addictions and others."

Integration statements are relatively scarce for this part of participants' histories. I attribute this to the imprint of other cultures and to metaphors describing the experience

as one of being lost, of not having insight or direction. There were some exceptions: Gina, in classic wry form, declared, "I like to think of myself as a piss tank," and John simply vowed, "I refuse to go back to where I came from—it ain't gonna happen."

Turning Points and Separate Journeys

All of the participants arrived at a point in their narrative where they could not continue their old relationship with alcohol. Joe described his low point:

> I remember one episode where I was drinking with the lower end of the community. My status was gone. My [equipment] was gone and I was [pause] yeah, we were driving around town with a shotgun looking for dogs to shoot [long pause and a sigh]. So, it was from there that I realized that, Jesus, if I don't, if I don't get out, then I'm not going to. (Joe)

There are many names for this point, but even here, the essential experience of having to change is interpreted rhetorically by the recovery culture, as a place of "hitting bottom." In fact, this description might be inappropriate for at least one participant. However, it is here that the participants decided to take paths that led in very different directions. Gina and George each chose to end their relationship with alcohol without 12-step programs or addiction counselling. Their stories will be revisited shortly. The other five participants sought assistance in some manner. Most of them found professional assistance at some point. Professional therapeutic relationships in fact provide another rich culture, but are outside the scope of this study. I believe that to properly explore the participants' experience of therapeutic culture using a social constructionist frame would require conversations with each of the professionals involved. Logistics and time precluded taking that approach. The ensuing conversations would likely require venturing into areas that, while significant, would be outside of the scope of this study as defined by

my research question and bounded by the participants' experience. The participants' view of the therapeutic intervention is, however, significant, as it influenced their decision-making along the way, as well as their current interpretation of their experience. For example, Judy stated:

> I remember her name and I had a lot of respect for her, she was way cool. Personally, I think that when my psychiatrist, way back in [community] in the early eighties, sent me to AA, I was misdiagnosed. When I went to the psychiatrist it was the drinking that was focused on, rather than "What's going on with the rest of the picture?" That was just latched on, "How often do you drink? Oh, every day? Oh," sort of thing. I was short treatment, Jeff, [chuckle] it wasn't anything long-term. (Judy)

Joe's story of his experience seeking professional help wasn't easy for him to discuss:

> I didn't go to AA right away. I went to see an alcohol and drug counsellor and he suggested that I go to AA. He was a hard-line AA member and had been to the depth of hell and dug himself out and became a social worker and, you know. He was talking the virtues of the AA program.
>
> I wanted to find new ways of behaving today that didn't involve alcohol that'll help me solve emotional problems. And I remember distinctly coming into a session and [pause] it was a current issue I was trying to understand. I was trying to understand why I was feeling the way I was feeling [pause] I was upset and [pause] I can remember this big feeling of pain coming up in my chest and I was starting to express that. [pause] And his response to me was "Sounds to me like you're just looking for an excuse to go get drunk." And I, it stopped me. And it was like a two-by-four upside the head. I was, Wham!
>
> And here I am, I'm going "Wait a minute," I said, "That's the farthest thing from my mind." "You're in denial about this! All you are doing is trying to sabotage yourself and you are clearly trying to find an excuse to drink." I'd been sober at this point for about eight or nine months.
>
> Then he says, and I can't remember whether it was this session or another session, he says "Well what you need to do is get physically active." Uh, I'm 28 years old, in pretty damn good physical shape. I'm working in the bush. And the guy wants me to go and exercise at a gym where he exercises, and he's offering this in such a way that it sounds like it's a suggestion. And he wants me to, swimming, he says, swimming is really good.
>
> And then the warning bells and whistles started to come pretty loud in my head. What is this guy doing? My feelings at that time when he said, "I think you should start going to the pool, and working out" were, it was like I was being slimed. I left there feeling [pause] slimed, like, dirty.

> I remember walking around for a while a couple of days later, before my next session. And I was walking, it really bothered me. And I don't really know where this came from but somehow, I found the courage. I walked in, and [laughter] the poor reception people, because I came in with a purpose. And I came in, focused, and I wanted to see him, and I wanted to see him immediately, because I had made a decision. I walked into his office, I walked in that focused, and sat down, across from him… I said "This is not what I need."
>
> Who the hell knows what was going through his mind? Maybe he was legitimately trying to say, "Exercise is a good thing."… He was pivotal. Because from that point, like I say, I dug in and realized that Goddamn it I'm the one that knows the truth about me. (Joe)

Other participant narratives were not as specific about the nature of their counselling experience; two participants discussed referral through an organized, sequential, multi-service process involving detoxification units, residential treatment, and support-recovery homes, and spoke positively about these experiences.

12-Step Culture

I have already provided a number of examples illustrating how 12-step culture has had a significant impact on participants' experience, and continues to influence their ongoing negotiation of identity. For the participants who attended 12-step fellowships, their stories situate this culture as a necessary but temporary place of transition. Their appraisals of the fellowships reflect both the negative aspects of the program as well as positive attributes that they have taken with them and incorporated into their new identities. Judy provided a powerful description of the risks being a vulnerable young woman entering the meeting rooms of Alcoholics Anonymous:

> Going as a young woman in her twenties alone into AA, oh man I was a target for all kinds of things. I think that to put it in a nutshell is, here came this middle-class, pretty provincial kid, into an organization of people who'd committed murder, kiddy-diddlers, prostitutes, and [pause] you know I'm not a snob. Some of those people were really good, but some of those people were severely damaged too. So you're mixing people, a young impressionable woman like I

was, on her own, and putting her into such a mixed pot without any sort of guidance, or governance, or something. I don't know what the word I want is, but, coulda used some help there. I had no idea that some people could be so deep, dark, and dangerous.

My worst experience at the hands of another AA member was one I chose to date. He had a prison record and a violent temper. I made him mad one day, and he came after me with a knife. He didn't stab me, but I thought he was going to and I ended up on the floor and he stepped on my head with his boot. I had to get my ear stitched shut. That was pretty scary. And I didn't know people could be like that.

One other really bad thing happened too, that I thought was terrible, and does reflect the organization as a whole, and not one individual. At your AA meetings, as I recall, different people take a turn each week to chair. And one week at my home group, which had about 30 or 40 regular members, I was given the honour to chair the meeting. And there was a man there who was a long time AA-er; in and out, the poor man was just chronic. About 40 minutes into the meeting as I was responding to something that one of the speakers had shared, he stood up and said, "Just shut up you fucking cunt,"—pardon me, but that was what he said.

And absolutely no one in the meeting did anything to help me. No one, and I mean, I was a young woman. There were people there into their eighties, and nobody, nobody said a word—nobody did anything to help me. I really didn't know what to do. So at that point I had everyone up, join me in the serenity prayer and closed the meeting.

And later the man apologized to my boyfriend, the one that, you know, ended up laying the beating on me? I guess he was worried he'd beat him up. And no one ever, ever stepped forward, and said, "Hey, you know, buddy, don't be going there." Nothing. I expected some help. That was just a strange moment. (Judy)

Some of the other common concerns about 12-step programs, and AA in particular, revolved around the political processes involved in the life of the fellowship.

Joe said:

> The problem with me and staying sober is how it is today. Sure the roots may be in how it was but…today is today damn it, you know? And I was having some trouble. I'm sharing my story about, "Jesus it's a tough time right now." And [pause] it was like they were a pack of fuckin' dogs. This old guy that lived in the dumpster and suddenly sobered up and he's been sober for…he was counting the hours for crying out loud; he was in the 14 thousand hours or something. But you know, he was telling me that I wasn't really an alcoholic, because you know something—I didn't really get to the level that he did. (Joe)

Joe also stated: "I found out that I was forfeiting myself, my thoughts, to the dogma of the group and buying into the part of wanting to fit into the group." Joe's concerns are also reflected in Beth's experience of the pressure to conform:

> I hated that everything seemed to come back to the alcohol and that if I didn't call my sponsor, work the program, go to x amount of meetings I would be beaten down by alcohol and go to all the places that the other members had gone when they would be drinking. It put a lot of fear into me—kind of like forcing yourself to go to church when you don't want to, because you'll go to hell if you don't participate in this ritual. (I call this fire insurance—not a love for God.) How real is that?
>
> Both the church and AA encourage you to spend time with other members and that outside people could be dangerous. I know that this was not always the case, but these attitudes are prevalent in those circles—it's not uncommon to run into these beliefs. My heart and head would wrestle with each other—I didn't know what was real fear and what was programming. One has to be extremely discerning and have clear boundaries to know what they believe in and how to be safe in AA. These skills were very muddy when I started AA. And I did not necessarily learn them in AA! (Beth)

Joe's and Beth's reflections summarize the feelings of several other participants who experienced considerable pressure to conform to the AA fellowship's perspective. However, while there is pressure in the fellowship for conformity, participants spoke about how the program doesn't address significant dilemmas for many members. Claire and John both offered insight into the frustration of tolerating forms of hypocrisy:

> You hear of a dry drunk. I mean people sober up for years and still gamble all their money away or screw around on their husbands or wives and beat their children. That's, to me, still the addiction or the problem, right? The substance was the part of it and then there's all the stuff behind it. But they have their clean time. (Claire)

Claire's comments reflect a complaint I have heard repeatedly during the last 20 years of my career, where injustices ranging from hypocrisy to criminal behaviour are rationalized in 12-step programs through what I believe is the abuse of the fellowship's philosophies and policies.

There was unanimous support for the fellowships among the participants as an invaluable resource for breaking the cycle of active alcohol abuse, and positive reflections about how they incorporated the experience to create a stronger identity:

> I don't have a problem with the 12 steps per se. I know they helped me change my life…I sincerely went there giving as much of my heart as I could. Hey, did I get burned? Yeah. Is my heart broken? In some respects. Am I a better person for it? Oh, you're right. Absolutely. I am a better person for it. I do understand what it means to be grateful. Where did I learn that? I learned that there. So [wiping tears], necessary evil. Gain as you lose. (Joe)

Similarly, Judy said:

> I gave it my all, I was just a real AA member. I did a lot of service work…one of my favourite service jobs with AA was going out in schools and talking and telling my story… There was some amazing comments from those little kids. But the scary ones were the kids that went, "My dad drinks like that."…I do a lot of volunteer work today, because that's one of the good things I learned from AA, is to get out there and help people. (Judy)

Joe's and Judy's descriptions reflect participants' desire to balance their critique of the fellowship and to give credit for the positive influence the program provided.

Each of the participants who attended 12-step programs and who now live an outsider experience credited the fellowships for introducing them to spiritual concepts, experiences, and growth:

> In AA they say to find a higher power whatever it may be. So I went out, and I could have a degree in comparative religion! I went to every different denomination of church in [community]. It took me a few years, and I went to some a few times. I really liked the Salvation Army, 'cause they had a band! (Judy)

John said:

> So I walked into the [meeting]; initially there was just the two of us for about a week and a half. Then one other guy, and then we had our first woman come. So that was our core group. Four of us. Uh, it stayed kind of small for a number of months. But a few months after I started going the one guy who'd been there, he said, "I want to show something," and he brought out this kind of a journal he had. He sat there for week on week by himself and so he would write. "I want you

> to look at the date and read what I wrote that day," and he had wrote a prayer asking for somebody to be sent. And that's the day I showed up. So weird spiritual stuff happened through that journey. Lots, I could write a book on some of the stuff that happened. That [pause] really makes me think about spirituality and bigger concept cause I'd never had that in my life before. So he gave me that, and that's something probably lost track of me for the last seven years, which is kind of a regret, I think. (John)

Judy's and John's comments provide an example of the broad range of personal spiritual experience for those who are working their program. Joe elaborated on his fifth-step experience, and explained that he believes this step is the most powerful turning point for many in the program. Joe had a profound sense that he didn't belong to the human family since his earliest memories. Consequently, being accepted and guided through the personal justifications of feeling like a "freak" helped free him:

> We get to step five[33] and I am shit scared because I've got, I've got a lot of baggage. I chose this guy in the group to share my story with, and he said "yeah"... I share my story, and [pause] this is what is so serendipitous—this is like a movie, but it actually happened. As I finished sharing my story, he said to me, he said, "Huh—so what's the problem with that?" Like, I am so full of guilt, for all the things that I have done in my life, the drinking and the other acting out behaviours [pause] I was just, I was so full of guilt and he looked at me and he says, "Yeah, so?" It was that day that I, I became part of the human race. I wasn't an outsider anymore. I wasn't this fucking freak that didn't belong on the planet. [pause] "You know," and quite sincerely he goes, "I still love ya." The sun broke, the storm blew over, and I left that place feeling free. (Joe)

Joe's story reflects the level of investment many make in 12-step programs, and the significance of forgiveness and acceptance for those dealing with shame associated with their addiction.

