Recovery from drug addiction: Discursive feats in the reconstitution of lives

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ABSTRACT

This study seeks to explore addicts' experiences of recovery from drug addiction in the context of contemporary discourses surrounding the topic. It takes as its departure point the idea that subjective psychological realities are set against a socio-cultural backdrop and are thus mediated by language. Of particular significance is therefore the role of discourse in the perception and experience of drug use and recovery. As such, the aim is to depart from accepted notions of the recovery process as being an individualised negotiation, but rather, one that is mediated by hegemonic social mechanisms underlying the reproduction and dissemination of mainstream treatment discourses. Findings from this qualitative analysis indicated that the recovery process appeared to be facilitated by the construction of the life-story narrative using a repertoire of *12-step* discursive resources, which had the effect of reconstituting the reality of participants' selves and past lives. Consequently, participants were observed to have constructed an enduring 'fellowship-addict' identity, which was to be carried with them into the future. Rhetorical strategies by which *12-step* conceptualisations of addiction were rendered amenable to recovering addicts included the medicalisation of deviance, the restriction of access to recovery resources, and the limitation of alternative discourses for self-actualisation.

Key words: addiction discourse; recovery; 12-step; drug addiction; identity; narrative.

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In Western societies today, there is a prevailing assumption that the field of rehabilitation for drug addicts is characterised far more by failure than success. Across the spectrum, the South African National Council on Alcoholism & Drug Dependence (SANCA) has reported a steady increase in alcohol and drug disorders, these being patterns of use of a maladaptive and clinically significant nature (Plüddemann, Parry, Bhana & Fourie, 2008). Worldwide, the issue of drug dependence is said to be one of the three leading causes of disability and behavioural disorders (Kresina, 2007), and the risk factors associated with intravenous use and the HIV virus has compounded this problem exponentially. Subsequently, the market for treatment facilities has flourished. Interestingly, the high failure rate of treatment initiatives in South Africa's major cities is not usually recognised by surveyors as a problem of approach or treatment philosophy, but rather, as a of lack of funding, infrastructure and the nature of addiction itself.

Davies' (1997) work on addict's conceptualisations of addiction showed that explanations appear to derive in predictable ways from the various settings and circumstances in which they find themselves. With regard to institutionalisation, these types of attributions appear to have significant implications for treatment outcomes. In view of this, it has been noted by Brill (1972) that successful treatment is usually associated with the acceptance of the particular ideology inherent in an institution's teachings and is used as an organising force in the life of the graduate.

What this alludes to is the importance of 'goodness-of-fit' in terms of user and approach, but also an awareness of the role of language in behavioural outcomes. Studies have found that repeated explanations in terms of stereotyped identities may eventually translate into these types of behaviour (Davies, 1997). Furthermore, explanations are not merely factual descriptions of events; they are functional statements motivated by particular ends, and affected to a large extent by the macro and micro cultural or social contexts in which they are verbalised. Thus, discourses surrounding the use and abuse of psychoactive substances is therefore of particular significance for researchers in this field. In fact, it has been suggested that the failure to accommodate discourse in the analysis of socio-theoretical phenomena damages the theoretical and empirical adequacy of it (Potter & Wetherell, 1987).

In this study, the process of recovery, as mediated by prevailing addiction discourses, is explored. Particularly, attention is paid to the social, hegemonic mechanisms by which recovery and addiction come to be understood, and what consequences these cognitive transformations have on the lives of former drug users. Following now, is a brief review of the relevant literature.

Addiction discourse

The literature on psychoactive substance addiction recognises this phenomenon as a highly variable and somewhat elusive experience. In its manifestation, substance addiction is said to be a chronic condition in which compulsive drug-taking behaviours, accompanied by social, psychological and physical dimensions, persist despite the overt negative consequences it produces (Cami & Farre, 2003). There are three core threads of the addiction theory literature, each which propose a variation on the root of addiction. These include the bio-medical search for pathologies residing in the individual (Davies, 1998), an epidemiological investigation of pathological populations (Gibson, Acquah & Robinson, 2004), and a contextually based theory, in line with a Foucauldian lens that emphasizes sociological conditions and socio-historical considerations (Foucault 1981 as cited in Hughes, 2007). It appears then that there is a certain confusion or disagreement as to the appropriate site of responsibility regarding the addiction process and this has important implications for users' understandings of their experiences.

In Western industrialised countries, the prevailing view of addiction is that it is a disease entity- a biological and individually based affliction (Gibson et al., 2004, Hughes, 2007, Reinarman, 2005) that accounts for the addict's flawed character and extreme lack of personal control (Brickman, et al., 1982). This conceptualisation of addiction has come to be known as the disease model and appears to be so widely accepted that alternate views on addiction barely enter into conventional clinical thought. It is based on the premise that sufferer's of addiction may be alleviated from their guilt and shame as an addict, and surrender to their powerlessness (Brickman et al., 1982). Prevailing addiction discourses epitomise the *12-step* philosophy on addiction and recovery and represent the foundation of most mainstream treatment institutions. (Crabb & Linton, 2007, Radcliff, 2008, Room, 2005). The core tenets include the disease model, admitting powerlessness and one's problem and seeking salvation through spirituality (Caine, 1991). See Appendix 1 for the 12 steps to recovery.

In the context of this study, the discourses surrounding the process of substance remission are of central significance because research has indicated that explanations as to the aetiology of addiction have performed a 'function' for the 'addicted,' that is, to qualify and reproduce many of their drug-associated behaviours (Davies, 1998). Similarly, addict's narratives and accounts of their drug-using experiences are in many respects similar to that of

their supervisors and therapists (McIntosh & McKeganey, 2000), both of which are deeply imbued with the discourses of addiction (Hughes, 2007). What this alludes to is the profound way that traditions of speaking about addiction have of informing the experience and view of the 'recovery' process.

Analyses of contemporary 'addiction' discourse have regarded it as a burgeoning social and cultural myth (Akers, 1991, Hammersley & Reid, 2002). The 'addiction myth' encourages the view that drug dabbling leads to the inevitable decline into the inescapable lifestyle of the 'junkie.' Essentially, it postulates that substance abuse is epitomised by addiction- the biological and chronic state of being dependent on a psychoactive substance (Reinarman, 2005) - and therefore is a moral claim on how *not* to behave. This moral reproof has its roots in the modern values of individualisation and self-control, and it is in this context that addiction is regarded as a social construction, a kind of discursive practice, because its parameters reside in the cultural terrain (Cohen, 2000, Hammersley & Reid, 2002).

In essence, the lived experience of deviant drug use is situated within the social construction of addiction and the process of recovery is delineated to recovery from the 'addiction' and not from the self, as constituted in a complex configuration of interpersonal relations, practices and social contexts (Gibson et al, 2004, Hughes, 2007). To this effect, therapeutic environments end up treating the drug-abuser as a helpless entity (Gibson et al., 2004).

