

**COUNTING THE STEPS TO RECOVERY:
PERSONAL REFLECTIONS OF ADDICTS ON WHAT THEY CONSIDER TO
BE THE MOST HELPFUL ELEMENTS OF THE TWELVE-STEP
PROGRAMME**

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30 June 2019

Declaration

I, Susan Deborah Spencer, declare that

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Student's signature
Date: 30 June 2019



Supervisor's signature
Date: 30 June 2019

Dedication

For my husband, daughters and mother, without whose support and patience, this dissertation would not have been possible.

Acknowledgements

I would like to express my sincere thanks to Dr Carol Mitchell for her on-going support and motivation, and for nudging me to the finish line.

Abstract

The Twelve -step programme of Alcoholics Anonymous and Narcotics Anonymous is an action-based, experiential form of treatment for alcoholism and addiction that is not easy to grasp from a theoretical perspective alone. Therefore this dissertation took an inside-out view of the twelve-step programme by exploring what elements in the programme recovering addicts consider as central to their sobriety. Particular attention was paid to the extent to which each of these core elements was seen to contribute to participants' development of constructive affect regulation strategies. Theorists who have contributed to this contemporary field of affect regulation, and whose work this research has used to formulate its focus, include Edward Khantzian, with his self-medication hypothesis, and James Gross, who has developed a process model of emotional regulation identifying strategies used to regulate feelings. Participants identified five themes that were pivotal to their recovery and could be understood using ideas from affect regulation theory. These included: The philosophy and principles contained in the twelve-step programme; regular attendance at meetings; understanding addiction as a disease; acceptance of a Higher Power; and service to others. Based on participants reports they appeared to improve their repertoire of constructive affect regulation strategies as a result of working the twelve-step programme.

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Chapter 1

Introduction

1.1 Introduction

The Twelve-step programme (TSP) is a set of guiding principles outlining a course of action for recovery from addiction. It was originally proposed by Alcoholics Anonymous (AA) as a method of recovery from alcoholism. The method was subsequently adapted and became the foundation for other TSPs, such as Narcotics Anonymous (NA), Gambling Anonymous (GA) and Cocaine Anonymous (CA) (Alcoholics Anonymous, 2001).

Members of AA, and other TSP self-help groups, meet regularly to help one another stay “clean” or sober. This is done through sharing their stories of addiction and working through each of the twelve steps contained in the TSP (Narcotics Anonymous, 1998). The step work and the group work are reported to assist many addicts in establishing a more stable lifestyle (Khantzian & Mack, 1999).

In this study, affect regulation theory is used as the theoretical framework through which to understand what study participants report as the essential ingredients of the TSP that they found of value. Affect regulation theory focuses on the innate capacity of some people to maintain emotional stability, manage arousing emotional states and moderate their stress. Affect dysregulation occurs when individuals feel overwhelmed and out of control in the face of emotionally arousing events and resort to external soothing methods, such as substance abuse, to regulate their affect (Schore, 2016). Addiction can be viewed as a vehicle, albeit ineffective, to manage emotional difficulties (Krystal, 1988; Wurmser, 1980).

South Africa ranks as one of the biggest consumers of alcohol globally (Department of Social Development, 2017). For this reason alone, it is important to understand more clearly what the underlying reasons for the success of TSPs might be before deploying them more widely in settings such as psychiatric institutions, prisons and the general population through public health initiatives.

1.2 Research objectives

Underlying insights and reflections of users of the TSP were explored to increase understanding and awareness of what they consider to be the key ingredients of this addiction treatment programme.

The objectives of this study were to:

- Increase understanding about the perceived ways in which the TSP assists addicts to achieve and maintain sobriety.
- Explore a possible link between attendance at twelve-step groups and increased skills in regulating affect.

1.3 Research questions

The study focused on answering the following research questions:

- What do recovering addicts consider to be the most helpful elements of the TSP?
- What are addicts' reflections on the role of the TSP in constructive affect management?

1.4 Methodological approach

A qualitative, interpretive research design, which was primarily exploratory, was used (Babbie & Mouton, 2005). A qualitative design was chosen as it provides a richly descriptive account of the phenomenon under investigation (Smith, 2015). An interpretive approach served to privilege the participants' experiences. Purposive and snowball sampling was used to select eight participants across South Africa, who attend or have attended TSP meetings in order to work on their abstinence from addictive behaviour or substances. A semi-structured interview was conducted. Thematic analysis was used to elucidate recurring ideas, identified as common themes in the data.

1.5 Terminology

In the TSP, addiction and alcoholism are viewed as operating on the same principles as one another (Flores, 2007). For the purpose of this study, both conditions were referred to as

addiction and references to AA include references to Narcotics Anonymous (NA) and other TSPs.

The terms “affect” and “emotion” tend to be used interchangeably among theorists. For the purposes of this study affect regulation and emotional regulation are used interchangeably.

Acronyms

AA	Alcoholics Anonymous
NA	Narcotics Anonymous
TSP	TSP
AOD	Alcohol and other drug
SUD	Substance use disorder
DOC	Drug of choice
SMH	Self-medication hypothesis

1.6 Organization of dissertation

The dissertation has been organized as follows:

Chapter one provides the reader with contextual and background information to the study. Chapter two focuses on literature pertinent to the study. Chapter three, details the methodological approach, including the research design, sampling method, data collection, data analysis and ethical considerations. Chapter four examines the findings generated through this research. Chapter five includes a discussion of these findings in light of the relevant literature. Chapter six concludes this study, indicates its limitations and provides recommendations for future research.

1.7 Summary

In this chapter, the research in its entirety was introduced. Objectives of this study were outlined. The conceptual framework was briefly discussed, along with its purpose and relevance to the study.