All of the participants who had attended 12-step programs tended to believe that the disease model of alcoholism was an overly simplistic explanation for their drinking.

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[33] "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs" (AA, 1976, p. 59).

Beth wrote a succinct description that was reflective of the types of opinions expressed by the participants:

> To say that alcoholism is disease is to miss the details of the picture. I think alcohol can manifest itself as a disease, but there is more to it—environment, culture, intent, personal reasons, spiritual reasons, other issues (i.e., core addictions, trauma). It would be a simplistic view to label alcoholism as a medical condition that responds to one kind of treatment. (Beth)

Beth's and other participants' reflection on the disease concept supports the polyvocality associated with multiple journeys with many uncharted territories.

As one might expect, these participants' integrating statements generally describe the 12-step culture as a necessary stop on their journey. Beth wrote, "I think AA is a good start, but can be limiting, even harmful, for some people later on. I used to think I failed AA; I now think AA failed me." Joe said, "Paramount in my emotional development as a human being that I went through that experience. Absolutely paramount. Glad I did it. Was it worth the pain? Hell yes! But I've grown." Claire stated, "According to them I'm relapsing. And I can respect that. I don't believe it, but...[12-step programs] gave me a life. *Totally*. I'm eternally grateful for the 12-step programs. I support them [pause], just not for me, today!" Judy said:

> It gave me a sense of community, a little bit when I was floundering, having lost my family, mostly geographically at that point...and [today] our house is totally a house of music and love. That's it in a nutshell; my life in AA was so restricted. It had to be certain people and certain activities [associated with members of AA]. (Judy)

John stated:

> It helped me, there's no doubt about that. It gave me people to be with that were trying to stay sober too, which is what I needed, and they supported me. I think that's AA's biggest asset—people caring. But I won't go back; I can see too clearly the shortcomings of it. (John)

These participant descriptions are reflections of a culture that was a part of their lives many years ago. While the stories provide positive appraisals of the program, there is a trenchant sense of unfulfillment within these participants' experiences, which began while they were fellowship members. Consequently, the motivation for change contributed to the next phase of each participant's journey.

Turning Points and Exit Stories

Participant descriptions of leaving AA varied considerably and are potent examples of how behaviours are interpreted from different cultural perspectives. Exit stories often began with negative appraisals of the fellowship:

> I slowly began to have an awakening that the unhealthy people were controlling the group. I just didn't want to be a part of that anymore. Sort of like, it's almost ironic in some ways, it's kinda like I didn't want to drink like that anymore, so I made some changes. But I didn't want to be in a community that really professed to be a helping community, and yet how can you learn to love? I'm a classic example of, "How the fuck do you learn to love yourself from somebody who doesn't love themselves?
>
> I opened my heart and I let people in, and there was some very manipulative people that gave the guise of being friendly, and open, and then really what it came down to, they just wanted me to be [pause] the dog—that they were just going to boss around and live vicariously through me and the choices that I'm going to make. And it was a part of those old-timers that had some sobriety, that were really trying to give back to their community. I'm sure that they thought in their minds it was fine. But the emotional upset and trauma that was caused in my life from some of those people [pause] was the motivator for me to take that risk and to move forward. And to let the group go. (Joe)

John described his own growing disillusionment:

> I started to become disenchanted. There were parts of it I still believed in and I think had good purpose. But I was already past that so when I moved away from it, it was with no regrets and I didn't miss it and I didn't have a lot of fear [pause] because I knew in here myself, where I was in regards to drinking and drugging at the time and I think that's far more important than being at a meeting. You've got to know within yourself what it is you want. (John)

For others, the exit story is not so much the idea of leaving a culture behind, but the experience of living within two or more distinctly different cultures, and the sense of movement from one toward another. Claire provided an example:

> So I think I started to learn more things. I started to question things. I started to get more self-esteem, right? The longer I stayed sober, started to get an education, started to feel good about myself, I was able to question some of the theories I heard in 12-step programs. (Claire)

Claire's narrative provided considerable insight into the deliberation involved in overcoming the ambivalence and moving from one culture to another:

> Whereas before, I needed to belong, I needed to feel accepted and I got to a point where [pause] because it was a big risk, right? I was going to absolutely turn away from everybody in the [program] which was my whole world. Like it literally was my world…I had to get to a point where I was okay with me no matter what…it was a big thing. (Claire)

Claire's narrative describes the personal stress experienced by people who live in different cultures of personal growth, each encouraging the integration of different knowledges and rhetoric. While it is arguable that all 12-step program members live in the dominant culture of society, I would argue that it is relatively easy for the privileged to avoid spiritual and ethical self-examination in modern society. Those who attempt to adapt principles to fit different personal needs may find little support under the gaze of 12-step fellowships' rigid rhetoric. Consequently, those who do choose to experiment with ideas or concepts considered impossible by AA will be interpreted by the fellowship as being either "insane" or an outsider.

"New Relationship With Alcohol" Culture

The concept of reclaiming a controlled relationship with alcohol is possibly more controversial than the culture of 12-step programs, as described in the foregoing discussion. The experience of successful, moderate, and controlled drinking after a career of alcohol dependency, as viewed from the perspective of the 12-step fellowship and the disease model, is a preliminary active phase of relapse where the alcoholic briefly maintains the semblance of control over his or her drinking. This rhetorical perspective assumes that this experience of controlled use will be short-lived, and will progress to a loss of control over alcohol with consequences indicating a rapid deterioration of capacity in all areas of the person's life, ending in a crisis worse than anything the person has previously experienced. In other words, an alcoholic who drinks is failing. This is in fact the experience of many people with a personal addiction history who attempt the experiment of controlled drinking.

For those invested in the context of the 12-step / disease model, the concept of controlled use is very dangerous. The idea can create false hope for newcomers, or any other non-vigilant member in the program, which can lead to relapse and potential disaster. Acknowledgement of people's successful experience is rhetorically untenable; it would undermine the epistemological assumptions that serve as the foundation on which the fellowship is built.

From the other side of the dilemma, those who develop the capacity to manage their drinking after a history of dependency may find the experience isolating. The disease model and 12-step rhetoric is deeply entrenched the belief systems of North American society. Consequently, former self-proclaimed alcoholics who now manage

their alcohol use may respond to the internalized gaze of the dominant cultural view on addiction and censor themselves to avoid anticipated judgements. For example, referring to the introduction of this thesis, outsiders may feel like there is an Andy Sipowicz on every channel or in every magazine wanting to judge them. So they may live a double life, not telling current friends about their past life experiences as "an alcoholic," and not revealing to 12-step member acquaintances their changed beliefs and practices regarding alcohol.

Fortunately, their vigilance and discretion is compensated by a number of benefits that render the outsider experiment a worthwhile venture for these persons. The experience provides vindication for a life in 12-step culture that required a self-concept of weakness, disease, and powerlessness. The process of renegotiating their alcoholic identity and use of alcohol provide challenging proving grounds where friendships, trust, appraisals of self-efficacy, self-concept, and even faith are put to the test.

All five of the participants who have a new manageable relationship with alcohol have years of experience in 12-step groups. Their narratives are similar to the migration of identity concept (Smith & Winslade, 1997), a conceptual framework that uses the metaphor of a journey from the culture of practices an individual wishes to leave toward a culture of practices he / she wishes to embrace. The journey or transition takes time; indeed, for each of the participants in this culture, at least a year or more passed from the point of first contemplating having a drink to finally having the first drink.

Participants typically discussed and interpreted the old relationship with alcohol through the lenses of existing frameworks, whereas their new relationship with alcohol reflects their current context and is a conceptual framework under construction. They are

in transition from one known and rhetorically confining culture to a new set of rules, practices, possibilities, and discourses. Consequently, participants tend to incorporate effective ideas and strategies from other cultures they have experienced into their conceptualization of this culture, which has become an integral part of their identity. Themes involve exit stories and stories of the first drink, the process of coming to the decision to take the first drink, and how success has created the need to reflect, reconsider, and possibly reinterpret the historical facts for each person's journey. This reappraisal could be considered a process of rewriting history.

Exit stories usually involve experiences that initially indicate a subtle but strong personal impression that, in spite of the benefits of involvement with 12-step fellowships, the person felt that he or she was not being true to himself or herself. Good / bad appraisals and the process of resolving ambivalence are key identity pegs in the process of leaving, toward developing a life better reflecting one's needs and preferences. Joe described a moment of casual reflection with a person he trusted that suddenly struck a disquieting chord:

> The naturopath, we started discussing spirituality, and I told him that at the time I was attending regular AA meetings. [pause] And, the conversation, I can't quote exactly, but to put it in a nutshell, I said to him, "Well, I'm an alcoholic." And his response to that was, "Well, you're only an alcoholic because you think you're an alcoholic." And, he kind of shocked me. [pause] And this guy, he's a very spiritual guy. And he suggested to me that as long as I kept telling myself that I am an alcoholic, then I would remain stuck there. And my response to that was, "Well, that might be the case but, don't take that away from me now." He planted a seed. (Joe)

Joe went on to describe other developments of dissonance between his needs and those of the fellowship:

> Part of the problem is that I'd grown and as the new people came in, they really need a resonance. I needed, when I went to my first AA meeting, I needed some

> resonance. I needed someone to say "Hey I know exactly what you're going through." I didn't get that. I got two people come up to me; one of them shook my hand and said, "It works when you work it." A woman come up to me, give me a hug and say, said, "Keep coming back." And [pause] I didn't get any resonance, that I was belonging in the community.
>
> And what I found in the 12-step group is that, and I hate to say this, is that the healthier that I got, and I did get healthier, emotionally, the less, not that I had less to offer, but I couldn't offer that resonance. And I realized that. And part of me said, "You know, it's time to step out and do this on your own." Stepping back out of this, this shell of community that I had around me, and step into the real world. (Joe)

Claire's story offered insight into the contribution of factors including an education, improved self-esteem, and the ambivalence and deliberation that can be a part of the outsider journey:

> I went into this [decision process] okay? I knew it was because for me I call it being programmed, because I believe that either I was going to be able to be this social drinker or I was about to make the biggest mistake of my life! So before I did that, I guess the biggest thing for me that would shift my beliefs was that I knew nothing else. I was 19 years old, actually 18 when I first tried to clean up. Like when I first went to a detox and treatment, and when I was first introduced...I just believed everything I was told as the word of God basically, the word of recovery.
>
> And then I started going to school and work toward my degree. And I started reading and learning different theoretical perspectives about addiction. The longer I stayed clean, started to get an education, started to feel good about myself, I was able to question some of the theories I heard about 12-step programs. Whereas before I needed to belong, I needed to feel accepted...
>
> Because it was a risk. I was going to absolutely turn away from everybody. Like it literally was my world. I had to get to a point where I was okay with me no matter what... I talked to my doctor. I spoke to my support group... So before I actually made the decision I researched it. Got people's opinions, so it wasn't like I just decided to have a drink one day. I thought about it for a couple of years before, actually.
>
> So it was a process for me. It wasn't like [pause] I just thought I could be a social drinker, because I believe a lot of people couldn't be and I know I was taking a risk. I have a son, I had a lot to risk. I cleaned up, I had nothing and I've worked hard for what I have today. I didn't really want to lose it, but at the same time I really felt like I wasn't really being me. (Claire)

Claire received more than feedback from her consultants, but insight as well:

> I spoke to my boss…she knew a little bit about my history and understands 12-step programs and has been in the field for a long time. She said to me these words that I will never forget. She didn't believe that drinking would hurt me. She believed that I had learned enough, and had enough tools, and had enough self-esteem in life to be able to drink. But what she was afraid might kill me was the shame that might occur, because when you live one way, clean time, it's a big deal, it's a huge deal. That was her concern and those words made me want to try it. It made me really realize that a lot of the stuff I believed was very shame-based, and that I really had nothing to be ashamed of if I was wrong. So what? I know how to get clean. I did it, I stayed clean for 13 years—I could do it again. (Claire)

Claire also pointed out the significant factor of being a role model in 12-step programs when experimenting toward a new relationship with alcohol:

> I sponsored a lot of ladies. What are they going to think? …there is a lot of people watching.
>
> I got from my sponsor, "Absolutely not, you're insane, you're in relapse, I'll be there for you though when you decide to clean up again." I lost a few friends, who to this day [pause] a woman who I'd been hanging out with for 10 years, been totally intimate with, gone way out of my way in my life to help her, and vice-versa, she has shut the door on me. And I understand that it's a scary thing for people to realize. I mean, your belief in those programs is that you're relapsing, and relapse ends to "jails, institutions, and death." And so if you have that belief then that's where I'm going. Everybody has their own coping mechanisms. For some people it was to have me leave their life.
>
> So, then I had a few people who said, "No matter what happens we're going to support you. No matter what! And yes we will be honest." …People had to watch me, and they have been watching me. I mean it's scary when you love someone and you're not entirely sure what's going to happen to them. (Claire)