Identity work

The centrality of the self has dominated the literature on drug-user's experiences of recovery (Anderson & Mott, 1998, Gibson et al., 2004, Hughes, 2007 McIntosh & McKeganey, 2000, 2001). These articles articulate the ex-addict's experiences during recovery as an intrapsychic dilemma involving the reconstruction of a 'spoiled identity' (McIntosh & McKeganey, 2001). Earlier work, however, focussed on the 'maturing out' hypothesis (Winick, 1962), which claimed that addicts eventually adopted adult roles, leaving behind their addict ways. This argument has been supported in various other studies, which pay tribute to the role of psychological and social maturation in 'pulling' the addict towards a conventional, hassle-free lifestyle (Meisenhelder, 1977). Unlike identity work theories, these theories of the recovery position it as a passive process, with little psychological angst or struggle.

Identity work conceptualisations assert that the notions of 'hitting rock bottom' (Brill, 1972), reaching the 'end of the road' (Bess, 1972) and experiencing 'turning points' (Gibson

et al., 2004) are regarded as the moment of insight in which addicts' realise that he or she must either give up the drug habit or face death (McIntosh & McKeganey, 2001). Furthermore, it is this understanding that observations of the self have become inextricably linked to their problematic drug use, and consequently the perception of drug use is altered to one that is invariably inappropriate (Hughes, 2007). Feelings of self-loathing, disgust and shame have been widely cited (Cloud, 1988, Gibson et al., 2004, McIntosh & McKeganey, 2000, 2001, Radcliff, 2008). Arguably, this negative appraisal of 'addiction' is in part a function of the prevailing societal values which call for a certain level of participation and behaviour in society.

The subjective experience of identity work has been conceptualised as an attempt to reconstitute a self that is devoid of a pervasive drug identity (Hughes, 2007). Unlike the work of McIntosh & McKeganey (2000, 2001), these theories have paid due consideration to the interrelated aspect of identity, in terms of networks of people and practices. Interestingly, while many authors have documented this experience as a two-step process- from drug to sober identity- Howard (2006) has brought attention to the recovery experience as involving a temporary, ambiguous identification with a 'recovering' identity, which is established deliberately to be ultimately transcended.

In the context of drug and addiction discourse, it is pertinent to consider the phenomenon by which addicts have found the 'junkie identity' to have been consolidated and emphasized in treatment (Luoma et al., 2007, Radcliff, 2008, Room, 2005). Treatment institutions require a sound conceptualisation of addiction in order to 'manage' their patients appropriately- a set of assumptions which are articulated in 'treatment philosophies.' Radcliff (2008) has problematised identity work in these settings, arguing that treatment programs are in themselves stigmatising and stunt the process of reshaping identities in a positive, drug-free light. However, the question remains as to whether it is necessary, or even possible, to formulate an identity that is entirely unconnected to drug use. Other authors have argued that the fellowship nature of certain programs, particularly *Alcoholics Anonymous* (AA), have a valuable capacity to counteract the stigmatising nature of addiction disorders (Thomassen, 2002).

Narrative means to sober ends

Recovery from drug addiction has invariably been linked to narrative work (Frank, 1995, McIntosh & Mkeganey, 2000, 2001, Speedy, 2000, Taieb *et al*, 2008). The 'narrative turn'

epitomises the growing trend of researchers and clinicians to draw on language resources as a means to construct meaning, organise events in time, deconstruct the assumptions associated with traumatic experiences (Speedy, 2000) and 'do' something through their performative nature (Gibson et al., 2004). A sense of unity is said to be accomplished through the construction of an internalised and evolving narrative of the self (McAdams, 2001) and therefore the narration of the addict's progression towards recovery has been identified as a mechanism by which to make something for which there is little certainty, intelligible (Diamond, 2002, Taieb et al., 2008). In response to the dominant endorsement of narrative work, Hughes (2007) has challenged this view and argues that the focus on narrative renders the embodied aspect of drug addiction invisible.

Frank (1995) writes, however, that the shape of the story being told is invariably moulded by the rhetorical expectations of discourses of illness and recovery. This sentiment is echoed in the work by Taieb et al. (2008) which states that addicts may in fact *need* literature, in the form of books, seminars and popular culture to aid in the construction of their identities, whether past, temporary or future. Treatment initiatives provide specified story models for recovery (Prussing, 2007) and addicts are taught a lexicon through which they are required to evaluate their lives in order to make lasting changes (Reinarman, 2005).

RESEARCH QUESTIONS

Although the association between prevailing discourses on addiction and the lived experience of recovery has been established, less work has focussed on the specific social mechanisms by which these discourses are sustained and indoctrinated. The aim of this study is therefore not only to map the relationships between *12-step* discourses and addicts' interpretation of their psychological dilemmas during treatment; but also to deconstruct the process by which these conceptualisations of addiction and recovery have been rendered acquiescent. In doing so I hope to discover how discourses on problematic drug use infiltrate the recovery process; and consequently, what personal consequences this has for the individual drug user. As such, my aim is to depart from accepted notions of the recovery process as being an individualised negotiation, but rather, one that is entangled in a wider configuration of practices, practitioners, institutions and knowledge claims.

METHOD

Much of the previous research on drug addiction has been conducted using a qualitative design (Cloud, 1988, Gibson et al., 2004, McIntosh & McKeganey, 2000). Large scale surveys, although able to reach a much larger sample, have failed to examine the complex processes in which social, structural and psychosocial factors mediate individual experience (McKeganey, 1995). A quantitative approach is therefore inappropriate for this project. For example, we cannot ask closed-end questions about 'recovery from addiction' when the notion of addiction itself has been a topic of considerable debate in recent times. In general then, qualitative methods will allow me to generate meaning-rich and meaning-diverse data, that is, a collection of verbal reports that cannot be taken as scientific fact, but that requires an in depth, contextual interpretation.

Theoretical framework & design

Discourse analysis is both a theoretical perspective and a method which concerns itself with the study of how language is organised into interpretive repertoires, carrying with it substantial power to influence the way that people experience and behave in the world (Potter & Wetherell, 1987). This occurs because discourses define cultural and social resources from which meaning can be made and as such, they constitute subjective psychological realities (Jorgensen & Phillips, 2002). Social phenomena are therefore understood as social constructions.

Discursive psychology posits that verbal accounts cannot be taken on face value as truths, but rather as responses which constitute discursive acts; that is, a kind of social action that achieves an end. Motivations underlie particular types of verbal reports and in this respect, speech is functional (Potter & Wetherell, 1987). The functions of speech are located in their context, since social conditions give rise to the forms of talk available.

Drug addicts are considered to be a sub-cultural group, and in the past, discursive psychology has been successful in its ability to comment on the social processes which contribute to the maintenance of structures of oppression (Burman & Parker, 1993). Particularly, certain discourses represent such structures of oppression. Access to discourse, particularly privileged access, is a crucial resource of power and can inhibit the kinds of meanings that are made (Van Dijk, 1993). When access to recovery discourses are controlled and limited by institutions, this puts the addict population at a considerable disadvantage.