Chapter 2

Literature review

2.1 Introduction

This thesis moves away from a biological understanding of addiction and towards a psychological one. As noted by Khantzian (1999), “suffering or psychological pain is at the root of addictive vulnerability, and individuals discover the pain-relieving properties of addictive substances” (p. 121). Affect dysregulation can be understood to be a key vulnerability contributing to the development of addiction (Aldao, Nolen-Hoeksema & Schweizer, 2010; Taylor, Bagby & Parker, 1999).

Addiction presents as a very prevalent and serious public health problem worldwide. It is implicated in wide-scale damage to individuals, families and societies, both directly and indirectly. This thesis argues that addiction results, in part, from difficulty in regulating one’s affect and, specifically, from the use of drugs to regulate affect. By extension, in order to treat addiction, it is necessary to inculcate a greater capacity for affect regulation (Adams & Robinson, 2001). The central hypothesis of this study is that AA’s TSP constitutes an effective treatment approach at least in part because it encourages a greater ability to regulate affect among its members.

Khantzian (1999) argues: “AA is one of the best established forms of treatment and rehabilitation. The nurturance, immediate acceptance, understanding and support of AA serve as an effective response for many to dependency problems, and as an acceptable replacement for alcohol” (p.331). Analysis of the TSP by “psychiatrists, psychologists, anthropologists, and psychoanalysts shows that the AA recovery program is complex, implicitly grounded in sound psychological principles, and more sophisticated than is typically understood” (Borkman, 2008, p. 10).

Khantzian and Mack (1999) believe that AA works by changing people’s lives emotionally, physically and spiritually, and attribute the success of AA to its recognition of the importance of managing and regulating affect.

2.2 The scope of addiction globally and in South Africa

Addiction poses a serious public health problem globally (Bukstein, Brent & Kaminer, 1989; Group for the Advancement of Psychiatry Committee on Alcoholism and the Addictions, 1991). Addiction often contributes to the corrosion of interpersonal relationships, leading to higher divorce rates, domestic violence and unemployment.

As indicated by the South African National Council on Alcoholism and Drug Dependence (SANCA), South Africa currently experiences high levels of abuse of alcohol and other drugs (AOD) (SANCA, 2017). The Medical Knowledge Institute (MKI) a non-profit organisation, which develops and facilitates health information workshops for members of disadvantaged peri-urban communities in South Africa argues that there are several individual and community factors influencing AOD abuse and a great need for the development of community-based AOD prevention workshops and for organizations to guide public health policy and service development for the treatment of AOD abuse.

Many South Africans are affected by substance abuse annually. One of the reasons for this is the presence of a large harbour in Durban making it a hub for both importing and exporting drugs around the world. This leads to greater availability and a wider variety of drugs (Myers & Parry, 2003). The International Narcotics Control Board's (INCB, 2009) annual report estimates that the number of South African's that regularly use drugs is double that of the global norm. Drug use costs the country large sums of money annually as a result of crime, health-related problems, absenteeism in the workforce and drug-related deaths.

Addiction contributes to severe and fatal medical conditions such as Korsakoff's syndrome, cancer, strokes and heart disease (Myers, Harker, Fakier, Kader & Mazok, 2008). By world standards, South Africa has extremely high rates of Foetal Alcohol Syndrome (FAS) (May et al., 2007). The Department of Social Development (2017) adds that FAS is one of the greatest contributors to intellectual disabilities and birth defects in South Africa. The department also points out that around 6 000 South Africans die in alcohol-related motor vehicle accidents annually. There is also a high correlation between regular alcohol abuse

and decreased adherence to anti-retroviral treatment (Hahn, Woolf-King & Muyindike, 2011). The financial loss resulting from absenteeism, injury, criminal offences, and family and relational problems is alarmingly high (Sacks, Gonzales, Bouchery, Tomedi & Brewer, 2015).

Myers et al. (2008) argue that long waiting lists at state-run rehabilitation centres presently obstruct those seeking treatment. In addition, rehabilitation facilities are often difficult to access because many people incur financial, transport, and other difficulties when trying to access them (Pasche & Myers, 2012). There are also too few state-run treatment services meet the need and private drug rehabilitation centres are financially prohibitive for most South Africans (Pasche & Myers, 2012). Pasche, Kleintjes, Wilson, Stein and Myers (2015) highlight that an additional challenge facing addiction treatment in South Africa is the paucity of health professionals trained to work in this area. In 2018, the South African Community Epidemiology Network on Drug Use (SACENDU) reported that there were significantly more admissions to rehabilitation programmes countrywide in 2017 than in 2016 (Dada, Harker Burnhams, Erasmus, Parry & Bhana, 2018). They also noted an increase in admissions among female students younger than 20 years of age, women older than 50 years of age and in the number of school referrals (Dada, et al. 2018).

There is little South African research pertaining to AA and the TSP, particularly that pertaining to the subjective experiences of members, hence the need for this study. There are currently 376 AA and 300 NA groups in South Africa (Narcotics Anonymous South Africa, 2018). Research confirms that the twelve-step methodology is an approach with universal applicability, partly because it is free and does not rely on professionals (Alcoholics Anonymous, 2001; Bekkeringa, Marilena, Paryloa & Hannesa, 2016; Del Boca & Mattson, 2001; Mäkela, 1996;).

2.3 What is addiction?

There are many different ways of defining and understanding addiction. Debate exists among researchers in the field as to whether it is a biological, psychological or social disorder. Goodman (1990) presents a psychological understanding of addiction, saying that it

.... designates a process whereby a behaviour, that can function both to produce pleasure and to provide escape from internal discomfort, is employed in a pattern characterized by recurrent failure to control the behaviour.... and continuation of the behaviour despite significant negative consequences. (p. 403).