Claire expands on the reaction of her family: "My father thought I was insane. I still smoke cigarettes and he says, "Are you absolutely crazy? You can't even go without cigarettes; there is no way you'll ever be able to use socially." However, Claire is also proud of the story of her first drink with her father:

> Right, like my parents went through hell with my addiction, so it wasn't all, "Okay Claire, we think you can do it." It wasn't that easy. You know, I had my first drink with my father at my sister's wedding, which would have been eight months ago. It was a weird experience. Remember, I was young when I cleaned up so I didn't drink with my father. We weren't allowed to do that, plus I left home very young [pause] I don't know. What my dad said was, "Do you realize

> this is the first time we've ever had a drink together?" And I said, "Yes, Dad," and he said, "Cheers". ...There was a part of him that liked it, but he was scared, eh? I mean my dad looked for me on the streets and did a lot of things to try and save his youngest daughter so he knew more about my life than my mother ever did. (Claire)

First-drink stories are a regular theme in the story about a new relationship with alcohol. These stories can have a wide variety of meanings, but whether planned or by chance, the event is another turning point signifying how far the participant already has travelled on her or his journey from 12-step philosophy toward a new outsider life. Joe said:

> The decision to drink really was a slow process that took a couple of years. I became friends with people who are responsible social drinkers. Since I grew up with out-of-control drinkers that always drank to excess, that's what I thought drinking was [pause] always to excess. By excess I mean getting really pissed. I found that the further I got away from the dogma of AA, the less fun I was having. By that I mean the social structure of the program filled a void. Without the social aspect, I was starting to feel lonely and I witnessed people that drank, had fun, and didn't get loony. I had my first sip while on holidays with friends and family. Nothing devastating happened, I didn't die. There was no relapse for me. I wasn't looking for my last drunk, I wasn't looking for acceptance from the crowd. I had my first drink after almost 12 years simply because I wanted to. I like drinking, I like the flavour, I like the social aspect, I like how I feel. The funny thing is that I didn't know how to drink socially before. (Joe)

Judy revelled in her first-drink story:

> It was just pure chance. I was with a girlfriend in [community]. We went to a really nice restaurant, I know the owner. It was a luncheon. He came over, and I had moved to [different community], so he hadn't seen me for a while. He came over to say, "Welcome, I haven't seen you for a long time," and brought over a bottle of wine. And I just thought, "Why not?" Why not; I'm over my year now and some months of deliberation and, why ever not? And I had a couple of glasses of wine, and was, absolutely, just whee! [laughter] No, I didn't do anything stupid... I remember how hard it swacked me. Clean as a whistle, you know? Absolutely, it does hit you hard. So, for those who are going back, [chuckle] go slow! (Judy)

These brief examples offer a glimpse into these participants' stories of developing a new, moderate relationship with alcohol. Both good and bad appraisals are apparent.

The metaphors that participants used to describe this culture were about transition and growth, such as taking a risk, or changing paths. This new culture is not uniform, but reflects polyvocality. The participants have incorporated different cultures into their conceptual framework to make sense of their experience. Finally, due to the status of this culture as being currently under construction, or negotiated as the participants live it, their integration statements reflect a sense either of arrival or of the continuing journey:

> Yeah, Jeff, I play a lot of music today. I play mandolin and duolin, and I'm taking lessons, and my husband is a musician...and yeah, our house is totally a house of music and love. And that's just it in a nutshell; that's kind of like a metaphor. For my life in AA was so restricted. It had to be certain people and certain activities...and I gave it my all, I was a real AA member.
>
> I can't tell you why my creativity was stifled other than I think that I felt I was really having to follow a lot of rules and toe the line. I don't go to night-clubs. Hardly ever. I'm not a night-club person. I go only ever to see a live acoustical band that I want to see... And so yeah, I felt like I wasn't free. I want to be free to explore everything...all roads lead to the top of the mountain. (Judy)

John said:

> I think it [AA] saved my life...there's good stuff in it for sure, but it hammers on people. But the 12 steps are a good guide. They're a good life guide. There's nothing wrong with them. I don't think it hurts for people to have to examine their lives. Most people don't. And I think of all the things that have happened to me, getting caught in active addiction forces people to stop and examine their lives and that can only be good. I don't know if it was Oscar Wilde or who said that "the unexamined life isn't worth living," and I think that's true and that's an edge that people who have addiction problems have, because they have to stop and think about them, where the rest of the world doesn't and they just go on living their lives and if they're miserable, they're miserable, right? It's a funny thing to say in some ways that I'm glad I have it, because I've had to stop and really look at who I am and examine myself, good and bad. Who I am; I don't know if my view has changed or whether I've come to a better understanding that I am okay, where I'm not so sure I was sure of that years ago, because of insecurities and fears and stuff and not even acknowledging they were there.
>
> Well, how can you move forward when you don't know how you operate in the world? How can you make a real decision when you don't even know what you're basing your decision on? (John)

Joe suggested that movement on his journey continues, and involves wilfully taking risks on the road:

> One thing that this interview process has brought up for me…I realized, by telling my whole story, I realized how much I have [pause] put on hold. That honestly I haven't been growing. I, I have been standing on one side of the road looking at Tim Horton's, waiting for somebody to bring me a cup of coffee and a doughnut.
>
> And fuck it, I think it's time I crossed the road. But that's huge changes… I think that the whole process has been learning to trust myself. [pause] Trust, love, it all becomes the same. To trust what is in my heart is connected to my head, and then for me that is the truth. And yeah, I had to go to AA to find this out. Is it an important step on my journey? Absolutely… But I believe God gave me free will to choose. And that's what I did, I exercised that choice. (Joe)

Joe's and John's narratives reflect similarities that are present to some degree in the stories of all five participants who learned to manage their alcohol use after years in AA. Gratitude is present for the contributions AA provided, including the chance to break a cycle that needed to be broken, and a social and spiritual foundation to stabilize potentially chaotic lifestyles. However, the strain depicted in these narratives seems palpable; it represents the effort to cope with "the way it works" (AA, 1976, pp. 58–71) when the program didn't harmonize with each person's burgeoning self-awareness and needs beyond what the fellowship was able to provide. In respect to the serenity prayer which is often used at AA meetings, these participants found the courage to accept what they could not change (12-step dogma), and the courage to change what they could, including their journeys of growth, which included manageable use of alcohol. They continue to develop their insight and wisdom to know the difference between "can't" or deficit perspectives, and "can"—that is, their own appreciation of possibility, creativity, love, strength, and capacity.

Abstainer Culture

Whereas five of the participants chose to seek support in coming to terms with their alcohol problems through various resources, such as therapy and/or 12-step fellowships, two of the participants decided to look closer to home to address their issues with alcohol. Gina and George each chose to quit drinking independently, without the traditional professional or support groups, and without using the pathological rhetoric often embraced by those resources. Consequently, their stories reflect different cultures than those experienced by the five participants I have profiled above. Their stories are free from many of the rhetorical metaphors described previously, and reflect the values and views of the dominant culture in British Columbia. Predictably, metaphors and theoretical developments within their stories seem less "exotic."[34] The stories nevertheless are as profound, and seem to possess a Zen-like, transparent quality. They are pragmatic, in-the-moment descriptions of daily life from a perspective acknowledging the importance of family, love, health, and hope. In comparison to the rhetorically grounded descriptions and metaphors used by those who invested in a 12-step culture for years, Gina's and George's stories reflect straightforward values of responsibility and self-reliance, not to mention a wonderful willingness to use humour as a source of strength. George's story provides an example:

> It just had to be my choice. We got the kids and they came from drug- and alcohol-abused families and everything else…they are my nieces and nephews. I was still drinking when we got the kids and one night [my partner] and I got into a *huge* fight, alcohol involved; the kids were witnesses—it was just a terrible scene and I quit drinking the next day. It was something the kids don't need to see.

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[34] I have used this term in reference to the phrase "exoticizing the domestic." It describes the narrative practice of deconstructing taken-for-granted internalized practices that serve the dominant story (White, 1993).

> They've gone through enough in their life. [My partner] and I talked about it. You know, we got to sort of be a family here and it's not going to happen if I'm drunk.
>
> So, that very next day after this happened was a choice that I made, but it was a family thing. I told each of the kids, "This is it, last day. I will not drink again. You will not have to witness this part of me again. So I have kept to that one.
>
> ...I don't miss it in the sense that I crave it or feel that I have to have it, but it's there all the time. ...You know it's been [pause] it's been a while and [pause] it's difficult. Some days it's really hard and others it's just a thought. ...But I got that [support] from [my partner] and we don't even have to communicate it. All I have to do is look at her. I see [family member] and [family member] every day, right? Niece and nephew, and I also got a cousin and his wife. (George)

George and Gina were invited to attend support resources, but each refused. George's story about tolerating a meeting to humour his former partner is described earlier in this work. Gina recalled her own decision to go her own way:

> Well I think it was a physical thing for me... Not that I'm shying away from the alcoholism itself. It's just I know that's what contributed to what I've got in my [body] right now. And I wish it would go away [chuckle]. I think it's with the too much alcohol, my age, I don't have an immunity system like a younger person would have.
>
> I was reading this pamphlet when I was going to the hospital for my dressings, and it said, "If you think you've got a drinking problem, come and see us. And maybe we can help you." I was *entertaining* the idea, but I never got around to it! [laughter]
>
> ...I always liked talking to the minister; he was a real good talker. And he visited me in the hospital, even when I was admitted to [name of hospital] in [another community], he'd visit when he came to town to visit friends. He said that if I ever needed help, "Call me. I'll come down there anytime you want, and we'll help you." He said there were all kinds of groups that'll help you; it doesn't have to be Alcoholics Anonymous. I said, "I quit," and he said, "I'm so proud of you." I promised myself that I was going to quit, so I quit. I said, "But I've pretty well made up my mind that I won't fail. If I fail, I'll remember what you said. That you helped me." Yeah, and I wouldn't be ashamed to call. Sure it would be admitting my weakness, but you've got to deal with it. Face it. (Gina)

Their metaphors have a Zen quality as well, reflecting the beliefs that every moment is a choice, that one should take each day as it comes, and that one should seek family support and a better life. Some of the strategies and theoretical developments

discussed by George and Gina reflect concepts and even language similar to those found in AA programs. Ideas such as "one day at a time," the term "alcoholic," and other concepts derived from recovery culture appear in George's and Gina's narratives. Perhaps these ideas have become a part of mainstream culture. This is similar to another phenomenon whereby people who have never been involved with the feminist movement have assimilated feminist ideas—or ideas which would have been immediately labelled as feminist 20 years ago.

George's appraisals offer an example of the sense of responsibility found in his narrative. When discussing his worst experiences when he decided to make changes, his response was based on his values, rather than on the behaviour of others: "To me rock bottom is [pause] where you think that your life is not going forward anymore." George tended to save the positive appraisals for descriptions of his current everyday life relationships. His ethic of responsibility is ever-present: "I don't have the kids worrying if there's going to be a huge fight tonight, they have a safe place; I've got a wife that knows I'm going to be to be home every night."

George's personal theory regarding his success reflects values of personal ability, responsibility, and action: "I believe that it is a mental thing...you have control over that." Gina also maintains a sense of personal responsibility, but her outsider story of change reflects a powerful spiritual influence:

> I knew I had something to look forward to...I guess that's why I didn't die. Because I was sort of critical there for a long time. But the strange thing was, I had this dream where these Indians—I was in this room, in my hospital bed. And there was a couple of cots there, and these Indians were sleeping there...I didn't know what was going on. The nurse was talking to me, and I was trying to look at these people and, "What are all these Indian people doing in my room?" [chuckle] And he was there and he had on blue jeans, and denim embroidered shirt, black braids; and she had sort of brownish hair, and she was real short. And they looked

> familiar, but I didn't know them. So [Gina's daughter] thought maybe it was [name of a Cree Healer friend], but [name] was up here praying for me.
>
> But you see I had a brother that died in the flu epidemic in the twenties, and two sisters, and I used to help my mother go and clean their graves. So these Saskatoons used to grow on the graves. Mother's saying the bead ceremony, you know, [laughter] the Rosary, and I'd be eating the berries…so [name] said that maybe that's who was in your dream. Your brother and your sister, because you ate some of their spirit! [laughter]) But it's strange how some of those things shock you back to reality, because I was in and out of a coma… So [niece] came to see me then, and she says, "Oh, you're not going to die. Your ancestors in [community] said get word to [name]," that's what they called me back home, "She's a healer." (Gina)

I found that George's and Gina's integration statements each tended to reflect the same transparency, grounded in personal experience rather than in rhetoric: "The choice I made I feel great with" (George); "I can't see myself ever drinking again. It's gone. It's just one of those things that happens in your life" (Gina). "Personally I've never relied on other people" (George). Even here, Gina's dry humour was ever-present: "There's lot's of people like me. Except that I had to quit. Spoil a perfectly good record by having to quit."