Furthermore, when recovery is made to be synonymous with a medical model of addiction, and addicts are obliged to submit to this avenue of recourse, then addiction-as-disease discourse and those who embody it can be considered hegemonic.

Participants

Ten participants were recruited on the basis of their subjective identification with a recovering 'addict' identity, and who were currently occupying a counselling role within one of the various drug treatment facilities in the Cape Town region. Although this sample is limited in number, studies of a qualitative nature are primarily concerned with acquiring in-depth meaning in a specific context, and its scope is therefore justified. Objective measures were not used to verify participants' 'recovering' status as this was seen as inconsequential in exploring their personal interpretation of the recovery process. The focus on counsellors in particular hoped to bring to light the ideological functions of discourses that are embedded and exchanged within the institutional settings in which these roles are enacted. Furthermore, this sample represents a population that is in direct, day-to-day engagement with concepts relating to addiction and disease; concepts which are assumed to be internalised on the basis of affiliation with particular institutions.

An initial set of participants was contacted via a government sponsored internet directory of drug treatment facilities in the Western Cape region (CapeGateway, 2009). Due to the nature of this community of 'wounded healers' (Frank, 1997), most participants were very enthusiastic about sharing their stories and aiding me in my research. Willing persons were recruited, and from there on snowball sampling was used whereby existing participants offered recommendations and contact details of acquaintances in the field. The sample that was developed consisted of four female and six male, white middle-class individuals, ranging between the ages of 28 and 59 years old. Of these ten, ex-heroin users comprised 40% of the sample, and ex-alcohol and cocaine users constituted 30% each. It was common for participants to have dabbled in a variety of substances, but these figures represent the composition of drug-of-choice. Despite the degree of symptomatic variation among these addiction sub-types, my interest lies in the subjective experience of recovery through which an overarching identification with the 'addict identity' is mediated.

The skewed demography of the sample appears to characterise this disproportionate representation of race and class within the population of registered therapeutic workers in Cape Town clinics. The reasons for this are beyond the scope of this study, but perhaps hold

an interesting avenue of research for future studies. Another dimension on which participants varied was the time spent in active addiction, and the number of years in recovery. See Table.1 for details. It is reasonable to assume that the structure of addict's stories may differ as a function of these variables.

Table 1. *Summary of Characteristics of Participants*

*Name**	*Age*	*Sex*	*Drug-of-choice*	*Years spent in Active Addiction*	*Number of years in recovery*
Alison	35	F	Heroin	11	6
Craig	39	M	Cocaine	10	3
Debra	25	F	Alcohol	2	4
Diane	44	F	Cocaine	2	7
Graham	42	M	Heroin	9	5
Ian	47	M	Cocaine	20	7
Matt	49	M	Alcohol	16	10
Megan	58	F	Alcohol	4	7
Ryan	36	M	Heroin	6	9
Sean	28	M	Heroin	7	3

*Pseudonyms

Data collection

In pursuit of the research agenda, narrative data was gathered during an hour-long face-to-fact interview with each participant in order to examine the construction of their recovery experiences. The interviews were semi-structured, so that participants were 'steered' rather than forced in the direction of the research focus. Semi-structured interviews can be likened to a conversation between the researcher and the participant in which the researcher encourages a general direction of enquiry without imposing a structure upon the interaction (Babbie & Mouton, 2001). As such, this kind of qualitative interviewing is especially fitting in exploring the ways in which discourses are utilised because they encourage this kind of flexible, iterative process which simulates 'naturally occurring interactional talk'.

Questions, in this context, function as subtle probes that are adept at exploring depth without biasing subsequent answers. I allowed the participants to take primary responsibility for the direction in which they took the interview; however, in the attempt of fostering the

telling of stories, it was important to facilitate this process by asking open-ended questions about temporally located experiences and meanings (Riessman, 1993). Refer to Appendix 2 for the interview schedule.

Interviews were then recorded on a digital device and transcribed verbatim. In the case of poor sound quality or misunderstandings, participants were contacted telephonically and asked to recount those areas of concern. Furthermore, prior to the interview, participants were required to read over and sign a consent form (see Appendix 3), which informed them about the use of their data, their rights as a participant and the protocol for future communications and debriefings.

Data analysis

The interview transcripts were analysed into form and content using a narrative approach, while a critical discourse analytic framework was used to analyse how the stories and their content were shaped by discourse. Deriving from Riessman's (2005) typology of narrative techniques, structural narrative analysis was performed in order to focus on *how* stories were framed as opposed to simply categorising themes. Theoretically, structural narrative analysis aims to uncover the central 'message' of stories, and the means by which tellers make their stories persuasive. Hence, key structural elements of the stories were identified, encompassing temporal orientation, complicating action or turning points, resolution and evaluative commentary. Special attention was paid to context, for it defines the kinds of cultural and social resources from which meanings can be made. Important questions asked therefore included: "For whom is the story told?" "Are there signs of intertextuality?" "How does the story frame its protagonist?"

Narrative methods are adept at highlighting the existence of particular discourses, especially in stereotyped stories. Critical discourse analysis (CDA) therefore provided the lens through which the meaning inherent in the narratives could be conceptualised. CDA is a radical approach to discourse analysis that pays special attention to the relations between discourses, power and social inequality (Van Dijk, 1993). Specifically, it tries to explain changes that occur on a social level to changes in discourse and how these kinds of transformations occur as properties of social structure and interaction (Fairclough, 2005). Its principal tenets are therefore that power relations are discursive; that discourse constitutes society and culture; and that discourse performs ideological work that is visible only through a deconstruction of text (Fairclough, 2005). As such, CDA is an interdisciplinary approach to

studying text and draws upon the resources of discourse analysis while paying particular attention to these core issues.

The initial step of analysis took the form of a content analysis in order to identify the various ways in which the discursive focus was constructed in the text. Hence, I asked the question, "How do participants speak about 'recovery from drug addiction?" This 'aboutness' of the text was mapped by organising various themes and topics into discrete clusters. Discursive objects and subjects were then identified and analysed in terms of the functions that they appeared to serve, both institutionally and individually. A key question concerned the manner by which addicts, as subjects, were framed by prevailing discourses and this therefore involved a close reading of the connotative value of language in particular contexts.

More specifically, performing a CDA requires knowledge of how particular groups exhibit their power through discourse (Fairclough, 2005). Commonly, modern hegemonic groups attain power through cognitive strategies which enable them to manufacture consent. Van Dijk (1993) refers to this as 'mind control' where the group under consideration is persuaded to adopt particular beliefs and opinions in a manner that appears to be for their own interests and of their own accord. This process occurs via the manipulation of mental representations so that the in-group discourse achieves salience and desirability, while alternative discourses are neglected and framed in a negative light (Van Dijk, 1993). Hence, special attention was made in identifying the representation and availability of discursive objects surrounding drug use by focussing on elements such as connotation, tone, style and framing.