A biological explanation of addiction understands it to be a disorder of the brain and implicates neurobiology and neurochemicals in its aetiology (Malenka, Nestler & Hyman, 2009). Nestler (2013) explains that although there may be psychological factors contributing to addiction, it is fundamentally a condition of the brain involving pleasure-seeking behaviour, through drug use, despite negative consequences. Brain changes result from on-going usage, giving rise to compulsive drug-seeking behaviour and an impaired capacity to control one's use. Neurobiological understandings of addiction link neural changes in the brain resulting from substance use, which result in diminished cognitive control, impaired ability to make choices and increased cravings for the drug (Volkow, Koob & McLellan, 2016).

Addiction can be understood to include both chemical and process addictions. Chemical addictions include both alcoholism and other mind-altering substances, such as heroin and cocaine. Process addictions, or behavioural addictions, include gambling, internet gaming, sex and shopping. Both chemical and process addictions have symptoms of tolerance and withdrawal (Heather & Segal, 2016). The American Medical Association (AMA) classified alcoholism as an illness in 1956. In 1987, the AMA said it would now be called the disease of addiction. The Society of Addiction Medicine (2011) provides the following brief definition of addiction:

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours. (p. 1).

Christie (2008) argues that addiction occurs when one develops a tolerance to a substance or behaviour, which requires that one use more each time to avoid painful symptoms of withdrawal, resulting in a cycle of compulsive use and relapse. The symptoms of tolerance and withdrawal considered by many to be central to addiction are included in the Diagnostic

and Statistical Manual IV (DSM-IV) and the Diagnostic and Statistical Manual 5's (DSM-5) diagnostic criteria. DSM-IV (American Psychiatric Association, 1994) refers to addiction as Substance-Related Disorders and identifies two subgroups:

- Substance Use Disorders (SUDs), which refers to problems arising in an individual's life, as a result of their drug habit. SUDs are characterized by dependence (tolerance and withdrawal) and a more severe level of substance use i.e. substance abuse.
- Substance-Induced Disorders (SIDs) result from intoxication, withdrawal or substance-induced mental disorders such as psychosis or bipolar mood disorder. SUDs lead to distress in social, occupational or other important areas of functioning.

According to DSM-IV-TR (American Psychiatric Association, 2000) a substance can refer to "a drug of abuse, a medication, or a toxin" including "alcohol; amphetamine or similarly acting sympathomimetic; caffeine, cannabis; cocaine; hallucinogens; inhalants; nicotine; opioids; phencyclidine (PCP), or similarly acting arylcyclohexylamines; and sedatives, hypnotics, or anxiolytics" (p. 175).

The DSM-5 (American Psychiatric Association, 2013) also distinguishes between SUDs and substance induced disorders. DSM-5 grades SUDs in severity from mild to severe, depending on the number of criteria with which a subject presents. DSM-5 includes gambling disorder, a process, rather than substance use disorder, under Substance-Related and Addictive Disorders. The DSM-IV and V definitions of addiction, plus the description of addiction put forward by AA, and the definitions presented by various theorists, all contribute to painting a picture of addiction that is accompanied by severe and life-threatening problems, biologically, psychologically and socially.

Several theorists have moved away from a biological understanding of addiction and found greater use in seeing addiction as a means of managing difficult psychobiological states. They have recognised that there is a wide discrepancy in people's capacity to regulate affect. For some, the experience of feelings might be more intense, frequent, or longer lasting, than for others (Linehan, 2014). These people may then experience affect dysregulation, causing them to struggle with down-regulating, increasing or moderating

overwhelming feelings. Still, others understand addiction as a means of managing psychological pain (Kurtz, 2008; Flores, 2013; Kaskutas, 2008; Kelly, 2017) or a means of self-medicating specific affective states (Khantzian, 2003). Others see addiction as a choice (Schaler, 2000), or a moral failing, or a bad habit. Mate (2010) suggests “Addiction is any repeated behaviour, substance-related or not, in which a person feels compelled to persist, regardless of its negative impact on his life and the lives of others” (p. 136).

AA defines alcoholism as “an illness, a progressive illness, which can never be cured but which, like some other diseases, can be arrested” (AA’s pamphlet, 1952; Cook, 1988). Alcoholism is defined in AA as a physical, spiritual, and mental disease. In AA addiction is understood to be a sickness or malady from which there may be recovery, but not cure (Cook, 1988). Kurtz (2002) highlights that there has been some controversy over the years about whether AA described or describes alcoholism as a disease, sickness, or malady. He adds, that for many of its adherents, the concept of addiction as a sickness, malady or disease is found to be a useful explanation as it provides an antidote to the experience of badness that is familiar to most addicts.

2.4 Roads to recovery

While AA is the most widely used treatment for addiction globally, other options have arisen in the last few decades (Kelly & White, 2012). As this dissertation focuses on the TSP, other treatment options have been identified, and their similarities and differences to the TSP highlighted, but they have not been elaborated on, in the interests of brevity.

2.4.1 Secular Organization for Sobriety

James Christopher, a discontented AA member, started the Secular Organization for Sobriety (SOS) in 1986, in a bid to eliminate the spiritual elements present in the TSP (Christopher, 1988).

2.4.2 Women for Sobriety

Women for Sobriety (WFS), like the TSP, is an abstinence recovery programme, but only for women. It was founded in 1976 by sociologist, Jean Kilpatrick, an alcoholic, who believed

women needed groups that were free from men and role expectations, (Kirkpatrick, 1978). Similar to AA, WFS is spiritually orientated, operates through members sharing their experiences in a group format and advocates recovery a day at a time approach (Kelly & White, 2012). Addiction is understood to result from loneliness and emotional neglect (Kaskutas, 1996).

2.4.3 Motivational Interviewing

Motivational interviewing (MI) is a counselling technique developed for use in working with people suffering from addiction. It was co-founded in 1983 by two psychologists, Miller and Rollnick. It aims to assist patients in dealing with resistance to recovery and developing self-efficacy through interviews (Miller & Rollnick, 2012).