Identity

In the model I have used to account for the participants' experiences, the fundamental goal of their journey and the motive behind their negotiations between past and present cultures is the transformation of identity. How the person sees herself or himself has profoundly affected each phase in these participants' relationship with alcohol. Consequently, this experience is of the most personal nature, especially for these participants who chose the path least travelled. Any summary of their personal identity and any subsequent assumptions perceiving these persons' self-concept as that of a homogenous group (similar to the rhetorical view of alcoholics within the culture of

Alcoholics Anonymous) would be a mistake of such magnitude as to ignore the central premise of this research. Each of these participants came to a realization that it was worth the effort to change—either to abstain, or to seek help and migrate through therapeutic and fellowship cultures of support. At the same moment as you read this, these people are negotiating their relationship with alcohol and everything else they value through their experience of everyday life, appraising, contemplating, questioning, and integrating their conclusions, weighing their experience with their self-concept. Even though each of the seven participants described their praxis of growth within their experience quite differently, some shared themes emerged from several of the participants' stories.

Strong Conviction / Belief in Self; Personal Faith

All of the participants described throughout their narratives strong conviction, a belief in themselves, and a sense of personal faith. They each demonstrated self-examination and took personal responsibility for their behaviour. Their decisions to make changes reflected the common threads of having faith in themselves, and having the conviction to follow through on their decision, for example, Joe's assertion that "I am one of the strongest people that I know." John challenged and questioned his own behaviours during our conversation. Beth's story is one of many dimensions: healing from addiction, sexual abuse, and other oppressions by passive, loving resistance and nurturing self-discipline; her journey of love, strength, and inspiration continues. Gina attributed the fact that she is still alive and recuperating to her faith. All of the participants have demonstrated faith in themselves, and a deep sense of responsibility to achieve their true potential. It matters to them to make a difference for the better whether for their own life

or for their loved ones. Most of the participants reflected the importance of being grounded spiritually, describing a broad range of experience, from "spirituality can be music" (Judy) to the types of powerful visions that John described. Gina's account provided credited her original community and native culture with providing the spiritual grounding that helped her overcome deadly affliction and pain. This spiritual connection was also expressed through the primal experience of love and acceptance in the face of judgement as described by Joe.

Focus on Abilities, Capacities, and a Meaningful Life

Each of the participant narratives reflected a focus on ability, capacity, and what made life meaningful. Each was enthusiastic about what they were able to achieve, their strengths, and their successes. This contrasts with the recovery culture perspective that peace and serenity are proportional to a person's surrender to and acceptance of a weakness beyond his or her control. In contrast to 12-step story protocol of "the way it was, and the way it is today" (AA, 1976, p. 58), which is focused on alcoholism, all of these participants have made significant gains in their lives beyond sobriety discourse. George took a stand for his family, which included loving, nurturing, and guiding children whose lives already had been traumatically disturbed by alcohol. Claire gained her graduate degree and has a career in social work, helping others overcome addiction in their lives. John is completing his graduate studies, and Judy has reclaimed her creativity, found the love of her life, and has meaningful work. Most importantly, they attribute their present successes to their own decisions, commitment, and efforts, in collaboration with

the people who supported them in their lives, rather than eschewing their own abilities and deferring credit for a better life to a program or a group.

Those participants who attended 12-step groups found them to be a critically important step on the journey of growth, but acknowledge that their journey continues beyond the borders of 12-step culture's map. The journey itself beyond the frontier invites outsiders to map their own territories, use their own compass, and honour their own strength and creativity.

Resisting Limiting Rhetoric

All of the participants were resistant, to some degree, to embracing a rhetorical perspective (AA, 1976; American Psychiatric Association, 2000) that objectified, pathologized, or categorized them in a manner limiting their discretion in making their own self-appraisals. All of the participants refused to see themselves as having a disease as defined by the culture of Alcoholics Anonymous. Even in ambivalent moments of reflection, John vowed never to go back to the practices and perspectives of the fellowship: "I know their shortcomings" (John).

The participants have developed their own theories about their relationship with alcohol, which currently and successfully serve their needs. It bears repeating that each of the participants is determined not to abrogate their right to decide the nature of their own problems and to choose their own solutions.

Adaptability

All of the participants demonstrated significant ability to adapt, incorporating strategies into their repertoire and using them to change their lives. John, who was ambivalent about his current alcohol use during the interview, has now reasserted his ability to manage his drinking based on careful self-appraisal. Independently he has found a way to incorporate some ideas borrowed from AA discourse, along with self-chosen behavioural goals regarding life skills and relapse-prevention strategies, and used a narrative approach to integrate them with his relationship with alcohol. Most of the participants have borrowed strategies from 12-step programs or other resources, applied vigorous effort, and achieved / maintained their successes.

Many of the techniques that supposedly originated in a particular framework such as AA have leaked into popular culture. The "One day at a time" and "easy does it" slogans of AA are as common in dominant culture as the behavioural carrot metaphor. The once exotic has been domesticated, and is now common. It reminded me of how careful I need to be as a researcher not to attribute ideas to a specific culture unless acknowledged by the narrator.

Participants' self-concepts and their interpretations of the significance of particular experiences were dynamic; the metaphor of re-authoring history applies here (White, 1993). Essentially, participants retrospectively reframed the facts of their past with new knowledges as they integrated new metaphors and insights into their identities.

This is how history is rewritten culturally, and also individually, as we write and rewrite our stories. Different cultures compete for the dominant interpretation of "the facts." As a social worker, I believe it is vital to continually bracket my own perspectives,

rhetoric, and cultural views of my work with clients, preferring to view conversations with persons seeking help as phenomenological research. As clients discuss their views and experiences, I can offer support either through insights other clients have found on a similar journey, or for their pioneering work in their personal frontier.

Isolation and gratitude were two specific themes I found in conversation with participants that relate to the culture of silence regarding relationships with alcohol and life choices that conflict with the disease model and AA rhetoric.. Isolation was demonstrated by the great difficulty participants had in trying to identify any other persons they knew who shared similar experiences and successes. The second phenomenon, gratitude, related to some of the participants' experience of having someone take an interest in their stories. Examples of this include comments as, "I wanted to be part of this, I wanted to tell my story, because I feel, underneath it all, a desire to move forward again" (Joe). Judy explained:

> When you called, it was so respectful. And I'm using the word *respectful* very literally, meaning whatever it is in Latin or Greek, meaning "to see." After all this time, somebody wanted to see what happened to me. And that was really wonderful, because it's a part of my life; I don't try to shut it out, my husband certainly knows about it. It's a part of who I am today. And for someone to phone up, and someone I know; I would probably even have discussed it with a stranger, to just say, "Wow," you know, "What the hell happened to you? I'd really like to know." That's neat. That doesn't happen to a lot of people. (Judy)

Participants' feelings of isolation and gratitude are indicative of the marginalization that occurs for people whose experiences challenge the status quo.

CHAPTER FIVE

DISCUSSION

> Professional people need to know how to respect and honour my experience in overcoming addiction. (Beth)

In this research, I have explored the experiences of seven people and their changing relationship with alcohol. Each of these seven lives well outside of the parameters of alcoholism and its treatment as defined by the disease model and 12-step rhetoric, yet each also had serious problems with alcohol in the past. In the previous chapter, I presented information from the participant interviews, along with my social constructionist culture identity theoretical model, that addressed the experiences of those overcoming addiction outside the 12-step / disease model culture.

The information provided in chapter 4 has satisfied the first two objectives of this study: to describe the experiences, issues, decisions, and outcomes of the sample group; and to identify the contributing factors that restrained the participants from using the medical model and 12-step approaches. In this chapter, I will discuss the last two objectives: to describe the needs and preferences of people who decide to deal with an addiction problem outside of the 12-step / disease culture; and to describe the implications of participant needs and preferences for social work practice. During the interviews, the participants effectively stated their needs and preferences, and what they hoped helping professionals, including social workers, would learn from their experiences. Consequently, I have chosen to include quotations from participant narratives to address the third objective for this study. I will address the fourth objective

in my discussion of the implications of this study for social work practice. I will address, in the remainder of this chapter, how this study relates to the literature reviewed in chapter 2, contributions and limitations of this study, and implications of this study for theory and future research. I will also address the impact of this research process on participants and on my personal experience.

Participant Recommendations to the Helping Profession

Each participant offered their own ideas about what they felt professional practitioners need to know in order to help others struggling with addiction problems. Here's what they had to say.

Joe's response addressed his own experiences with counsellors:

> You have chosen your career. I have chosen my career; in some ways I love my job, because it gives me many things. But, you know, you choose to be an RCMP,[35] then you choose the uniform. It is a choice that you make. And if you choose to be in social work, or a counsellor or something, you're choosing to help people. Then you better have helped yourself.
>
> Hey. I've got no problems with an alcohol and drug counsellor being an alcoholic. I also don't have a problem with alcohol and drug counsellors who have never touched a drink. I don't have a problem with that. But, I have a problem with alcohol and drug counsellors that never dealt with their issues. And never dealt with the emotional reasons for them drinking. Me, this is my story. It isn't about disease, it's about [long pause] my drinking was about un-dealt-with emotions.
>
> ...And so as a professional, I realize that that's extremely difficult to do—to suspend judgement. When you are the resource broker, and you are trying to allocate resources, how do you fit a person like me into that system? I don't know. Advice? I still honestly have to say, I think [pause] you need to have done some of your work. No perfection. And suspend the judgement. I think that if you have done your own work I think that you can easily suspend your judgement.
>
> That's been my absolute best experience, a group situation. I found what works the best is a three-point system, i.e. there is a facilitator, co-facilitator, and one or more people that act as a unit in the group, that is the base of the group. These people have done enough work on themselves that they can offer some of themselves back.

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[35] Joe is using this profession as a metaphor.

> One more thing to say about the group process. It was a project. It had a beginning, a middle, and an end. Okay? And then you move forward. And the worst part about AA is that, here I am—I want to quit drinking and then there's the rhetoric that these people are trying to pump into me, that, "Oh, you're here for life." Why the hell do I wanna be around a bunch of hypocritical people for the rest of my life, with the threat that if I have another drink I'm going to die? I mean, how coercive is that? A beginning, a middle, and an end. And then you have to step out and try what you've learned. (Joe)

Joe's advice implies that the need for professional helpers to understand his theoretical framework: that addiction is merely a destructive solution for underlying issues. Consequently, the therapeutic relationship requires the helper to have explored and worked on her or his own personal issues. Joe also argues that help is most effective when it is timely—implying that clients should attempt to function without an ongoing therapeutic crutch. This notion is strongly supported in Social Learning theory (Marlatt, 1985).

While Judy provided some hints at her own etiological assumptions about addiction, her advice is simple:

> I've got a bit of a biologist, science kind of slant with my work, and I don't believe it's a disease until I have the proof.
>
> You know what I mean? I think that definitely there is a chemistry difference between people with addictions and others. But that's all addictions, be it whatever. And I think that hopefully, eventually medical science will be able to address that. And not by Band-Aids; you know, giving people mood-altering drugs and so on, but by giving people naturopathic diets that give them whatever's missing that causes that imbalance. That's what I'd like to see; that would be my answer to your magic wand question.
>
> You asked a question about what could help doctors and psychologists and social workers and people like yourself to do better? The only thing I have to say, is give people the room to do whatever works. (Judy)

Judy's last statement implies the need for client-centred practice. I infer that giving people the room to do whatever works means providing therapeutic space to respect the client's perceptions of problems, solutions, goals, and outcomes.