According to Lieblich, Tuval-Mashiach and Zilber (1998), analysis in qualitative work requires listening to an additional analytic voice - the reflexive voice. Specifically in narrative studies, meaning is co-constructed via the interactional process of dialogue, and this means that special attention must be made to interpretation in pursuit of validity. An acknowledgement was therefore made to both explicit interpretative forces, which concerned research expectations, but also implicit frames of reference such as my own discursive orientation. Furthermore, as meaning in the current study was understood according to its functionality in context, it was important to deliberate carefully over the extent to which meaning could be made beyond the original text. The problematisation of context therefore ranged from forces within the interview context (researcher-participants interactions), to the personal lives of the participants, and the broader sociocultural discursive environment in which all were operating.

FINDINGS & DISCUSSION

In general, findings indicated that participants' institutionalised recovery from drug addiction appeared to involve the retrospective reconstruction of their life-stories via the hegemonic acquisition of core discursive devices. Consequently, transformations in identity were steered towards the adoption of an enduring 'addict' identity, as articulated by *12-step* philosophy.

Thinking in narrative form

As was expected, an initial analysis of the interview transcripts indicated that recovery from drug addiction centred on the process of constructing a coherent life-story narrative. In this sense, the narrative served as a cognitive tool for organising the chaos of life in 'active addiction' into a logical sequence of events so that destructive behaviours could be scrutinised. Without recovery, as Blomkvist (2002) notes, narratives remain fragmentary, displaced and contradictory. For the participants, recovery therefore involved coming to terms with what it meant to be addicted by situating the addiction within the context of their life stories. For this reason, the actual time spent in treatment programmes occupied an insignificant role in participants' explanations of the recovery process. Their accounts of treatment were poorly specified and little to no mention was given voluntarily to the experience of detoxification. Sean and Graham's accounts of treatment programmes reveal this trend well:

> So, I arrived and went through 28 days at Kenilworth clinic...Um...it took me about 3 weeks to detox, to become normal in the physical sense, although I was still very mentally ill of course. But so I was basically there for 3 weeks, so from there I went to extended primary at Tabankulu in Kommetjie for 3 months, then I went to Tharaguay for 2 months, where I work now, and then I went to tertiary Tabankulu for one month, and then I rented a flat with a friend (Sean).

> Ya...I was in rehab for 9 months, and I really enjoyed the process...and I got into the movie industry before but when I left rehab I got into the restaurant business (Graham).

Participants portrayed institutionalised treatment as a simple train of events. Instead, the transformative process of recovery took place within the broader context of a series of life

events, and as such the task of recovery was conceptualised as a linguistic construction. This constructivist nature was apparent in the rehearsed character of many of the stories, such as in Alison's narrative: "His name was Rob...that's important- it comes up *later,*" and Matt's: "I'll come back to that just now...so, from 30..."

Accounts of experiences with drugs and addiction therefore appeared as crystallised structures of thought, representing the life-story, and as such they progressed in a chronological order. Alison began her account at the beginning of her relationship with drugs and indicates that the motivating force was grounded within the circumstances of her family life:

> So...as a school girl, I went to an all-girls school, I started using Thins, which has a component of ephedrine in them. It gave me the opportunity to burn the candle at both ends...I come from a family of high achievers.

She indicates progression by the use of time-reference words such as 'eventually' and recounts her addiction as initially being a positive experience:

> I eventually got quite enamoured by the drug culture scene in Cape Town at the time, the rave partying scene. Loved it, and the idea of it and very quickly it stopped from using elicit chemicals to illicit ones.

Finally, at age 29, Alison describes how she was offered a place in a psychiatric unit where she was able to reflect on her life, a practice which served as the precursor to full recovery:

> Thankfully one of the nurses came up to me and said why we don't book you a bed in the psychiatric unit...and I had time there to reflect alone. I was in secondary phase withdrawal so it wasn't a pretty time, but it was time by myself, and I think that it was a turning point where I came to the conclusion that I had nothing left...

This theme of requiring a moment of reflection on past events in order to embark on a process of recovery was common to almost all accounts and it represents the point in which drug-using experiences could be conceptualised as problems likely to wreck further devastation in the future. Graham speaks of his experience of profound poverty as being a "good thing because it brought [him] down to reality from planet cuckoo land." Ian described

sitting in a nephew's house in which he had "this epiphany" where he realised that his life was going nowhere, and after which he decided that "that was it!"

Narrative studies on recovery from drug addiction have indeed observed this phenomenon whereby retrospective appraisals of life render the past comprehensible and amenable to interpretation (Ricoeur, 1991). Narratives therefore enable a foundation upon which recovery can be conceived. By imposing order on past events, a trajectory for the future is set up and this provides guidance for prospective action (Howard, 2006). Hence, after his "flash of insight," Matt saw his behaviour for what it was, as the process of reflection allowed him to make the connection that he had a drinking problem and that "today [was] going to be like every other fucking day." Insight into the future allows the addict to pre-empt his/her actions. This view departs somewhat from Hyden's (1997) notion of the narrative as simply serving as a means to *convey* recovery. Instead the construction of the narrative is taken to be a vehicle in which recovery may take place (Frank, 1995, McIntosh & Mckeganey, 2000, 2001) and therefore accounts for the similarity in structure within the transcripts.

Previous research has implicated the capacity to craft a continuous narrative in the process of identity formation (Rimmon-Kenan, 1999). In fact, McAdams (2001) has argued that identity does not only involve narrative work, but that identity *is* a life-story; one that has been internalised and "contoured by the person's current goals and anticipations of what the future might bring" (p.117). Without the ordering of life-events in a logical sequence, a pattern of the self cannot emerge.

Reconstituting lives

One of key findings of this research undertaking was that participants appeared to have reconstructed their life stories in a retrospective fashion, reinterpreting events through the lens of recovery. Recovery, as described by others, is a culturally-specific evaluation, and therefore the transition to 'health' requires of the individual that they reorganise a matrix of cultural knowledge into their own self-understandings (Cain, 1991; Hyden, 1997).

The treatment context appeared to play a major role in facilitating this process of retrospective insight, particularly with regard to the effects and causes of addiction. Ryan mentioned, "I realised I was really depressed...well, they said you are really really depressed." Matt repeatedly qualified his accounts by reminding that "I didn't know at the time," "I had never made the connection" and "I didn't realise at the time". Similarly, Megan

responded to a question about why she was not managing to control her drinking by answering, “Well, look I know now how it works...I know now that that, you know, I was fully in the spiral of addiction.” This phenomenon resembles what Pillemer (1998) has termed *retrospective causality*; a reinterpretation of the past events as symptoms of an underlying cause and which is only made possible in a time-locked sequence of events as in the narrative.

For Alison, the terminology provided to her within the treatment setting gave her the resources for retrospectively understanding her behaviour during ‘active addiction’. She stated, “I saw myself get sloppy. I called it sloppy because at the time I didn’t have the terminology to describe what was going on with me...it was actually me getting more and more powerless.” This use of recovery jargon in explaining events was apparent in many of the narratives. Sean talked about his tendency to “isolate” when using drugs; “I’d kind of isolate, stay in my room.” The use of the verb without its necessary object indicates that the word has been claimed by recovery programmes as a short term to describe ‘addict-type’ behaviour. Other forms of jargon could be seen in Matt’s accounts. He spoke about the fact that his father grew up as an “adult-child”, a term specific to alcoholic circles:

> Have you heard of the term adult-child? It’s not really a mainstream psychological expression although mainstream psychology has adopted it. It’s a broad term in the recovery industry...well, anybody who grew up with an alcoholic parent...