2.4.4 Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) emphasizes cognitive processes (Lewis, 2013). Treatment is aimed at increasing an individual's awareness of the thought patterns triggering their addictive behaviour. People are taught skills to modify negative thought patterns and improve coping skills (The Hazelden Betty Ford Foundation, 2018).

2.4.5 Acceptance and Commitment Therapy

Psychologist Stephen Hayes founded acceptance and Commitment Therapy (ACT) in 1986. It uses mindfulness techniques and behavioural activation to increase an individual's ability to engage in positive behaviours despite experiencing uncomfortable and painful thoughts, feelings or bodily sensations (The Hazelden Betty Ford Foundation, 2018).

2.4.6 Rational Recovery

Rational Recovery (RR) was founded in 1986, by social worker Jack Trimpey. He began by adapting Albert Ellis' Rational Emotive Behaviour Therapy (REBT). From this, he developed Addictive Voice Recognition Therapy (AVRT), a treatment aiming to assist people in identifying their 'addictive voice,' which is considered to act as a trigger for using (Trimpey, 1995). Unlike many recovery programmes, there is a charge for this one (Lewis, 2013).

2.4.7 Harm Reduction Alliance

The Harm Reduction Alliance is an international body aimed at developing public health policies and services to decrease the negative impact of addiction, rather than decreasing consumption. It became consolidated as an approach in 1990. Harm reduction advice and services offer support with either abstinence-based treatment or with advice on how to reduce the harm of using. This includes information on the safest ways to use drugs, self-care, needle exchange programmes, health advice, mental health support, safeguarding children or family, legal advice and social services. It strives to meet people where they are, without judgement, and without an agenda to push them in any direction in order to decrease the harm of their addiction (Newcombe, 1992).

2.4.8 Celebrate Recovery

Celebrate Recovery (CR) is a Christian, religious organization offering support for recovery. John Baker founded CR in California, in 1991. Baker, also an alcoholic noted he would have preferred AA if it were more Christian. CR began using the twelve-steps of AA but developed into a more overtly Christian organization based on eight principles derived from the bible. CR focuses on recovery as well as offering support for those recovering from emotional challenges (Baker, 2005).

2.4.9 Moderation Management

Audrey Kishline started the Moderation Management (MM), in 1994. MM provides services to those wishing to moderate and not necessarily stop their alcohol consumption. However, in 2000, Kishline concluded that although she would continue supporting MM meetings for others, she decided that abstinence was what she required and began attending SMART groups, AA meetings and Women for Sobriety meetings (Humphreys, 2004).

2.4.10 Self-Management and Recovery Training

Self-Management and Recovery Training (SMART) began in 1994. It is an international non-profit organization that serves as an alternative to the twelve-steps without an emphasis on spirituality. It split off from Trimpey's AVRT model (Lewis, 2013). It is abstinence-based and

uses many techniques of Rational Emotive Behaviour Therapy (REBT) founded by psychologist, Albert Ellis, in 1956 (Ellis & Velten, 1992). It focuses on identifying and then modifying self-sabotaging thinking, feelings and actions.

2.4.11 Medication Assisted Treatment

Several treatment approaches such as SMART recovery, the Harm Reduction Alliance and TSPs work in conjunction with Medication Assisted Treatment (MAT) (The Hazelden Betty Ford Foundation, 2018). Medication is used primarily to help individuals to prevent relapse, manage withdrawal symptoms, decrease cravings, and to detoxify patients (SMART Recovery, 2017).

2.4.12 Life Ring

The Life Ring for Secular Sobriety began in 2001. It is a non-spiritually-focused self-help group that uses CBT to strengthen the “sober self” (Kelly & White, 2012).

2.4.13 The Twelve-Steps of AA

The TSP of AA comprises two elements:

- The twelve-steps (step work); and
- Regular attendance at meetings (AA, 2001).

Many other TSPs have been adapted, since the original AA, which began in 1935, such as Narcotics Anonymous (NA); Cocaine Anonymous (CA); Co-dependents Anonymous (CODA); Gamblers Anonymous (GA), Overeaters Anonymous (OA) and Sex and Love Addicts Anonymous, (SLAA) (Alcoholics Anonymous, 2001; Alcoholics Anonymous South Africa, 2018; Passetti, Godley & Godley, 2012).

The first step of the twelve-steps involving admitting one is powerless over one’s use of alcohol. The following two steps involve surrendering one’s control to a ‘higher power’, which is essentially a power other than one’s own. Once the alcoholic becomes sober, past behaviour and misdemeanours come to the fore, resulting in a profound experience of shame and remorse (Khantzian, 2013). These states, along with fear, guilt, and resentment,

are considered to act as triggers to use. AA focuses on ways of managing or reducing these emotions through working the twelve steps, each one having a particular aim (Tonigan, Rynes, Toscova & Hagler; 2013). Steps four to nine include taking a 'moral inventory,' 'making amends' and 'serving' others suffering from addiction (in step twelve) in order to instil members with a sense of empathy, altruism and hope, leading to important behaviour changes (Borkman, 2008). (See Appendix 7 for a complete list of each of the twelve steps of AA).

2.5 Research comparing AA to professional treatment modalities

Although there are a number of different treatment approaches that claim significant success, many people who are in recovery cite the AA as having been essential to their recovery. Many authors have found those attending AA were more likely to achieve abstinence than those attending behaviour therapy (Humphreys, Moos & Cohen, 1997; Tonigan et al., 2013). They found improved rates of abstinence, and improved interpersonal relationships in the first three years, of recovery. Vaillant (2005) concurred with these findings suggesting that AA is as effective, or more effective than many conventional treatments.