This is George's response to the question, "What do you think that professional people (social workers, therapists, and the like) need to know from your experience about overcoming addiction?":

> I think [pause] as witnessing the Ministry's[36] problems that they have—they're understaffed, they're underpaid, and they have one social worker for two handfuls of kids. They cannot protect them all, they cannot be eyewitnesses to everything that goes on in the houses were they are.
>
> They need somebody [pause] to go around to these places and [pause] take every little issue that these kids have and take it seriously. [pause] Don't take it with a grain of salt. Don't take it that you've heard it [pause] from other kids or whatever. Listen to the kid, 'cause the kid is trying to tell you something. And if it is alcohol-related there is a reason why, there is a reason this kid is drinking at 12, there is a reason this kid is doing drugs, there is a reason she is on the street selling her body.
>
> And it's not even in the foster homes; it's in every home. Like I know friends of [name] that are, you know? You just want to scream, at some of the shit that goes on with their parents, you know? And what can you do about it? I know society has come along way from [pause] listening to your neighbours fight and get into a fistfight and the husband is yelling at the wife and all's you do is close the window. But it still goes on, you know?
>
> I just [pause] I just wish that the kids that are in trouble would get help earlier. A lot of them. Because nine times out of ten, when they do get help it's too late.
>
> I think one-on-one as in a...big brother situation for instance, I think, that that would be a great thing. For an individual, big brother-big sister type thing, because they obviously need guidance of some sort.
>
> I would [pause] I would like to see a more [pause] a more personal setting you know, for only one evening and let the kid open up to you as a friend... I'm thinking of [pause] getting the kid, sort of out of the circle of the drugs or the alcohol...show him the other side [pause]. Yeah, no kid is going to sit there and enjoy being preached to. Not preached to, but "alcohol is bad, drugs are bad"—probably down the line.
>
> You know, you take a kid out, you take him camping, take him [pause] all over and do whatever you do with your young son, or your nephew or whatever and he's away from it. He understands that you don't have to be drunk. You don't have to be stoned to have a friend, to have a good time. To be involved, right? That's the kind of thing that I'm thinking.
>
> I wish that [pause] that somebody would have taken an interest in me as a young child and done that sort of stuff with me. I mean, somebody I could look up to and say he does drink and party and he's got a good home life and [pause] he's got a job [pause] and you know [pause] something that I could look forward to

[36] The Ministry of Children and Family Development of British Columbia, responsible for the protection and welfare of children.

> that way. Where all I had were my friends, and alcohol was their buddy as well as mine…
>
> Yup that was the gist of it. I feel that [pause] that kids today, they're probably in worse than I ever was because before when I was going to school, you know everybody partied on the weekends and stuff, but drugs wasn't the problem that it is today. Kids, you know [pause] you got to get to them early in my eyes. (George)

George's response reflects his values about nurturing children, which he believes needs to be the principal focus for preventing or reducing the harm of substance abuse.

Gina's answer, in response to why she decided to participate in this research, reflected a holistic worldview, addressing everything from the desire to live to self-care:

> You're going to pass it along, and maybe somebody will benefit from it, they'll be open about themselves, and, just spewing your guts out about what your problem is. Don't be afraid, don't try and hide it. You want to do something. Everyone wants to help themselves, nobody wants to die. Nobody wants to.
>
> See, I read an article about the last execution in British Columbia…He didn't want to die. And he swore all along he wasn't scared. And that always stuck with me ever since then; nobody wants to die. [pause] Wherever there's life there's hope, and I'll always remember that. And that's what these people should be saying. "Let's see about what we should do." Just remember that they don't want to die. You know, there's hope.
>
> Physical health is very important, three meals a day, especially for someone that is drinking, that doesn't want to quit, they should have three meals a day, and take vitamins. And when you do decide to quit drinking, you have a better chance of survival, physically when you do go into detox. When I had that flu there, I wasn't eating very much, and when I came out of it, I had an awful time… It's very important to have your daily nourishment. And the more you eat the less you drink. And then even if you do drink just as much, the food helps to absorb the alcohol.
>
> I think if your body's well nourished, you'll go out and do things; be more active. I've seen people in slovenly homes, sitting there with a can of beer, and the mess, and they usually have pets [laughter], and they're dirty too; that's no way to live. Animals don't live like that; pigs, in the wintertime, they rest in the corner, and they kept a clean place to sleep. And they never mess around where they ate. People have got a lot to learn from animals.
>
> And when you're not eating properly you're sitting there with a can of beer or something, and neglecting the kids. If you'd have kept your health up you could be doing things with the children. Well, my children are my pride! (Gina)

Gina's response reflects the need to recognize and develop goals with people in a holistic manner, addressing issues from physical health to a healthy environment, parenting, and hope that provides motivational and spiritual grounding for a person to reclaim a life worth living.

John's insights underscore the need for patience, persistence, and empowering people who are overcoming alcohol problems:

> I think the most important thing I think for people working with people with alcohol and drug problems is it's a process. Relapse is normal. I'm trying to think if I know of even one person who never had a relapse. Including myself up till the time I actually got it, like I tried to quit a hundred times. You know? It didn't work. 'Course I wasn't trying to get any support or figure out a way to do it, I was just going to stop drinking.
>
> Well that didn't work. So I think it's important to understand that it's a process and it takes time and it's the whole piece of the person has to be with it. It has to be integrated with their physical well-being, their spiritual life, or getting some sort of spiritual connection; [pause] not necessarily in the AA sense, but just in the sense of becoming comfortable with self.
>
> Because if you're not comfortable with yourself you're going to take something to change how you feel. I think there's a lot of core stuff around that and people need to be supported through it and it can be a very frustrating experience for people trying to work with them who want quick change cause it doesn't happen that way. It just does not happen. So patience and caring. Caring for them all the way through it and if you do that long enough you're going to see some of them change.
>
> And give them power. Give them their power. And that's one of the things that AA takes away, it dis-empowers. Turn your power over to this higher power which means you're weak and powerless so, and I think people need to get control of their lives and I think that's part of what happens after five or six years; they take their power. They get on with their lives. That doesn't mean that you can't have a spiritual connection or whatever it is but it also means that you're aware of your own, where you do have some power. (John)

John's advice reflects Gina's ideas about working from a holistic framework, and Joe's theoretical view that addiction masks underlying issues. I infer that his thoughts about patience and perseverance, about the non-linear process of recovery, and the need for empowerment suggest client-centred approaches. "Give them power" implies the concept

of therapy as a political act, a perspective amenable to feminist and narrative therapeutic frameworks.

Claire, responding to the question, "Imagine that you have been given a magic wand, which will help you create the ideal circumstances for people like yourself to resolve their addiction problems. What would you like to do?" demonstrated her insight as a practitioner:

> What would I do? Oh wow, that would be so much fun! I would have everything in one centre. And what I mean by that is after they were all detoxed and stabilized and all that kind of stuff, instead of just preaching the 12-step programs, going through the little alcohol and drug system during recovering planning, I would have them meet people in the programs that were.... Say the 16-step empowerment program because it's a lot different than a 12-step program. And yet they would meet the 12-step program people. They would meet people who are doing what I'm doing today. Like harm reduction I guess would be the word cause I can't really find a word for it. Yeah, so they would have all the choices, all the time in the world right? You can learn about them all, and they all have their own little workers of course, [laughter] cause we got lots of money. One-to-one here, who had no opinions except to totally inform them and completely empower them to make their own choices. Then I think people would get recovery, but it costs a lot of money. Because I think that when we're making choices for other people we're not empowering them so we see them over and over and over again. But I also think they don't have the money to do that, right?
>
> Well, no magic wand? The next best thing would be what I try to do. Is still informing people. Information taking, understanding people for where they're at I think is the key. I believe that referral is very important. I mean, I do recovery plans with 20 people a day. And they listen to me and most of them just do whatever because they don't know. So if I'm being the best I can be that day, because I'm not overworked, without the magic wand I guess, just time and really informing them. Instead of saying, "Well this is our system of care, you should go from here to this 28-day program, support recovery program, then this 30-day treatment program, and ..." Because that's what's there.
>
> Everybody is an individual. Yeah. If my experience could stop those people [professional practitioners] from clumping people with addiction issues into one certain criteria. I mean, especially if you've been in the field for a while it's hard as human beings not to expect people to be a certain way. So that would be for right across the board for them to absolutely listen. And understand a person's individuality, because if that happened, then I guess decisions based off that would be thoroughly off the person's needs and only the person's needs. And not what has been normal or accessible or affordable. (Claire)

Claire's professional advice to colleagues strongly promotes client-centred practice: to eschew assumptions that clump clients into one category, to understand a person's individuality, to absolutely listen, completely inform, and completely empower. Claire recognizes the authority of her professional status, but argues that decisions need to be made based only on the person's needs, which I believe would take priority over the dominant discourse of institutional privilege. Claire's belief in referral implies a professional duty to help situate clients back in their lives with resources that fit their needs.

Beth clearly provides an invitation for practitioners to accept and support clients who need to find their own path to a better life:

> The ideal circumstances for people like me to resolve addiction problems would be to work with someone and /or a group that is not going to try and peg me into an already set pattern of use and that has the attitude of exploring who I am, what I need, what and how to be happy, healthy and fulfilled in ways that are not going to hurt me or others. A program of some sort that teaches ways of living in the world. This scenario would be expanding, empowering, and full of experiments. It would be far removed from disease and a continual alcoholic identity.
>
> Professional people need to know how to respect and honour my experience in overcoming addiction. This means cultivating an attitude of being present, curious, and knowing how to *listen.* They need to be quiet, focused, and aware of their own feelings, programming, and experiences. The helper's reference point may not be true for the individual who is sharing.
>
> As a final point, I believe healing from an addiction involves accurate knowledge, the permission to change strategies, refresh old ideas, and most importantly people who are genuine and who can listen without judgement. (Beth)

Beth's advice also promotes self-determination reflecting client-centred practice, but with a distinctly postmodern flavour. She suggests a focus involving a counsellor's intimate self-awareness, genuineness, and listening without judgement; and a process that eschews deficit rhetoric and promotes experimentation and exploration of needs, identity, and fulfillment in the context of the world.

When I reflect on these persons' narratives and their suggestions intended for the professional practitioner reading this work, I believe they are asking to be listened to and respected as individuals, and to not be judged. I believe they meant that they'd like their issues to be treated in a manner that respects their individuality, and not as problems that fundamentally limit how they should see themselves. They prefer to be responded to as unique persons—not as potential AA group members or as clones. I believe they respect practical solutions for alcohol problems, including abstinence, especially in the beginning of the process of reclaiming their lives.

I infer from their stories and recommendations that the best methods of responding to their needs incorporate a client-centred focus that is reflected not only in the strategic service provided, but in the assessment process as well. I suggest this would mean having client-centred assessment tools that provide information that is meaningful from the client's perspective, and that could be used directly to guide the service plan. This perspective is inherent in the Harm Reduction approach to supporting change. I also infer from their recommendations that assessment tools and therapeutic strategies require a holistic approach, from the essentials of nutrition to feeding the soul spiritually.

I infer from their recommendations that social support is a crucially important part of their reclamation. I believe they prefer supports that eschew theoretical dogma and the prescriptive assumptions informed from pathological views of alcohol problems. They value structure, the ethic of personal responsibility, and specific tools for success, but they also need a sense of personal validation and intimacy that comes from being heard and respected by others who care and who possibly know the experience.

Finally, I infer from their stories that there is a fundamental role for social workers in the support for people overcoming alcohol problems; that is, practitioners who honour the fundamental principles of client-centred ethical practice as defined in the code (British Columbia Association of Social Workers, 1999; Ministry of Health Services, 2002). This practice can be reflected in the development of each practitioner's assessment and service skill repertoire, as well as in resource development work, from facilitated groups to other community-based supports. One of the most touching experiences for me during this research was the joy these people expressed about having their stories finally heard and treated with respect and consideration.

It seems only natural that any framework developed to understand and help people will not fit everyone's experience, and I expect that the framework I have used for this study is no exception. Nevertheless, it is my hope that the participants are satisfied that this work reflects their experience, preferences, needs, and strengths.

Summary of Results

This study has provided information addressing the experiences, issues, decisions, and outcomes of seven participants who chose to overcome alcohol problems outside of the rhetoric of the disease model and 12-step philosophy. This study also documented factors that restrained the participants from using or continuing with the disease model and 12-step groups. A model was developed (Figure 1) to organize the information gathered.

A Model

This model used a social constructionist perspective, that personal identity is constantly negotiated in discourse with different political cultures. This perspective provides one way of understanding the impact of different rhetorical views on an individual in a process of change. Theoretical paradigms, such as the disease concept, were described in this model as cultures because each could arguably be used to distinguish rituals and purposes demonstrated by people who had made a commitment to the specific value system. For example, 12-step rhetoric defines the philosophy and practices of a specific fellowship of people, such as Alcoholics Anonymous. Consequently, each of these cultures of rhetoric provides a voice negotiating meaning regarding how behaviour is interpreted, for example being an alcoholic.

On the other hand, participants in this research demonstrated a dynamic, ever-changing self-concept described in this model as personal identity. Common factors in participant identities, in contrast to deficit identities associated with certain rhetorical cultures, included strong conviction and personal faith, a focus on strengths and capacities, resistance to accepting limiting rhetoric, and an ability to adapt. The methods and tools used to negotiate the meaning between participants and different cultures of rhetoric include stories, metaphors, good and bad appraisals, everyday life experience, theoretical development, and integration statements. Changes participants made in their lives were illustrated through the use of these tools and methods. For example, Joe, in the process of exiting Alcoholics Anonymous, made negative appraisals about the program, employed "time to go" metaphors when interpreting stories of experiences in the

meetings, began to develop a different theoretical perspective, and used more positive appraisals about his identity.