The adoption of jargon is important to studies of a critical nature as it highlights the transformation of identities, which as a mental construct, tells us much about the frame of reference of group members and the kinds of ways a person is likely to act in the world (Cain, 1991). This stems from the critical discursive perspective that language is a potent carrier of cultural meaning. When words are applied to a particular set of behaviours, they function to frame the meanings and connotations of such behaviours in a specified way (Chandler, 2002). Hence, ‘being by yourself in your room’ can transform from an innocent personal past-time to a pathologic marker of addiction when the term ‘isolate’ is applied to it.

These kinds of semantic reorientations appeared to be facilitated by a language which had the resources to describe participants’ lives as embedded within a *culture of addiction*. This phrase, adopted by White (1991), refers to a set of assumptions about what it means to be an addict, particularly, that the life of an addict revolves around the promotion of drug use. This kind of retrospective insight indicates that the ‘minds’ of participants had in some way

been altered. In this case, it appears that this was achieved through the ability of language to constitute social realities. The transition to recovery was therefore seen as wholly dependent on the acquisition of the recovery vocabulary, as the use of this set of words was indicative of an endorsement of a 'recovering' identity, while simultaneously rendering 'recovery' possible. As such, the historical *truth* of the narratives was seen as less significant than the way in which participants *acquired* the 'recovery narrative'.

Narrative devices. Since recovery involved a retrospective narrative construction in the context of treatment, this means that 'recovery' is especially acquiescent to the influence of discourse. Following Foucault, life-stories should be treated as discursive formations (Rice, 1992). In fact, the stories of participants were found to conform, on the whole, according to a repertoire of discursive resources in order to constitute and structure the life-story narrative. These included two core devices; powerlessness and denial, and their respective sub-categories- notions a 'higher power' and a phenomenon of 'splitting'. This unanimity in the conceptualisation of addiction and recovery was accounted for by the hegemony of prevailing recovery discourses in treatment centres, which take the form of the 12-step model. While the key to recovery was spoken of as "working the programme," this was seen as secondary to the acquisition of a discursive repertoire that enabled group membership to the therapeutic community and its body of therapeutic resources. In the section that follows both the types of narrative devices employed to construct *fellowship narratives*, and the rhetorical strategies by which these devices were rendered amenable to recovering addicts will be addressed.

Powerlessness. The concept of powerlessness over one's 'addictive' behaviour, which resides at the heart of 12-step discourse, was observed to be a major theme running throughout the narratives of all participants. The strategies by which participants reinterpreted their behaviour according to the notion of 'powerlessness' was by direct use of the term, by expressing contrary desires to drug use, or by identifying a lack of control over one's behaviour:

> My mind was so powerless at the time that what was meant to last me until Sunday evening only lasted me to Saturday morning and I demanded to be driven back to Cape Town (Alison).

> I didn't choose to be an addict, and I'm certainly not grateful that I am (Diane).

> Every day I would get caught on this jet stream that would pull me in this direction of losing myself (Debbie).

More commonly, however, powerlessness served as a rhetorical device to convey a lack of control over a series of negative drug-related consequences, which signalled what *12-step* discourse defines as 'unmanageability'- the degradation of one's life into a state of affairs that is at odds with any reason or rational conduct (AA, 2006). For Matt, his powerlessness over his drinking was such that the only way out of his troubles that he could envision was suicide:

> ...Those last two years, constantly depressed, trying to hold it together. Financial unmanageability like you'd never believe...committing fraud. Um...it was a nightmare, a lot of inner turmoil, because I didn't want to do that, it went against my moral fibre, and of course the shame of that...I just drank more and more. Every morning for the first 10 minutes of the day I would fantasize how I would kill myself.

Matt's accounts express what Bril (1972) and others have termed 'hitting rock bottom' – the point at which the individual has become incapacitated by their addiction, and all avenues of resolve have been exhausted. 'Hitting rock bottom' is therefore considered to be one of two entry points into recovery, the other being a rational, wilful decision to turn one's life around (McIntosh & McKeganey, 2001). McIntosh and McKeganey (2001) have observed in their work that the identities of those who reach 'rock bottom' are generally more profoundly 'spoiled' than other groups. The concept of powerlessness as a resource for explaining the maintenance of *bad* behaviour is therefore seen as a useful device for alleviating the burden of guilt and explaining seemingly irrational decision-making. At its core then, 'powerlessness' functioned as a rhetorical device for explaining how a 'good' person can do 'bad' things. Participants appeared to successfully draw upon this conceptualisation: Ian remarked: "I'm a helping kind of person; that was one of the reasons why I used." For Matt, he explained his "inner turmoil" about crime by emphasising that "it went against my [his] moral fibre."

Weinberg (2000) has argued that recovery in the 12-step tradition involves a conceptual feat; that the promise of regained self-control comes at the cost of accepting one's own

powerlessness. Participants therefore need to be *convinced* by means other than an emotional play on their conscience, that the internalisation of their passivity was the *only* route to recovery. The present analysis identified two techniques for what Van Dijk (1993) calls 'mind control,' both which encompass an appeal to 'authority'. Firstly, powerlessness was grounded within the medical model of addiction with its associated professionalism and expertise. Secondly, the role of a 'higher power' appeared to be institutionalised as a way of meeting addicts' needs for management after admitting powerlessness, in this case an external faith.

The *12-step* conceptualisation of repeated, irrational drug-use resides within the medical model of addiction (Room, 2005). As such, the notion that losing control is a disease appeals to the privileged status that medicine occupies in Western industrialised societies, and situates drug addiction alongside other afflictions such as cancer and arthritis. Indeed, participants made this connection. Ian recounted his beliefs about addiction-as-disease: "I'll tell you why it's a disease. One, a disease is manageable, it's never curable. So if I have cancer, HIV or diabetes, I can manage it but I can never cure it". The idea of diseases as involuntary, destructive afflictions, thereby claiming victims (Weinberg, 2000) was also apparent within the narratives. Participants' therefore tended to construct their life stories in order to portray victimhood, paying special attention to the role of other inherent, pathological markers of their 'disease':

> I started mixing lots and lots of drugs, and...I've got bipolar disorder...and that sort of triggered an episode of that...I didn't really know what was going on...didn't realise I had a mental disorder (Sean).

Diane was more blatant about the role of factors beyond her control in her drug use. She positioned herself as a passive bystander when she talked about her addiction, making special mention of her heredity, signalling the role of biology in disease transmission:

> No one wakes up in the morning and says, yes please, I think I'm going to be a drug addict today...yes please! No one does that. It's a genetic thing...my father was an alcoholic, and these things run in families (Diane).