In 1989, the National Institute of Alcohol Abuse and Alcoholism (NIAAA) in the United States started an eight-year project, Project MATCH to understand which types of alcoholics respond most favourably to which type of treatments (Project MATCH Research Group, 1999). It was one of the largest and most rigorous outcome studies ever done in the addiction field. NIAAA's motivation was to consider whether treatment should be uniform or tailored to the characteristics of specific individuals, as well as to the requirements of service users. Three treatment modalities were considered, namely: TSP, Motivational Interviewing (MI) and CBT.

Project MATCH (1989) findings showed that it made little difference which treatment modality was employed and that addicts who enrolled in a TSP were about as likely to enjoy recovery from their addiction as those enrolled in CBT and MI, two of the most commonly used psychotherapeutic modalities for addiction (Drummond, 1999).

These findings are interesting for many reasons, but of primary interest to this study is that, of the three, both MI and CBT require trained professionals, unlike AA which is run by a fellowship of addicts who join together, and support one another in working the TSP (Villa, n.d).

Longabaugh, Wirtz, Zweben and Stout (1998) re-interviewed 860 of the original Project MATCH participants three years after their treatment and found that those involved in AA were associated with better 3-year outcomes. Kaskutas (2008) praised the findings of Project MATCH for being rigorous and robust, especially with regard to highlighting better rates of abstinence for those attending AA than those attending MI and CBT. Kelly and Beresin (2014) also compared AA, MI and CBT and found that double the number of AA participants were abstinent after a year, and nearly a third more were still abstinent three years after treatment.

While the length of time spent in treatment has been shown to be an important factor in maintaining on-going sobriety, the frequency or amount of time dedicated to treatment has also been shown to predict higher rates of recovery. Kelly et al. (2006) looked at a sample of 5 227 of men and women with addiction receiving different forms of treatment. Their findings showed that participation in mutual-help organizations, such as AA, led to increased sobriety.

A Cochrane Collaboration (2006) review was compiled by researchers who examined the efficacy of AA by conducting a systematic review using available data from eight trials, conducted between 1966 and 2005, measuring 3,417 participants (Ferri, Amato & Davoli, 2006). Their review yielded controversial findings, showing that there was no significant difference between the results of AA and other treatment modalities. They also stated that those considering attending AA should be cautioned because of the lack of experimental evidence on its effectiveness.

Kaskutas (2008) responded to this review with concern, arguing that they obtained their data from quantitative studies, neglecting many qualitative studies that clearly demonstrated support for the effectiveness of AA treatment. She also expressed concern

that results from the Cochrane Review (2006) were not entirely accurate as one of the eight studies, Project MATCH, did, in fact, yield quantitative results demonstrating that AA was an effective treatment model. Following these concerns, Kaskutas (2009) looked at data from multiple studies into the efficacy of AA and found that experimental studies yielded less favourable results than qualitative research methods.

2.6 Research on helpful elements and strategies within AA

AA goes beyond providing support and becomes the basis for enduring and significant psychological development and change (Mack, 1991). Helpful elements in AA appear to be gained through the cognitive, affective and social tools derived from working the steps (Zemore, 2017). Valverde and White-Mair (1999) argue that “the unity of AA is to be found in its techniques more than its theories of alcoholism or views about God” (p. 407).

These techniques include structure, active participation, on-going support, and empathy, service, written inventories and presenting one’s life story detailing one’s deterioration at the hands of addiction and the consequences thereof (Khantzian, 1999; Krystal & Raskin, 1970).

2.6.1 Meetings

Much of the strength of AA is attributed to the therapeutic effects of the group meetings (Yalom & Leszcz, 2005). According to Flores (2007):

Group therapy is an essential and crucial ingredient in the treatment of addiction... The nature of the addiction process itself [is that it] either produces or exacerbates depression, anxiety, isolation, denial, shame, and transient cognitive impairment. It is now recognised that many of these issues, whether the person is addicted or not, respond better to group treatment than to individual therapy. (p. 75).

Inherent to AA is a context and structure for self-forgiveness and self-soothing through sharing. Meetings form a climate of verbal sharing and support (Zemore & Kaskutas, 2004; Pagano et al., 2007). Many basic socialization skills are learnt at meetings, such as not interrupting, speaking only about your own experiences and honesty (Makela, Arminen, Bloomfield, Eisenbach-Stangl, Helmersson, Bergmark & Kurube, 1996).

Sharing of life stories has been identified as a transformative agent promoting behaviour change, through talking and listening to others (Kelly, Magill & Stout, 2009; Pollner & Stein, 1996). Life stories, also known as a “drunkalogue,” follow the format suggested by the Big Book: “Our stories disclose in a general way what we used to be like [when drinking], what happened, and what we are like now” (AA, 1976, p. 58).

Khantzian (1999) suggests that the expressive aspects in AA help the addict to increase flexibility in thinking, which has tended to be obsessive and rigid. Pollner and Stein (1996) identified the sharing of a personal life story in AA to be a powerful resource for promoting behaviour change, through talking and listening to others. The Big Book (1976) states, “No matter how far down the scale we have gone, we will see how our experience can benefit others” (p. 84).

2.6.2 Fellowship

The AA members are known as a fellowship (Brande, 2018). AA philosophy emphasises the importance of identifying with fellow sufferers in recovery (Spickard, 1990). Being part of the fellowship decreases loneliness, which is central to maintaining recovery (Kurtz, 1991; Roth, 2004). Khantzian and Mack (1999) suggest that AA is curative because it encourages interdependence and connection within the fellowship, thereby replacing ‘chemical solutions’ for emotional suffering with ‘people solutions’.

The fellowship serves to provide members with a sense of belonging through which they are able to decrease their experience of shame and the stigma attached to addiction (Humphreys, 2004; Morgenstern, Labouvie, McCrady, Kahler & Frey, 1997). Belonging to the fellowship inoculates members from stress and stimulates mental wellness (Laudet et al., 2006).