Participants' stories tended to reflect a "migration of identity" (Smith & Winslade, 1997) metaphor, depicting life at different times with distinctly different attitudes in relationship with alcohol (see Figure 2). Descriptions common among two or more participants depicting a general period in life in relationship with alcohol were categorized in the model as distinct culture. These newly defined cultures are not similar to others such as 12-step culture, which represents a group of people with a homogenous philosophy. Nevertheless, these categories do represent times, philosophies, outlooks, and rituals and traditions constituting rhetorical perspectives that participate in the discourse of knowledges about overcoming alcohol problems. For example, the "old relationship with alcohol" described participants' "old days" of drinking, prior to making a decision to change. Other cultures derived from participant narratives are the "new relationship with alcohol" involving those who exited 12-step programs and successfully managed their alcohol consumption, and "abstainer pioneers" who chose to quit drinking completely, without the assistance of self-help groups or professional assistance.

Implications of this Study Regarding Literature Reviewed in Chapter 2

The participants in this study generally attributed their capacity to manage their alcohol problems to processes that I have interpreted as a renegotiation of identity. I have characterized this as a dynamic process of changing their self-representations and rethinking their internalized rhetoric and beliefs. Denzin (1993) describes an alcoholic from the recovery (12-step / disease model) culture as being in different phases of self-

knowing, such as the "alcoholically divided self," the "recovering alcoholic self," and the "new self," a similar analogy. Moreover, I have used the analogies of culture and the journey into different perceptions of self in a similar way to Granfield & Cloud (1999). These authors describe general experiences such as "slipping into darkness" and "natural recovery," describing the latter as a process of "cultural resistance."

Participants' experiences in my study are consistent with Granfield & Cloud's results in that I also found that identity formation is adopted in context, and that former addicts with minimal contact with recovery resources develop distinctly different self-concepts. Just as Granfield & Cloud described restraining factors that inhibited initial and ongoing investment in the culture of AA, so did my participants. As in their study, participants in this research discussed perceived contradictions between their personal perspectives and the rhetoric within the culture of 12-step or professional recovery resources. Categories that are developed in Granfield & Cloud's work, such as participants not wanting what the resources offered, and not needing the programs because their personal worldview was based on strength and capacity rather than on deficit, are supported in the narratives of these participants. Granfield & Cloud's findings are supported in relation to the common qualities found among the participants of this study; that is, a strong conviction and belief in self and personal faith, a focus on personal abilities and capacities, resistance to rhetoric that limits capacity regarding self-concept, and adaptability.

While Granfield & Cloud did use a narrative framework to ground their research and did incorporate the concept of culture, they did not develop a model. They also focused on a more specific group: people who had quit and remained abstinent from

substances such as alcohol for over a year. Their research does not, however, address the experiences of those who have developed the ability to drink moderately after years of living under the influence of disease rhetoric. I believe that a model was necessary in this study to explore multiple experiences of participants with differing but equally relevant outcomes and perspectives on overcoming alcohol problems, in contrast to conventional rhetoric.

Participant narratives in this study can also be interpreted using Kearney's (1998b) notion of journeys toward healthful self-nurturing. Kearney's description of self-destructive self-nurturing directly matches many of my participants' stories of their "old relationship with alcohol." Their stories about exiting from this lifestyle all include what Kearney describes as a "painful shift in awareness" (p. 501). Participant stories include evidence of Kearney's phases, including abstinence, honest self-appraisal, and developing better social connections. I do not believe enough demographic data were gathered in this study to consider Kearney's finding that the farther a woman's socio-cultural milieu from the predominant mainstream, the less likely she is to use formal treatment programs. Information from this study does not support Kearney's finding that the less incapacitating the addiction and the better her [or his] social skills and personal resources, the less likely it is that a person will seek treatment (although Kearney's study involved mostly women). However, participant experiences in this study that did not support Kearney's findings could be the result of political rhetoric influencing professional assessment and referral, which was not a variable that Kearney addressed in her research.

There is some emerging research exploring experiences such as Gina's and George's, of people quitting their drugs of addiction without treatment (often referred to as self-remission or natural recovery) (Granfield & Cloud, 1999; Kearney, 1998a). These studies provide evidence supporting the notion of personal resilience and resistance to the dogma inherent in the disease and 12-step models within the addiction recovery industry.

However, none of these studies have explored participants' experiences of reclaiming a moderate, controlled relationship with alcohol at some time after a history of serious alcohol problems. All of the research I reviewed interpreted any reintroduction of alcohol as a form of relapse, of revisiting problem behaviour. Clearly, the five participants in this study who currently manage their alcohol use would not agree with this interpretation. I do not believe that Judy's, Joe's, John's, Beth's, or Claire's experiences are unique. But due to the dearth of literature exploring this phenomenon, their narratives seem revolutionary.

Impact of the Process on Participants and Researcher

This research employed a qualitative process involving hours of interview time, focusing on participant experiences that may not have been deemed worthy of consideration by others in the past. Reflexivity and the social constructionist process also required in-depth conversations where my views and assumptions were made visible to each participant. Consequently, this work was a thought-provoking process for the participants and myself. I noted several themes or occurrences that emerged from the participants' reflections on their experience of the interview. First, some participants

spoke about feelings of gratitude and validation about someone having taken an interest in their experiences. I have described this response to the research in chapter 4.

The second theme emerged from John's and Joe's interviews. John was ambivalent about his relationship with alcohol at the time of the interview, and the process became an opportunity to vocalize internalized discourse regarding his drinking. I considered it a privilege to witness his courage and willingness to reflect upon his behaviour. Joe also invested in the interview process, to the point of tears several times. He told me after the interview that he had his own goal regarding the interview: to tell his story, hoping that the process might provide insight about what direction he needed to take on his journey toward love and acceptance. In other words, there were occasions when the interview became a therapeutic process for at least two of the participants. At the end of their interviews, I took time with Joe and John to debrief the process and to ensure that each had a plan and support. Since the interview, each has made changes in his life in keeping with the plans we had discussed. This continues the tradition of employing qualitative research methodology to provide validation and action or participatory empowerment to encourage change (Reinharz, 1992).

Another theme emerged in the conversations with participants when I requested feedback about the thematic analysis process. Each of the participants indicated suspicion and concern about the nature of the retrospective analysis. This concern was addressed through discussion and negotiation. I affirmed that the units of measure could not be used as clinical criteria, so the process couldn't be used to label them. I explained the function of the analysis—to ensure that their experiences with alcohol would not be trivialized by proponents of the disease model. I also discussed how I would in fact be critiquing the

disease model in the literature review. These points seemed to satisfy the participants' concerns. I was pleased to have taken this opportunity with the participants. My motive for this research was to pay respect to the experiences of people whose stories are untold because of fear of judgement, misinterpretation, and trivialization. Consequently, it was especially important to maintain this respect at this stage. I had a deeper feeling of respect for the participants when they showed concern and took the time to question a reductive process.

This study was my first venture in qualitative research; consequently, I was always questioning my behaviour and decisions in the process. In each interview I experienced a gleeful anticipation about collaborating with someone to better understand her or his experience in relation to addiction counselling theory and practice. The experience reminded me that counselling is, or can be, qualitative research. I was reminded, for example, of the importance of bracketing my perspective and of maintaining a respectful, curious, and collaborative attitude in the therapeutic process.

Theoretical Implications of this Research

Participant experiences challenge a number of "one size fits all" theoretical tenets grounded in the etiology of alcoholism as a disease. Specifically, in spite of personal histories of serious alcohol problems prompting professional assessment and referral to AA, some participants' current relationship with alcohol is *not* characterized by compulsive use, loss of control, nor progression (as described in chapter 2, in the section "The Medical Model"). Four out of the five participants who chose to experiment with controlled drinking have managed to do so successfully for a period of time ranging from

two years to more than a decade. These four participants indicated that they control their alcohol consumption and have not experienced compulsive urges or negative consequences attributed to their drinking. Consequently, there is no evidence of the phenomenon of progression. The fifth participant, John, who was ambivalent about his alcohol use, has made changes in the strategies he uses. He indicated that he no longer drinks and drives and that he responds to cravings with alternatives to drinking, enjoying a range of recreational and social activities.

Consequently, participant narratives challenge the primary tenet of the medical model of alcoholism: that it is an incurable disease. Disease concept proponents would argue that these four persons have demonstrated merely that they are not alcoholics. Although this is a possibility, this argument does not acknowledge the serious nature of each participant's past troubled relationship with alcohol (see Table 1). Nor does this argument address the fact that professionals, and/or fellowship members themselves supported these participants' inclusion into 12-step culture at one point, thereby accepting them as "recovering alcoholics." In fact, this argument tends to reflect the political nature of the disease concept, emphasizing that disease-focused theory has been constructed in a manner that prioritizes safest outcomes and risk reduction over self-determination, strengths, and capacities.

Applications of disease-focused theory (AA, 1976; American Society of Addiction Medicine, 2000; Canadian Association of Addiction Medicine, 2002; Diamond, 2000; Gorski & Miller, 1986; Jellinek, 1960) have a totalizing feel (Le, Ingvarson, & Page, 1995). Alcohol misuse is seen as symptomatic of the progressive illness of alcoholism, requiring abstinence and AA. Mandating a rigid prescription for

least-risky behaviour does not necessarily honour individual capacities, as attested by the participants in this research. In respect to the disease model, these participants demonstrate that not all persons with drinking problems are alcoholics, and that 12-step programs may not suit the needs and preferences of all persons with a history of serious drinking problems.

Participants in this study tended to be more effectively supported using harm reduction perspectives, which also promote safety, but in the context of individual needs and preferences. While harm reduction rhetoric does not generally recommend experimenting with high-risk substances, this perspective accepts the fact that risky behaviour does occur (Appendix E). Harm reduction principles support ideas such as using personal guidelines and limits to manage alcohol use, as well as establishing criteria to assess and, if necessary, abandon the experiment with controlled drinking (such as John's criteria about drinking and driving, and drinking alone).

The construction of meaning has been a significant process through the participants' experiences. Theoretical concepts relating to meaning can be substantiated within the narratives, and they represent a key area of theoretical interpretation. For example, the AA concept of "hitting bottom" (AA, 1976), Prochaska et al.'s (1994) process-oriented approach of becoming ready to change, and Frankl's (1986) assertion that meaning is constructed (that we have to create the meaning in our lives), can each provide poignant interpretations of participants' experiences through their narratives.

Practice Implications of this Study

This research presents several implications for social work practitioners in the addiction field. The examples provided below are not an exhaustive list; I hope to hear from other professionals in the field regarding other implications of this research.

Participant narratives illustrated a dilemma regarding assessment: most of the "new relationship with alcohol" participants were referred to 12-step fellowships by professionals. How do we effectively distinguish alcoholics, for whom 12-step referrals are appropriate, from other problem drinkers? Perhaps there are more effective methods of assessing client needs and preferences.

Participant narratives also illustrated a potential dilemma regarding resources. Claire provided an example of an alternative support community (Kasl, 1992; see Appendix D). In small, northern, and remote communities, professionals may refer clients to 12-step or other resources out of immediate necessity, lacking other resources that might provide a more fitting or effective service. In other words, ethical practice would indicate referral to the only resources available, a better-than-nothing scenario. Although all of the participants who attended a 12-step program in this research indicated gratitude for the program's support in gaining a period free from abusive drinking, there was also significant interest in the development of accessible alternative resources and support systems. Meanwhile, best practices guidelines for treating people with alcohol- and drug-related issues (Roberts et al., 1999a) suggest that "the majority of those who have problems with alcohol or other drugs do not seek help; especially not from specialized addiction services" (p. 58).

Advice offered to social workers by participants suggests a preference for client-centred practice. Client-centred approaches are supported by the codes of ethics for social workers and addiction counsellors (British Columbia Association of Social Workers, 1999; Canadian Association of Social Workers, 1994; Ministry of Health Services, 2002c).

Major Contributions of this Study

This study has provided evidence of possibility. Participants with serious alcohol problems in their past quit drinking without using deficit rhetoric associated with the disease model, or they abandoned the rhetoric and have successfully managed their drinking. These experiences have happened; this proves that they are a real possibility. Since my decision to end the information-gathering phase, I have heard from more people about friends or family members who have experiences similar to those of the participants in this study.

This study has made several contributions to the field of addiction research and social work practice. First, it has documented the experiences of people who have been marginalized by the rhetorical assumptions of dominant theoretical frameworks. Second, it has exposed dominant rhetorical deficit-focused perspectives as only one way of viewing people's experiences. Participants' narratives in this study reflect multiple knowledges, journeys, roads, and uncharted territories. Third, this research provides a social constructionist model depicting the negotiation of meaning between cultures of knowledge, which contribute to the transformation of identity. This model may have some utility for understanding experiences of people who choose to live in theoretically

uncharted territories. Finally, this study has drawn several implications for social work practice, regarding assessment procedures, therapeutic approach, and resource development.