Similarly, Megan spoke of genetics in her own addiction; however, she had less reason to do so as there was a lack of genetic evidence in her own family history:

> Certainly there is the genetic component, in my case I don't know who the alcoholics were in the family, that precede me or my grandparents. Certainly there are no signs of alcoholism. So it must have come from the previous generation...it happens...it must have come from the previous generation (Megan).

The significance of Megan's turn to biomedicine in the hope of understanding her compulsive drinking represents a common trend in contemporary societies. Filc (2004) has argued that the revered status of biomedical ideology reflects a shift in the distribution of power in the modern world. Through the medicalisation of behavioural phenomena, diseases lose their social dimension and their explanations remain purely medical. This occurs because medical discourse assign exalted positions to experts (Bailey, 2005) and medical entities therefore carry with them the weight of these expert and professional opinions. Craig understood that empiricism carried a great deal of explanatory power; he offered: "You know, studies point to addiction being largely genetic, and I think its 80% genetic, 20% environment. Likewise, Matt was particularly astute about reinforcing claims by stating a scientific basis:

> What the research has shown...looking at the research...what the research has shown is that if you come from a dysfunctional home, whether your mother is chronically depressed or she drinks the whole day...the ill effects are the same (Matt).

The role of biomedicine in the etiology of the participants' addictions appeared to fill an important explanatory gap in their own understandings of why they continued to behave in a counterintuitive way that was destructive to their lives. Even though Ryan was quick to draw upon the scientific literature in accounting for his addiction, he nevertheless remained in the dark as to why he had become an addict:

> Umm...ah...um... well, really, I think I should be able to know this by now...but I struggle. But I know perhaps...definitely if I look back I used to be obsessive as a child...and I know there was a lot of alcoholism on my father's side...and I think...the more I look back at it boarding school was probably the most emotionally challenging time. But ...nothing... it would be nice if I could find a reason. Perhaps if

> anything...mm...look you know I would be forcing it...the one thing I would settle on, you know...is that there is a predisposing disease (Ryan).

Another means by which the acceptance of powerlessness was facilitated was by reinterpreting recovery in spiritually symbolic terms, which could then be attributed to some 'higher power.' The fundamentality of a God, as He is understood (AA, 2006) in 12-step philosophy is paramount to accepting powerlessness. Resolving oneself of control, as Luik (1996) argues, is counterintuitive as individuality in the modern era lends itself to personal freedom and individual choice. Admitting powerlessness must therefore be accommodated for in one way or another, and a 'higher power' appears to fulfil this logic. Diane found a sense of spirituality when she failed to account for how it was that she, despite her addictive ways, managed to find her way to treatment:

> You have to ask yourself why are we the ones here? Why us? And I thought about it and it made sense to me, that there must be something because why did I manage to find that treatment centre...because I couldn't be so arrogant as to say it was all me!

Similarly, Craig puts his inevitable decline into addiction down to an inevitable trick of the universe so that he could become a counsellor and make amends for his father's death by a drunk driver:

> My belief is that, if we look at this from a spiritual angle, my father was killed most probably by an alcoholic...and then if I have to go through my own journey of addiction, the recovery, and then become a counsellor, so that I can help people to prevent themselves from killing other people.

The concept of powerlessness then, as a core tenet of recovery discourse, was a useful way of conceptualising irrational behaviour throughout the life-story narrative. Powerlessness was seen as a *natural consequence* of a pathological disease entity inherent in the individual. As offered by Davies (1992), claiming powerlessness is functional because it not only mimics the popular discourse within treatment institutions, but also allows the individual to manage their integrity. However, in keeping with a critical discursive perspective on language, by adopting this kind of discourse, participants' downplayed their own internal searching and

explorations into alternative discourses, and instead settled upon a *reasonable* explanation that was rooted beyond the realm of their own personal agency.

Discourses surrounding 'powerlessness' appear to have achieved their ascendancy not because of their scientific credibility, but rather, because they operate in hegemony. This is most convincingly demonstrated via the subtle, undercurrent of counter discourses which created contradictions within some of the narratives. Specifically, a discourse of agency regarding the use of drugs sat contrary to notions of disease and passivity. Graham recalled his heroin years as some of the best days of his life:

> And there's also the very strong brotherhood of those days. Some of my fondest memories will always be of those days, not always obviously, but that sense of connection, the brotherhood and the experiences you had (Graham).

For Graham, 'addiction' was a way of life; a deliberate and rational means for finding meaning and interpersonal connectivity. Later, however, he drew on addiction-as-disease discourse to explain his decline into compulsive drug use: "I would have been an addict anyway, even if I had lived in paradise." Rationality and agency have no voice in 12-step philosophy (AA, 2006), and consequently, no chance of welding themselves as acceptable devices around which to construct recovery narratives during institutionalised treatment.

Denial. Participants' reflections upon their prior resistance to recovery was explained by drawing upon the concept of denial as a discursive narrative resource. Indeed, it is widely established within addiction discourse that the addict's denial of their problem is evidence for the very existence of addiction (Keane, 2002). This follows naturally from the assumption that "dishonest addict ways" (Craig) cause painful realities, which must then be put out of consciousness. Prior to overcoming denial, participants conceptualised their decline into the *drug culture* as a 'blind' activity, characterised by total unawareness of the 'dangers' that lay ahead. Alison quoted: "Now, it never occurred to me that I shouldn't use...I thought how can I accommodate my drug using and waitressing?" For Graham, the dangers of heroin were unapparent: "Of course, no one knew the dangers of it, what a dangerous drug it was!" Similarly, Ryan was unaware of his dismal state: "And, I also hadn't realised how messed up I had become in that time."

Claiming oblivion, retrospectively, to one's problematic behaviour appeared to function as a useful strategy for distancing 'bad' acts from the integrity of the self. To take Keane's

(2002) proposition further, that "the mechanisms of denial are presented as descriptions of disease" (p.79); the disease-aspect of denial in the present study had the effect of 'splitting' the individual from their pathology. The concept of splitting originates from the literature on dissociative identity disorder as a means for expelling traumatic experiences from the consciousness of one's mind so that the *self* is preserved (Spanos, 1994). As a result, the individual develops a 'split personality'- their original self, and an alter ego. Craig mentioned: "Plus, I didn't have a mobile phone...and the whole thing was set up by my addict...because the addict is always 5 steps ahead of you." For Matt, addiction meant that he had to live two different lives: "I was a reprobate by night...the double life just got worse." Diane, however, was more blatant in her descriptions of the 'other' residing within her: "I had all these things to deal with...it was like a split personality. I didn't know who I was."

Overcoming denial about the *other* and its associated behaviours was therefore seen as a right-of-passage into recovery. However, the acceptance of the disease label was not met passively. Resistance was a predominant theme running throughout the narratives, signifying their struggle with denial. Alison recalled: "I went into treatment furious. Furious furious, fuming! You know, addiction cut short and I was very difficult to engage with." Similarly, Ryan spoke about his placement in a treatment centre: "I was very challenging...very much a know-it-all...about what I needed, what was going on." The centrality of accepting denial within the context of a particular treatment institution was that participants' were forced to surrender their own understandings of the addiction process. As such, their accounts mirrored that of the prevailing treatment discourses. This sentiment is echoed by Keane (2002), when she argues that the concept of denial functions to position addicts as delusional mental patients. In this sense, their potential ability for self-determination is further compromised.