The nature of the social support offered by AA, such as round-the-clock availability of support, modelling of abstinence by older members and practical, common-sense advice highlights some of the strengths of the fellowship (Kaskutas, Bond & Humphreys, 2002). This

social network provides members with skills to manage abstinence, cravings and triggers while experiencing painful and difficult affect (Kelly & White, 2012; McIntire, 2000).

The social network of AA facilitates change by providing behavioural and emotional support for abstinence, and bolstering self-efficacy (Longabaugh et al., 1998). Bandura (1999) suggests that self-efficacy and confidence in one's capacity to remain sober in AA arises from the opportunity to learn new behaviours through seeing them role modelled by others in a functional social network. According to Bandura (1999):

Self-efficacy beliefs promote desired changes through cognitive, motivational, affective, and choice processes... Perceived self-efficacy exerts its effects on every phase of personal change—the initiation of efforts to overcome substance abuse, achievement of desired changes, recovery from relapses, and long-term maintenance of a drug-free life. (p. 214).

2.6.3 Spirituality

Through surrendering and letting go of control to a higher power, members are provided with a soothing, compassionate and non-judgmental framework, which facilitates forgiveness (Laudet et al., 2006). AA posits that recovery results from a 'spiritual awakening' (Kelly, 2017). As noted by Khantzian (1999):

Once alcoholics surrender to the human reality of interdependence through AA and accept their powerlessness to control their alcohol alone, other beneficial aspects of AA begin to provide a basis to address, repair, and strengthen other vulnerabilities involving defects and dysfunction around one's feeling life and behaviours. (p. 424)

2.6.4 Service

The original text of AA known as the "Big Book" states: "Selfishness – self-centeredness! That, we think, is the root of our troubles... Above everything, we alcoholics must be rid of this selfishness. We must, or it kills us!" (AA, 2001, p. 62). Therefore a central principle in AA is the summoning up of the "helper principle" and the recognition that "helping you helps me" (Riessman, 1965). As stated in AA (2001, p. 89) "practical experience shows that nothing will so much insure immunity against drinking as intensive work with other alcoholics".

2.6.5 Awareness of feelings

Difficulties experienced by addicts with affect dysregulation are highlighted in the Big Book of AA. For instance, one individual stated that “...we couldn’t control our emotional natures, we were a prey to misery and depression, we couldn’t make a living, we had a feeling of uselessness, we were full of fear, we were unhappy...” (AA, 2001, p. 52). An important curative factor in AA is that it addresses problems in affect regulation (Khantzian & Mack, 1989). The twelve-step philosophy explains that working the twelve-steps promotes self-reflective behaviour (Dodes, 1990). Being able to self-reflect is a core skill needed to manage difficult feelings. Khantzian and Mack (1999) suggest that “one of the main benefits of AA is that it helps and, more often, inspires people who have been out of touch with or inattentive to their feelings to attend to and take charge of them” (p. 588). Khantzian and Mack (1999) believe that the first job in recovery from addiction “is to identify feelings, even the fact that we have them” (p. 581). Krystal (1988) highlights the need to teach those seeking treatment for addiction, to identify and name feelings.

2.6.6 Practical tools

The AA program provides members with practical tools for managing the stresses of daily living (Valverde & White-Mair, 1999). These include an emphasis on action and doing, as opposed to being passive. The teaching of recovery-focused skills contributes to increased confidence and self-efficacy around managing negative affect without relapsing (Kelly, Stout, Tonigan, Magill & Pagano, 2010).

2.7 Affect dysregulation

Affect regulation and dysregulation is a common concern in a range of theories of personality development, psychopathology and mental health treatment, including modalities such as emotion-focused therapy (EFT), mindfulness-based cognitive therapy (MBCT), mentalisation based treatment (MBT), cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT) and psychoanalysis (Berking et al., 2008). The principle of affect regulation also features strongly in studies on addiction (Flores, 2007; Khantzian & Mack, 1994). Many authors consider affect dysregulation a core feature of addiction (Aldao et al., 2010; Taylor, Bagby & Parker, 1999; Fonagy & Target, 1997).

Affect regulation is an intricate process involving checking, assessing, and adapting one's emotional reactions to both internal and external stimuli (Cole, Michel & Teti, 1994). It involves an ability to decrease, increase or sustain emotions, through responding in a flexible and considered manner to emotional stimulation, by applying a variety of affect regulation strategies (Ekman & Davidson, 1994; Aldao et al., 2010). Davidson (2000) explains that:

Affective style refers to consistent individual differences in emotional reactivity and regulation.... It is a phrase that is meant to capture a broad array of processes that either singly or in combination modulate an individual's response to emotional challenges, dispositional mood, and affect-relevant cognitive processes. (p. 1196).

Affect regulation involves a cognitive, physiological, and behavioural process, which allows individuals to modify their experience of both the intensity and duration of their emotions (Bridges, Denham & Ganiban, 2004; Ekman & Davidson, 1994). Affect regulation includes regulating one's own affect as well as that of others (Niven, Totterdell & Holman, 2009).

Fonagy and Target (1997) describe mentalising as a reflective mode, where one can think about how one's thoughts may impact and be impacted by actual events. They emphasize the importance of being able to identify, reflect, and understand what one is experiencing. They add that without this ability, one is compromised in one's ability to think and reflect. In addition, the ability to regulate affect contributes to the expression of more socially appropriate feelings (Cole, Michel & Teti, 1994; Zeman, Cassano, Perry-Parrish & Stegall, 2006).

Unlike affect regulation, affect dysregulation refers to an inability to moderate the impact of arousing stimuli on one's emotional equanimity and the ensuing thoughts and actions that often accompany emotional overload. Affect dysregulation is triggered by cognitive processes that are activated by extreme emotions (Chapman, Gratz & Brown 2006). Affective dysregulation impacts negatively on an individual's awareness of others and therefore on their interpersonal relationships. It is expressed in impulsive, excessive, and socially inappropriate behaviour (Koole, 2009), leading to higher levels of emotional,

psychological and social dysfunction (Bandura, Caprara, Barbaranelli, Gerbino & Pastorelli, 2003).