Limitations of this Study

There were several limitations in the method of this study. Data sources were limited to narratives of participants; other artefacts, such as artwork, poetry, music, or photographs, were not used. Also, third-party information, such as accounts by family members, friends, or professionals or other documentation (for example, discharge summaries from treatment programs), was not used. While these alternate sources may have provided stronger verification of participant narratives, the social constructionist process (presuming that truth is mediated collaboratively) required significant limits on a conceivably never-ending process.

I neglected to gather demographic data such as age and income level in a standard manner, which might have constrained my interpretations in some ways, providing a check on assumptions. This study might have benefited from having more participants. However, the enrichment of discourse provided by greater numbers would ultimately have compromised the extent of detail, for example the amount of quotation provided from a particular participant's narrative.

There is an important corollary to this research. My study has provided evidence that some people have successfully reclaimed a relationship with alcohol after a history of serious alcohol problems. However, I do not endorse this as a blanket recommendation or even as a possibility for everyone considering a plan of moderate

use. Participants in this study who have learned to manage their drinking attributed their success to a period of life ranging from several years to more than a decade as an abstinent person, during which they were able to make significant investments in a different life. They created, with the help of others, a new life that was generally exclusive of the "old relationship with alcohol" culture. They adapted; many achievements in their health, relationships, education, and personal growth were integrated into their respective identities as capable persons. It was within this context of an integrated, healthy, nurturing, and disciplined self that these people chose to negotiate a new relationship with alcohol in their life. Consequently, I do not recommend that people consider the decision to experiment with alcohol lightly. These participants all clearly indicated that abstinence was a necessary part of their journey in order to take a stand against an addictive drinking pattern. I would recommend that anyone who is contemplating a decision to experiment with controlled drinking make an appointment with a counsellor!

Implications for Future Research

This research has raised more questions than answers. The following questions may provide an interesting basis for further inquiry: How do people like George and Gina manage to abstain from alcohol without a "recovery community" of others with similar experience and commitment? How can alcoholics be distinguished from problem drinkers to better balance their individual needs and capacities? What role can social workers play in helping clients address therapeutic injury[37] resulting from dominant approaches to

[37] The therapeutic work in assisting people exiting 12-step programs has been described as analogous to that of assisting people exiting cults (Apple, 2001).

treatment? How can social workers help develop alternative support communities in northern remote communities, such as those in northern British Columbia? What ethical dilemmas do social workers face in developing alternative resources whose etiological assumptions challenge those of the 12-step fellowships? What implications does this have for social work practice in assessment, service provision, referral, and resource and community development?

Prospective researchers may wish to explore common participant qualities described in this study such as strong conviction, belief in self and personal faith, a focus on personal abilities and capacities, resistance to rhetoric that limits their capacity regarding self-concept, and adaptability. I would be interested in learning whether these qualities are present in the narratives of others overcoming addiction identities.

Further research might help to more fully describe the culture of silence manifested in these participants' experiences. Other researchers may be interested in exploring this topic using more specific parameters, such as women, aboriginal people, or people residing within more specific geographical boundaries. I believe prospective participants are out there, waiting for listeners!

Conclusion

This study has described the experiences, needs, and preferences of people who have chosen to address alcohol problems beyond the rhetoric of the disease model and 12-step framework. In the process, some of these people have faced marginalization as a consequence of blazing their own trails through theoretically uncharted territories. Their narratives helped to explore issues surrounding deficit-focused paradigms of addiction

treatment. They participated in the development of a social constructionist model to help understand discourse relating to their experiences. Their narratives demonstrated how overcoming serious alcohol problems can involve multiple knowledges, journeys, roads, and uncharted territories in the quest for a more fulfilling, more meaningful life. Several implications for social work practice were discussed regarding assessment, therapeutic approach, and resource development.

One of the most significant concepts of the discipline known as cultural studies is the idea that knowledge is relative; there can be no end point. Consequently, there is no conclusion for this research into alternative experiences and journeys relating to alcohol problems. I hope that this information will serve to invite the possibility of openness regarding how we in the helping profession see and serve the people we are asked to assist.

In summary, the experiences of the participants in this study contradict rhetorical assumptions that are often the foundation for strategic practice in the addiction field. Perhaps the best way to address this point is through the commonly used pickle metaphor. Essentially, cucumbers can become pickles, but never vice versa. Yet this research provides evidence of pickles "reclaiming cucumberhood." This research also clearly documents participants who were able to stop the pickling process on their own without professional or conventional help. Finally, this research supports the social constructionist view of pickles and cucumbers as linguistic conveniences that serve the viewer more than the person under gaze.

The persons in this study said they were willing to volunteer their experiences, providing that their stories might offer hope and assistance for one other person out there.

I respect and reflect on their sentiment as a personal challenge, and respectfully invite you, the reader, to consider their stories when reflecting on your own practice.

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APPENDIX A: THE 12 STEPS OF ALCOHOLICS ANONYMOUS

(AA, 1976, pp. 59–60)

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 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 B: DEFINITIONS OF ADDICTION

Addiction defined by the Canadian Society of Addiction Medicine:
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A primary, chronic disease, characterized by impaired control over the use of a psychoactive substance and/or behaviour.[38] Clinically, the manifestations occur along biological, psychological, sociological and spiritual dimensions. Common features are change in mood, relief from negative emotions, provision of pleasure, preoccupation with the use of substance(s) and / or engagement in behaviour(s) despite adverse physical, psychological and / or social consequences. Like other chronic diseases, it can be progressive, relapsing, and fatal (Medicine 2002).

Defined by the American Psychiatric Association (*DSM-IV-TR*):
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Criteria for Substance Dependence:

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:
  (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
  (b) markedly diminished effect with continued use of the same amount of the substance
(2) withdrawal, as manifested by either of the following:
  (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
  (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
(3) the substance is often taken in larger amounts or over a longer period than was intended
(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use
(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
(6) important social, occupational, or recreational activities are given up or reduced because of substance use
(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused

[38] *Primary, chronic, disease, impaired control* and other items in this definition are clinical terms.

or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) (American Psychiatric Association, 2000, p. 197).

Diagnostic criteria for 291.81 Alcohol Withdrawal:

A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.
B. Two (or more) of the following, developing within several hours to a few days after criterion A:
   (1) autonomic hyperactivity (e.g., sweating or pulse rate greater than 100)
   (2) increased hand tremor
   (3) insomnia
   (4) nausea or vomiting
   (5) transient visual, tactile, or auditory hallucinations or illusions
   (6) psychomotor agitation[39]
   (7) anxiety[40]
   (8) grand mal seizures
C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder (American Psychiatric Association, 2000, p. 216).

[39] The DSM-IV-TR glossary defines this term as "excessive motor activity associated with a feeling of inner tension. The activity is usually non-productive and repetitious and consists of such behaviour as pacing, fidgeting, wringing of the hands, pulling of clothes, and inability to sit still" (American Psychiatric Association, 2000, p. 819).

[40] The DSM-IV-TR glossary defines this term as "the apprehensive anticipation of future danger or misfortune accompanied by a feeling of dysphoria or somatic symptoms of tension. The focus of anticipated danger may be internal or external" (American Psychiatric Association, 2000, p. 820).

APPENDIX C: THE MINNESOTA MODEL

Points by William White
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The birth of the Minnesota Model of chemical dependency treatment can be traced first to the arrival and spread of Alcoholics Anonymous across Minnesota in the 1940s, then to three different treatment sites in Minnesota: Pioneer House, Willmar State Hospital, and Hazelden. The philosophy of treatment that emerged and evolved within these three sites included 11 tenets:

1. Alcoholism is an involuntary, primary disease that is describable and diagnosable.
2. Alcoholism is a chronic and progressive disease; barring intervention, the signs and symptoms of alcoholism self-accelerate.
3. Alcoholism is not curable, but the disease may be arrested.
4. The nature of the alcoholic's initial motivation for treatment—its presence or absence—is not a predictor of treatment outcome.
5. The treatment of alcoholism includes physical, psychological, social, and spiritual dimensions.
6. The successful treatment of alcoholism requires an environment in which the alcoholic is treated with dignity and respect.
7. Alcoholics and addicts are vulnerable to the abuse of a wide spectrum of mood-altering drugs. This whole cluster of mood-altering drugs can be addressed through treatment that defines the problem as one of *chemical dependency*.
8. Chemical dependency is best treated by a multidisciplinary team whose members develop close, less-formal relationships with their clients and whose activities are integrated within an individualized treatment plan developed for each client.
9. The focal point for implementing the treatment plan is an assigned primary counsellor, usually recovered, of the same sex and age group as the client, who promotes an atmosphere that enhances emotional self-disclosure, mutual identification, and mutual support.
10. The most effective treatment for alcoholism includes an orientation to AA, an expectation of "step work" groups that combine confrontation and support, lectures, one-to-one counselling, and the creation of a dynamic "learning environment."
11. The most viable, ongoing, sobriety-based support structure for clients following treatment is AA. (White, 1998, p. 209)

APPENDIX D: 16 STEPS FOR DISCOVERY AND EMPOWERMENT

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1. We affirm we have the power to take charge of our lives and stop being dependent on substances or other people for our self-esteem and security.
2. We come to believe that God/the Goddess/Universe/Great Spirit/Higher Power awakens the healing wisdom within us when we open ourselves to that power.
3. We make a decision to become our authentic Selves and trust in the healing power of truth.
4. We examine our beliefs, addictions, and dependent behaviour in the context of living in a hierarchical patriarchal culture.
5. We share with another person and the Universe all those things inside of us for which we feel shame and guilt.
6. We affirm and enjoy our strengths, talents, and creativity, striving not to hide these qualities to protect others' egos.
7. We become willing to let go of shame, guilt, and any behaviour that keeps us from loving ourSelves and others.
8. We make a list of people we have harmed and people who have harmed us, and take steps to clear out negative energy by making amends and sharing our grievances in a respectful way.
9. We express love and gratitude to others, and increasingly appreciate the wonder of life and the blessings we *do* have.
10. We continue to trust our reality, and daily affirm that we see what we see, we know what we know, and we feel what we feel.
11. We promptly acknowledge our mistakes and make amends when appropriate, but we do not say we are sorry for the things we have not done and we do not cover up, analyse, or take responsibility for the shortcomings of others.
12. We seek out situations, jobs, and people that affirm our intelligence, perceptions, and self-worth and avoid situations or people who are harmful, or demeaning to us.
13. We take steps to heal our physical bodies, organize our lives, reduce stress, and have fun.
14. We seek to find our inward calling, and develop the will and wisdom to follow it.
15. We accept the ups and downs of life as natural events that can be used as lessons for our growth.
16. We grow in awareness that we are interrelated with all living things, and we contribute to restoring peace and balance on the planet. (Kasl, 1992, pp. 338–339)

APPENDIX E: PRINCIPLES OF HARM REDUCTION

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Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use to managed use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself.

Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition or formula for implementing harm reduction. However, the Harm Reduction Coalition considers the following principles central to harm reduction:

- Accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them, and both affirms and seeks to strengthen the capacity of people who use drugs to reduce the various harms associated with their drug use.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviours from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.
- Calls for the non-judgemental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harms.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harms.
- Does not attempt to minimize or ignore the many real and tragic harms and dangers associated with licit and illicit drug use. (Harm Reduction Coalition, 2003)

APPENDIX F: INTERVIEW QUESTIONS

I'm trying to determine how conventional ideas about "addiction" and "recovery" interfere with certain people's efforts to change, and what professionals need to know from their experience…

Now…

1. How would you describe your relationship with alcohol today? How is this different from the way it used to be? How has this influenced the way you see yourself?

Then…

2. What led you to believe that you needed to address this problem in the first place?
3. What were the best and the worst things about your drinking?

What Happened…

4. How did you manage to reclaim your life from alcohol problems?
5. What are the most significant (positive or negative, affirming or surprising, defeating or empowering, or…) highlights regarding your own journey toward overcoming the impact of addiction in your life? What did these experiences tell you about yourself?

Why…

6. What is your perspective on the 12-step programs such as AA from your experience?
7. What are your impressions about the idea that "alcoholism" is a disease?
8. If the founders of AA were to ask you for advice about changing their program, what ideas would you suggest?

So…

9. Imagine that you have been given a magic wand, which will help you create the ideal circumstances for people like yourself to resolve their addiction problems. What would you like to do?
10. What do you think that professional people (social workers, therapists, and the like) need to know from your experience about overcoming an addiction?

And…

11. What motivated you to want to be a part of this research, and to do this interview?

Is there anything else that you would like to discuss that you think we haven't covered in this conversation?

APPENDIX G: RESEARCH INFORMATION AND CONSENT TO PARTICIPATE

Thank you for your interest in helping me explore the journeys people make from a lifestyle of addiction. I am attempting to find interested people to interview by speaking with others who have already participated in this study.