In the context of this study, consenting to denial was seen as a hegemonic feat of mainstream treatment institutions. As Weinberg (2000) has stated, participants in treatment programmes inherit a language of addiction that is non-negotiable. Institutions are structured in ways that both constrain and facilitate the kinds of thinking that are expected for recovery. Without admitting denial, participants were denied access to particular types of treatment resources. Alison recalled her second time in treatment:

> The counsellors were particularly hard on me because they saw me as capable of working the system and um...so they approached me and said, well, this time it's not going to cut it. I just couldn't get it. And I was actually kicked out for what they said was bad behaviour.

As Caine (1991) has observed, participants of treatment programmes must acculturate themselves to the system of meaning within the institution if they wish to remain in treatment. Similarly, Megan explained how advancement to secondary care was dependent on the successful progression through steps one and two of the *12-step* philosophy; the admittance of powerlessness and the step of "the willingness to do what is needed." For her, successful recovery meant "doing what you have to do...surrender to the process, and there's a lot to be trusted." Recovery, in this fashion, is a hierarchical process, with access dependent on particular understandings of the self as endowed institutionally.

Conceptually, overcoming denial appeared to be accomplished by the construction of what Weinberg (2000) has termed the *ecology of addiction*- the dichotomous situation in which an addict will be situated, consisting of life in addiction versus institutionalised recovery. The creation of this ecology appeared to be facilitated by the attribution of 'disease' to events that were not directly associated with addiction-related behaviour. If participants were allowed to envision their immoral behaviour as a part of their addiction and beyond their control, in this context then, admitting that they had 'a problem' presented as a small price to pay. Alison justified her decline into prostitution as consequence of her addiction to heroin: "I'll just say that females are one thing in the drug culture...they have no choice to be abused." Sean accounted for his criminal acts by framing them as a taken-for-granted addict trait: "I would already be engaging in dodgy behaviours like stealing money from my parents...crashed a lot of cars...you know, the usual sort of stuff that drug addicts do." Likewise, Matt retrospectively revisited his denial: "I had never made the connection why I had already crashed two cars."

Participants' reinterpretation of bad events, as a consequence of drug use, culminated in a view of their lives as a web of diseased events and circumstances. The common distinction which appears to mark addicts' narratives of recovery from other recovering groups was therefore the establishment of an ecology of addiction (Weinberg, 2000), which essentially, is a form of rhetoric. Moreover, the enthusiasm with which participants offered, in detail, a series of immoral and shameful events in their lives was also understood in terms of this concept- that they could be both 'bad' and 'good', if their wrong-doing was understood as *disease*. This idea resonates with Reinarman's (2005) view that the addiction-as-disease concept allows for both the disowning and owning of deviance in a way that is socially acceptable.

The 'addict' identity

That participants' narratives were assembled according to a *12-step* repertoire of discursive resources had the effect of structuring addicts' stories in specific ways. Previous research by Hanninen and Koski-Jannes (1999) concentrated on the minor distinctions across narratives, specifically, addicts' accounts of what they thought to be the 'key' to recovery and therefore categorised narratives according to themes such as 'will power' stories, 'personal growth' stories and 'love stories'. In the present sample, however, the majority of participants drew upon the prevailing *12-step* discourse as a principal organising factor in order to explain their addiction and their progression to recovery, and stories therefore progressed in specific ways and addressed particular issues. This may be accounted for by the fact that all participants currently counsel at *12-step* institutions.

Evidently, by framing their life-stories in terms of the concepts of powerlessness, denial, splitting and salvation through a higher power, most participants' narratives were identified as what I have called, 'fellowship stories'. These kinds of stories take as their departure point an 'addict' protagonist, whose behaviour embodies the central tenets of the 12-step literature, as exemplified by the aforementioned discursive concepts (AA, 2006). Specifically, the '*12-step* addict' suffers from a progressive disease, one that can never be cured (AA, 2006); and consequently, the adoption of a 'fellowship identity' is seen as a life-long commitment.

Fixed identities. The current findings depart from McIntosh and McKeganey's (2000) work in that recovery from drug addiction does not appear to involve the construction of a non-addict identity. Instead, via the reconstitution of their life stories through the lens of addiction, participants' successful recovery necessitated an understanding of the self, present, past and future, as an 'addict'. The hallmarks of the recovery process were seen as overcoming denial and accepting powerlessness, and as such, participants were expected to internalise these concepts and participate in ongoing treatment, articulated as 'working the programme.' While the adoption of the addict identity ensures membership to *12-step* organisations (Caine, 1991), participants understood this conceptualisation of their self to be a permanent characteristic. Commonly, participants referred to themselves as an 'addict' or a 'recovering addict', and not an 'ex-addict' even though they had not 'used' for years. For Matt, he saw himself as "A Recovering addict...as a recovering addict...uh...I know what will

happen if I drink." Sean stated: "As an addict, I'm naturally like, dishonest and manipulative...I still have all those behaviours in me and they can come up at any time."

The concern here is clear: the 'addict identity' is like a double-edged sword. It serves to remind individuals that they must abstain from drug use; however, the negative attributes of an addict label remain- as in Sean's case, where he reminds that he is inherently dishonest. The narration of events according to the 'powerlessness' concept appeared to cause this effect; robbing participants of their agency. As such, they felt enduringly tied to the fellowship. Craig noted:

> I have to put my recovery first. And you have to be careful because I'm now three years sober and it's so easy to forget how bad it was. I'll start only going to one meeting a week...calling my sponsor less, and suddenly I will feel that I'm not okay, and that's because I've not been working my programme (Craig).

Howard's (2006) contribution to research on recovering identities has shown that labels which serve as a temporary bridge to recovery may inadvertently become lasting if identification with a disorder label is wholly internalised. This generally occurs when identities serve a new found psychological need. In the current research, it was speculated that participants' profound sense of loss and loneliness motivated their desire to identify with the fellowship:

> I had lost so much in life, and people would say, but what have you lost? And I was like shit, what had I lost? I still had my family, my house. But I had to find out who I was again...a profound loss (Diane).

A sense of loneliness was epitomised by participants' feelings that they were 'the only one' struggling to manage their lives:

> I can't describe what it is like to sit in a room with people who have the same problem as me. Because I thought I was the only freak out there (Craig).

> He said, that's ok, there are millions of us in the world. Of course, I had thought I was the only one (Matt).

Identification and participation within the fellowship appeared to function to reinforce addict identities. Listening to others' stories facilitated interpellation, as expressed by Matt's remarks regarding his first-ever meeting: "I immediately identified with him, immediately saw that I was just like him." This identification process endowed a sense of belonging, since he wasn't 'the only one' anymore. Furthermore, the retelling of life-stories, as evident in their rehearsed character alluded to before, was also seen as a factor in the maintenance of the addict identity.