Affect regulation and dysregulation exist on a continuum of physiological arousal and have different qualities in terms of tolerance, modulation, recognition and articulation of affect (Khantzian, 1999; Schore, 2016; Wurmser, 1974). Arousal that is appraised as overly intense interferes with cognitive capacities that would otherwise be engaged to successfully navigate the experience of an emotional storm or rollercoaster (Varona, 2017).

2.7.1 Edward Khantzian's Self-medication hypothesis (SMH) of addictive disorders

Prior to Khantzian's Self-medication hypothesis of addictive disorders, many studies provided evidence in support of affect dysregulation as a high-risk factor in addiction. As early as the 30's Rado (1933, p. 94) suggested that "it is not the drug or behaviour alone that determines susceptibility to addiction, but the vulnerable person and the impulse and need to use it". Krystal and Raskin (1970) observed that certain individuals battled to tolerate affect and that this predisposed them to addiction. Substance dependent individuals were found by many theorists to show increased levels of anxiety and an impaired capacity to self-soothe (Krystal & Raskin, 1970). In the absence of internal mechanisms to moderate particular psychobiological affective states, addictive substances were sometimes employed to perform this task (Putnam, 1992).

However, it was Khantzian, who in 1975 captured this thinking, conceptualizing it as the SMH, which he then published as a comprehensive theory in 1985. Khantzian arrived at his understanding of addiction as self-medication of affect dysregulation, through his clinical experience over many decades of working with this population. He stated, "while biological psychiatry has produced extraordinary discoveries regarding what drugs do in the brain, the SMH attempts to understand what drugs do in the person and for the person" (p.5). According to Khantzian (1985), not all people who take a certain drug become addicted, only those to seeking to alleviate suffering arising from an inability to regulate their affective states. Khantzian (1999) explained that "drugs and alcohol act as buffers,

dampers, or augmenters in coping with the painful emotions that one's relationship with self or with others engenders" (p. 335). According to Khantzian (1999):

We all, to a degree, rely on "outside" stimuli or substances to reduce pain...regulate affect. We might, therefore, think of the substance-addicted population as being composed of individuals who cannot achieve a state of affect regulation that relies enough on internal resources or strength, or upon human relationships that are sufficiently mutually enhancing or intergrading, to avoid excessive substance dependence. (p. 575)

Khantzian (1985) added that rather than seeking pleasure from drugs, individuals are attempting to self-medicate emotional pain. Drugs act as a "protective system" for those experiencing difficulty managing their emotions (Wurmser, 1980). In support of the SMH, Mate (2010) insists that we need to understand addiction in light of that from which the addict is seeking relief. He says that "....the issue is not the quantity or even the frequency, but the impact" (Mate, 2010, p. 136). According to Levin (1999) "Khantzian has changed the ways we think of and understand addiction and addicts to a degree matched by few, if any others" (p. xiii).

Through his clinical experience, Khantzian (1985) came to see that individuals who abuse drugs show a significant amount of specificity in their drug of choice (DOC). Therefore the behaviour or substance to which an individual becomes addicted sheds light on the internal state they are attempting to medicate. He observed that certain individuals are primarily drawn to amphetamines or stimulants, such as cocaine, to increase their emotional arousal, while others seek out opioids and sedatives, such as heroin, to quell emotional states such as anger (Pervin, 1988).

Experiencing emotions in and of themselves is not necessarily difficult, but it is the interpretation that one attributes to these emotions that may increase arousal, rendering these feelings more arousing or activating. Krystal (1988) noted that affect dysregulation arose out of an inability of the user to recognize and articulate feelings, i.e. alexithymia. Several theorists recognized that alexithymia prevented users from being able to process and manage their affect and the behaviour it stimulated (Krystal & Raskin, 1970). Some individuals wrestle with the experience of feeling overwhelmed by intense affect such as

rage, shame and loneliness (Krystal & Raskin, 1970) while others feel devoid of affect (Khantzian, 1999 Krystal, 1988). Another set of users tends to alternate between emotional flooding versus feelings of emptiness (Krystal and Raskin, 1970; Wurmser, 1974). Furthermore, those with SUDs frequently experience emotions as bodily sensations, which they find alarming and manage through using (Zeman et al., 2006). Difficulties are often experienced by addicts in empathizing with the expression of affect in others (Wurmser, 1974).

In addition, negative affective states resulting from coming off a drug-induced high frequently lead the addict to use again, resulting in a perpetual rollercoaster of moods (Maremmanni, Perugi, Pacini & Akiskal, 2006). Chronic substance use contributed to further erosion of emotional regulation strategies, leading to increased dependence, tolerance and drug usage (Rado, 1933). Khantzian (1999) emphasizes how drug use increases in a bid to cope with the intoxication-withdrawal cycle. Khantzian (1985) and Kurtz (1991) add that the experience of disapproval and criticism from others concerning the addict's behaviour intensifies their experience of shame, setting up a negative feedback cycle, where usage induces shame, perpetuating the need to repeatedly use to obliterate this shame.

Addiction is often understood to be a disorder of intimacy where an inner sense of shame prevents addicts from being vulnerable or dependent on others (Cole, Michel, & Teti, 1994; Zeman et al., 2006). Roth (2004) describes addiction as a 'disease of isolation', noting that people with affect dysregulation experience social anxiety. Others concur with this understanding, pointing out that individuals suffering from addiction also tend to avoid being vulnerable or dependent (Adams & Robinson, 2001). This absence of human contact paves the way for addicts to rely on their drug of choice as a substitute for connection with others. This serves to compound the individual's sense of shame, further corroding their affect dysregulation, and again resulting in a "cycle of shame" perpetuating on-going usage (Chapman et al., 2006). According to Khantzian & Mack (1999) "successful management of emotions means giving up the immediate highs that the drugs provided in favour of deeper, delayed satisfactions that come with sobriety" (p. 581).