My purpose for this work is to understand how the experiences and needs of those overcoming addiction, without the 12-step / disease model culture, impact social work practice. This work will create opportunities for the voices of people who prefer alternative ways of healing from alcohol addiction to be heard

- by others who are attempting to deal with addiction in their own lives, and who are struggling with the 12-step approach or the "__ Anonymous" culture
- by social workers and counsellors like myself, therapists, or other professionals who try to help people in these circumstances.

This research will be used toward a thesis to complete my Master of Social Work degree, but will also be used toward informing professionals and developing resources for people who cannot heal in a 12-step culture / community.

If you decide to participate:

(A) I will arrange with you a time when we can have an interview. During our conversation, I will be inviting you to discuss your thoughts and feelings about some questions that I have attached for your consideration. Your involvement is completely voluntary; you have the right to withdraw at any time.

(B) Your anonymity will be protected, by changing names and other information that would serve to identify you. Please discuss other ideas you have about protecting your anonymity.

(C) I will be recording our conversation to ensure that the documentation of your thoughts and experiences is accurate. I will also make arrangements with you to review the written transcription of our discussion so we're both sure that it's accurate.

(D) No one will have access to the tapes or transcription of the interview except for certain trustworthy persons who will transcribe the tapes. All documents, interview tapes, and transcriptions will be kept secure. The tapes will be stored until the research is completed.

(E) Once you are satisfied with the written transcription, you can choose to either allow me to destroy the information on the tapes, or allow me to retain the tapes under the same security measures for a specific future purpose that would meet your satisfaction (this will require your written permission).

(F) At this time I will also make arrangements to discuss progress in the research with you (to make sure the process honours your thoughts and perspectives), and discuss your preferences for obtaining a copy of the completed research results.

(G) I want to ensure you will be satisfied there is no risk for you concerning this study. If you have concerns or questions throughout this process, please talk with me. I can be reached at

APPENDIX I: LETTER TO PARTICIPANT

October 21, 2002

PERSONAL & CONFIDENTIAL

Claire[41]
[address]

Dear Claire,

I want to thank you for your kindness and consideration in providing me with your stories, perspectives, and insights during our conversation on August 1. It was a treat to talk with you! I've been working away on this research, and wanted to get back to you about some of the ideas and themes I've been wondering about while reviewing conversations from all of the participants.

I've enclosed a copy of the transcript I produced of our conversation, for your personal use. I confess using some editorial license, as I described in the interview. Whereas your side of the discussion is concise, clear, and succinct, I find that I use my words like a postmodern artist: I generally throw loose phrases and ideas out there, and wait to hear if others get my gist! In order to make my side of the conversation comprehensible, I tightened up my sentences. My criterion for the editing was to maintain the intention and meaning of discourse. I'd appreciate your feedback about the transcript; after all, even the punctuation and grammar reflects my bias of your conversation.

In order to expedite matters, I've taken the liberty of trying to put some ideas together regarding the themes within participant stories, so I could check with you to see if these ideas honour your experience. As a result, I dove into the process and quickly became overwhelmed by the number of different themes, metaphors, perspectives, and meanings of the stories collected. For example, you are one of three participants who each had many years of experience in 12-step programs, and who were able to resume an active, manageable relationship with alcohol. Two other participants have succeeded in abstaining from alcohol and never sought assistance from counsellors or self-help groups. Finally, one participant has a story very similar to yours, but is reappraising his relationship with alcohol after overstepping his own boundaries about responsible use. As you may imagine, there are at least two very distinct and seemingly exclusive journeys discussed!

I found that in order to make sense of the information, I had to develop a model of sorts, which I've tried to describe in a summary I'm enclosing. The essence of this framework is that people who overcome addiction in their lives have an identity that is

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[41] The name has been changed for the purpose of anonymity and to ensure the integrity of the participant's information, referenced using this same pseudonym elsewhere in this document.

constantly negotiated, mediated in relationship with different cultures, in proportion to their experience with those cultures. I don't believe the model is as complicated as it may sound.

Claire, I need your input regarding this general model and the themes I've inferred. It is important for me to know if these ideas honour your experience. I'd really appreciate it if you'd call me with your feedback, and I want to ensure your anonymity regarding any insights or recommendations you offer.

The information from your conversation with me has made a very significant difference in the work. Whereas other participants made recommendations for social work practitioners to consider, your comments were grounded within the context of clinical / therapeutic professional practice, adding immensely to the credibility of the ideas discussed. You are the only participant who continues to maintain a positive relationship with the 12-step fellowship community, as well as the only one who is employing a program (Charlotte Kasl's 16 steps) in your everyday life. Your stories and insights really enriched my study; thank you for this gift! Naturally, any feedback you can offer me regarding the framework I developed and the themes I've generated will be used to ensure your experience is integral to the work.

I'm looking forward to hearing from you at your earliest convenience (I'm flying at this to see if I can get the work submitted by the end of the year). Meanwhile, I hope that you and your family are happy, healthy, and that you're continuing your holistic integrated practice. Thanks again for your kindness and interest,

Sincerely and gratefully,

Jeff Talbot,
Student

Encl: Transcript of conversation, Tape G, and
Summary of conceptual framework and thematic development.

APPENDIX J: FRAMEWORK DRAFT FOR PARTICIPANT CONSIDERATION

What I heard from their stories:

Social Construction, Identity and Culture: A Sketchy Model

The participants' conversations reflect their present sense of identity or self-concept, situated "now," temporally in context to their story including their history / herstory, and their future. Their narratives include stories of their experience with different alcohol-related environments, arguably considered as cultures. Each of these situations involves other people, specific and exclusive rituals, practices, and meaningful experiences. Viewing these different milieus as culture has been accepted practice.

Though participants' narratives resemble a generally linear story line, each person's current identity has been cumulatively impacted by their experience within each of these cultures. Each of these culture's rhetorical views of the person's current relationship with alcohol is a mediating factor in the person's self-concept and her / his identity. Consequently, there is an ongoing relationship between personal self-concept and different cultures, proportional to the person's experience, where meaning and consequent identity integration is constantly negotiated.

CULTURE AND IDENTITY are mediated and expressed through

STORIES:

Each participant's conversation is a story,
Within each conversation, each participant had a number of stories, allegories to reflect turning points, best / worst moments, and so on.

METAPHORS REFLECTING CULTURE:

"A friend of Bill's," "I took the pledge," "I have an intimate relationship with alcohol today," "Cunning, baffling, and powerful…," "I was firmly captured and imprisoned by the alcohol," "the word of recovery"…

GOOD / BAD APPRAISALS:

This "inventory process" is a strong descriptor of change, and is a significant part of a number of important therapeutic models. The following examples are about experiences with AA.
"It was like they were a pack of f-----g dogs…"; "I could not sit there and listen to these people step up to the podium and tell me their lives are s--tier than mine"; "To give AA their due, I learned some good things there"; "It gave me people to be with that were trying to stay sober too"…

EVERYDAY LIFE EXPERIENCE:

This is the "common ground" between personal experience, social and cultural context, and theoretical perspectives. The medical model tends to

minimize the "everyday-life" context, reducing phenomena into pathological criteria.

THEORETICAL PERSPECTIVES / DEVELOPMENTS:

Explanations regarding identity, relating to alcohol history, cultural rhetoric, and current lifestyle; "The pain and anxiety of growing up in that household, that's why I drank"; "Alcohol, it isn't the substance that's the problem, it's the user"; "No, you've got to help yourself, you say I'm not going to drink anymore"; "It's about a number of things. It's about running, it's about not facing reality. It's about fear. It's about pain."

INTEGRATION STATEMENTS:

Affirming statements regarding self-concept in relation to cultural influence: "Let's say I was an alcoholic"; "The choice I made I feel great with"; "I didn't make this decision thinking everybody was going to accept it. I didn't make it for them, I made it for me."

CULTURES: Including the following:

"OLD RELATIONSHIP WITH ALCOHOL" CULTURE:

The culture and life about the "old drinking days"
Stories: families of origin, patterns and consequences of drinking, the good and bad times
Metaphors: "selling my soul"; "life of the party"; "hitting bottom"
Good / bad appraisals: having status as a "bad dude"; "people who drank weren't boring"; "I still have great big marks across my chest here from the ruptures, from seizing."
Everyday life experience: "After a couple of days we would keep drinking because we were scared to stop – we knew what was coming"; "I always liked vodka. Not that I'd drink it straight…and I always measured it."
Theoretical perspectives: "I grew up in an oppressive environment, rife with sexual, physical, and alcohol abuse!"; "I think that definitely there is a chemistry difference between people with addictions and others."
Integration statements: "I like to think of myself as a piss tank"; "I refuse to go back to where I came from—it ain't gonna happen."

12-STEP CULTURE:

Life in Alcoholics Anonymous or other fellowships
Stories: about AA rituals in the meetings, the steps and practices, from service work to sponsorship, friendship, relationships, and another chance.
Metaphors: "turning it over," "twelve stepping," "easy does it," "spiritual awakening," "program," "higher power."

Good appraisals: support, a sense of belonging; "I'm eternally grateful for 12-step programs"; "I do sincerely know what it means to be grateful. Where did I learn that? I learned that there. So [wiping tears], necessary evil. Gain as you lose."
Bad appraisals: "diseased" identity, stories of severe judgements and abusive people, patriarchal culture.
Everyday life experience: "In those years, it was a great source of pride, to have not drank for ten years, because I met very few people who had done that."
Theoretical perspectives: "AA taught me that I'm a loser…so I was basing my life and who I believed I was on my supposed greatest weakness."
Integration statements: "I'm not willing to abdicate my power to another set of a--holes"; "Was it worth the pain? Hell yes, but I've grown."

"NEW RELATIONSHIP WITH ALCOHOL" CULTURE:

Themes include refusing rhetoric and reclaiming life as a responsible user of alcohol. These persons each have experience in 12-step groups, and their narratives are similar to the "migration of identity" concept.
Stories: Exit stories, ambivalence, consulting others, others' reactions, first drink, success.
Metaphors: "Taking a risk," "I've changed paths," "He planted a seed."
Good / bad appraisals: "I cleaned up and I had nothing and I've worked hard for what I have today. I didn't want to lose it, but at the same time I really felt like I wasn't really being me"; "I had nothing to be ashamed of if I was wrong."
Everyday life experience: "I had my first drink with my father at my sister's wedding…What my dad said was, "Do you realize this is the first time we've ever had a drink together?" And I said, "Yes Dad," and he said, "Cheers."
Theoretical perspectives: "I learned how to manage my drinking"; "She believed I had learned enough, and had enough tools, and had enough self-esteem in life to be able to drink"; "Everybody is an individual…stop clumping people with addiction issues into one certain criteria."
Integration statements: "I stepped off into the world"; "I don't view myself as an alcoholic anymore. The truth is I never was"; "I had to get to a point where I was okay with me no matter what"; "I am the one making the decision."

ABSTAINER / PIONEER CULTURE:

The experiences of those who chose to quit drinking without the help of therapy, 12-step fellowships or using the medical model.
Stories: Borrow a little rhetoric from addiction culture, and have a transparent "Zen" quality reflecting responsibility and behaviour. Stories honour self-reliance, family life, and health.
Metaphors: "Every moment is a choice," "Take each day as it comes." family support, better life.

Good / bad appraisals: "To me rock bottom is…where you think that your life is not going forward anymore"; "There's lot's of people like me. Except that I had to quit. Spoil a perfectly good record by having to quit."
Everyday life experience: "I don't have the kids worrying if there's going to be a huge fight tonight…they have a safe place…I've got a wife that knows I'm going to be to be home every night"; "Personally I've never relied on other people."
Theoretical perspectives: "I believe that it is a mental thing…you have control over that"; "I knew I had something to look forward to…I guess that's why I didn't die."
Integration statements: "The choice I made I feel great with"; "I can't see myself ever drinking again. It's gone. It's just one of those things that happens in your life."

IDENTITY:

The participants in this study shared the following attributes; these qualities were demonstrated through their stories.

Strong conviction / belief in themselves: These people demonstrated on occasion through their stories the courage to look at themselves, and take personal responsibility for their behaviour.

Focus on their abilities and capacities: Narratives tend to reflect a focus on what they were able to achieve, their strengths, and their successes.

Challenge / resist limiting rhetorical semantics: All of the participants were resistant, to some degree, to invitations to embrace rhetorical perspectives that objectified, pathologized, or categorized them in a manner limiting their discretion in making their own self-appraisals.

Adapt: All of the participants demonstrated significant achievement in changing their lives. One participant who was ambivalent about his current alcohol use during the interview has now quit, based on careful self-appraisal, on his own. All of the participants have borrowed strategies from 12-step programs, or developed strategies from their own efforts, to maintain their successes. Participants' self-concepts were dynamic and changeable via interpretation of the meaning or significance of experience; similar to the concept / metaphor of re-authoring history.