Luik (1996) has argued that the concept of the 'addict' is ideological rather than scientific. In the present analysis, the 'addict', as an ideological entity, appeared to be particularly effective in ensuring the growth of the *12-step* institution. This opinion rests on the work of Levine and Moreland (1994) who have noted that cohesion and growth within groups depends on the extent to which members match a 'group prototype,' and that changes within individual evaluations of personal 'prototypicality' threatens commitment to membership. Hence, identification with the 'addict' persona is vital for group preservation, and 'individuality' is therefore discouraged. This sentiment is echoed in the first of the *12-step* traditions, that "the common welfare should come first; personal recovery depends on A.A unity" (AA, 2006, p.9). By pledging anonymity, members therefore appear to surrender their individual identities in pursuit of the group identity- the 'fellowship' addict. As a story-telling community, the 'fellowship addict' therefore serves as a valuable vessel through which member socialisation can take place.

There is not scope within this study to explore the broader ideological functions of the maintenance of addict identities to its full extent. However, what we can surmise from the existence of mainstream addiction discourses is that an addict identity, which serves as a constant reminder that one must abstain from drugs, is ideologically consistent with the contemporary 'war on drugs' (Buchanon & Young, 2000). Addiction is therefore a moral approach on how not to behave; one which is delivered in hegemony by framing it as a medical, incurable disease.

CONCLUSION

The starting point of this study was the epistemological orientation that discourses shape and configure subjective psychological realities. Accordingly, the aim of this research was to explore the conceptualisation of recovery from drug addiction as it is understood by individuals who had experienced institutionalised treatment. The major findings were as follows: Firstly, the recovery process appeared to be mediated by the construction of the life-story narrative. In doing so, participants drew upon a repertoire of *12-step* discursive resources, which had the effect of structuring their narratives in particular ways, essentially reconstituting the reality of their selves and lives. Specifically, while narrative devices appeared to be especially useful in establishing coherence in participants' cognitive circumscriptions, the stylised narratives also hinted at the counter-productivity of notions of 'powerlessness' and 'denial'. Narratives then, not only function as structures of meaning, but also as structures of power.

Consequently, participants were observed to have constructed an enduring 'addict' identity, as articulated by *12-step* philosophy, and which was to be carried with them into the future. This continuity across the narratives appears to have achieved its pre-eminence not because of the scientific credibility of addiction-as-disease, but rather, because the discourse appears to operate in hegemony. In general, the rhetorical strategies by which the *12-step* conceptualisations of addiction were rendered amenable to recovering addicts included the medicalisation of deviance, the restriction of access to recovery resources, and the limitation of alternative discourses for self-actualisation. Whether this is a factor of institutionalisation cannot be claimed out rightly as this study did not take a comparative approach, and this might prove an interesting direction for future research. Nonetheless, the 'addict' identity is problematic, as it limits the scope of ways of being and denies addicts of the opportunity for alternative sources of recovery and personal insight.

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APPENDIX 1

The 12 steps to recovery as articulated by *12-step* institutions

Step 1 - We admitted we were powerless over our addiction - that our lives had become unmanageable

Step 2 - Came to believe that a Power greater than ourselves could restore us to sanity

Step 3 - Made a decision to turn our will and our lives over to the care of God as we understood God

Step 4 - Made a searching and fearless moral inventory of ourselves

Step 5 - Admitted to God, to ourselves and to another human being the exact nature of our wrongs

Step 6 - Were entirely ready to have God remove all these defects of character

Step 7 - Humbly asked God to remove our shortcomings

Step 8 - Made a list of all persons we had harmed, and became willing to make amends to them all

Step 9 - Made direct amends to such people wherever possible, except when to do so would injure them or others

Step 10 - Continued to take personal inventory and when we were wrong promptly admitted it

Step 11 - Sought through prayer and meditation to improve our conscious contact with God as we understood God, praying only for knowledge of God's will for us and the power to carry that out

Step 12 - Having had a spiritual awakening as the result of these steps, we tried to carry this message to other addicts, and to practice these principles in all our affairs

(AA, 2006)

APPENDIX 2

Interview schedule

The course of questions will differ to a large extent depending on where the participants take the first question, that is, they might offer information that subsequent questions aim to elicit.

1. Can you tell me a little bit about yourself?
   My hopes with this question are that it will serve as an introductory exercise, and allow the participant to position him/herself in the context of life experiences, from their own appraisals.

2. Can you describe your journey through recovery?
   I expect that through the use of the word ‘journey’ it will encourage a narrative of the recovery process. This word is also part of the commonly drawn treatment vocabulary, and will therefore serve to prompt particular types of stories associated with the recovery process.

3. Recovery-wise, where do you see yourself in 10 years time?
   I believe that this question will help in giving insight into the way in which participants evaluate their current circumstances, in relation to their desires and hopes. It may also shed light on whether or not they see themselves in a transitory phase.

4. Looking back, what do you think you would do differently?
   By asking this question I hope to explore the ‘universals’ of the participant’s ideas about drug use. For example, if they believe that their initial drug taking experiences was an inevitable step towards ‘dependence,’ or if they attribute other life circumstances to their history with drugs.

APPENDIX 3

Consent form

UNIVERSITY OF CAPE TOWN

Purpose:

The purpose of this research project is to investigate the recovery process of ex-addicts in the context of their addiction rehabilitation experiences.

This project is being conducted by me, Donne van der Westhuizen, a Psychology Honours student at the University of Cape Town, as part of the course requirements for my degree. Any further enquiries can be approached through me; below are my contact details.

Researcher:

Donné van der Westhuizen
(021) 674 1811
vwsdon002@uct.ac.za

Procedures:

This study involves one audio-recorded interview lasting approximately one hour and at a setting of the participant's choice.

Possible risks or discomforts:

This study should pose little harm to your mental or physical well-being. Should you feel uncomfortable at any time you maintain your right to withdraw from the study, including the data recorded up to that time.

Benefits:

Your participation will be in service of academic research, particularly in the domain of addiction rehabilitation.

The interview may allow you a safe space to have your voice heard and your thoughts freely expressed without the worry of prejudice.

Privacy and Confidentiality:

The data obtained will be used purely for research purposes, and none of your personal information will be disclosed to any third party.

You have the right to refuse to answer any question asked of you, and may withdraw from participation at any time for any reason, without stating that reason.
I (*name*.....) agree to participate in this research project.
I have read this consent form and the information it contains and had the opportunity to ask questions about them.
I agree to my responses being used for education and research on condition my privacy is respected, subject to the following:
-I understand that my personal details may be included in the research / will
be used in aggregate form only, so that I will not be personally identifiable
(*delete as applicable.*)
- I understand that I am under no obligation to take part in this project.
- I understand I have the right to withdraw from this project at any stage.

Signature of Participant / Guardian (if under 18): _____
Date: _____

Signature of researcher: _____
Name of researcher: _____

Date: _____