2.8 James Gross's process model of emotional regulation

Individuals habitually attempt to control their emotional experiences and are able to develop affect regulation strategies to enable them to learn ways of moderating upsetting thoughts, feelings and actions in a more adaptive manner (Chapman et al., 2006; Gross, 2002). Affect regulation strategies offer alcoholics and, addicts in recovery, tools to prevent relapse and manage cravings (Chooan et al., 2016).

James Gross's process model of emotional responses suggests that emotions develop as part of a multi-factor process. They begin with a situation (internal or external) that is recognized, which leads to appraisal of its intensity and importance. This model takes a number of factors into account such as external and intrinsic influences, as well as antecedent-focused appraisals occurring before emotional responses, and response-focused appraisals, or strategies, occurring after responses have been generated (Gross & Munoz, 1995). In addition, reactions from other people to our emotional responses may serve to change the situation significantly, impacting again on possible emotional responses that may be employed (Gross & Thompson, 2007). Gross (1998) uses this multi-modal model to put forward a situation–attention–appraisal–response sequence which is initiated by psychologically and emotionally important situations, which may be either external or internal.

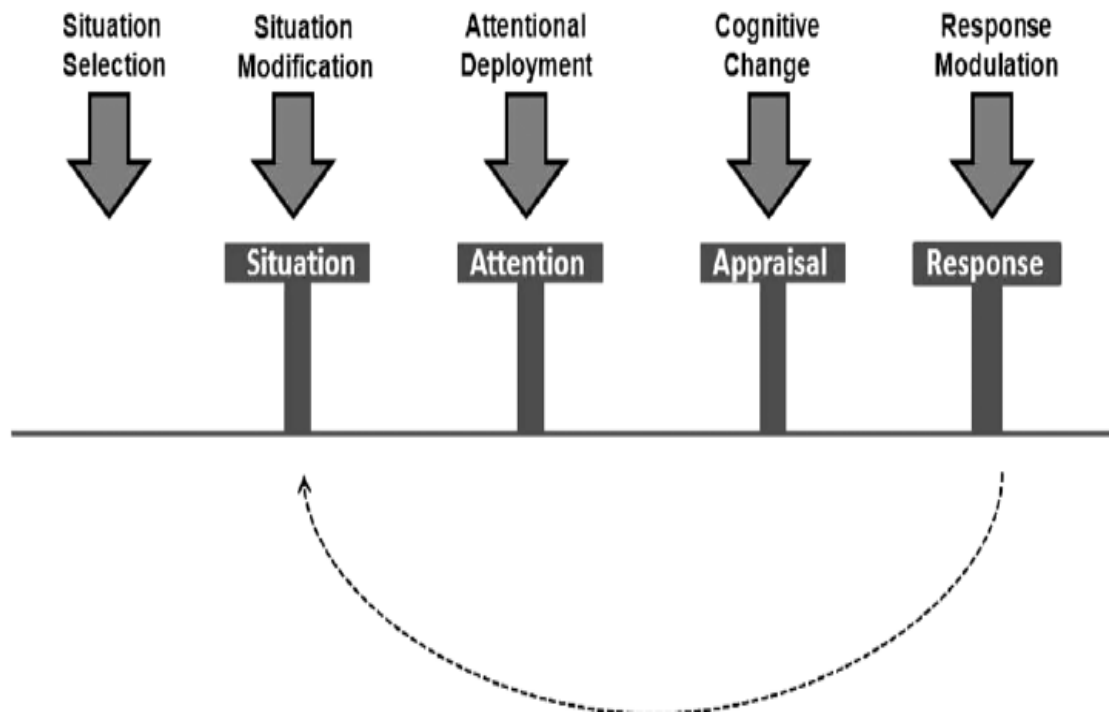


Figure 2.1: The Process Model of emotional regulation put forward by James Gross (1998, 2002)

This model outlines five families of strategies that may be employed to decrease, amplify or maintain emotions (Gross, 1998; Gross & Thompson, 2007; Beer & Lombardo, 2007).

Through using various strategies, individuals may be able to gain greater control of their cognitions and emotions enabling them to appraise and assess situations. Emotions may be regulated through carefully selecting situations in which one finds oneself, and people one surrounds oneself with (Beer & Lombardo, 2007). Emotions may be regulated prior to a stimulus, through situation selection, situation modification, attentional deployment and cognitive change. Emotions may also be regulated subsequent to an emotional cue being triggered using response modification. Adaptive responses may differ, depending on the situation (Kopp, 1992).

Gross's five families of emotional regulation processes:

These five points represent five families of emotion-regulation processes and include the following:

- **Situation selection** involves intentionally moving towards or away from certain situations to protect one from having to confront challenging emotions (Gross, 1998). It entails careful consideration of the short-term benefits of emotion regulation possibly gained through avoiding a difficult situation, such as a shy person fearing to face a social engagement, versus longer-term costs of confronting the task and feeling better in long run (Gross & Thompson, 2007).
- **Situation modification** involves altering the emotional impact of a stimulus by changing one's external environment. Altering the physical space between oneself and another may introduce sufficient change to regulate one's emotion (Gross & Thompson, 2007). A situation may be modified through the presence and support of another person (Gross & Thompson, 2007).
 - **Humour** may be used to alter internal environments. This would constitute a cognitive change and is discussed shortly (Gross & Thompson, 2007).
 - **Verbal prompts** may be used to modify a situation through facilitating problem-solving, or clarify information (Gross & Thompson, 2007).
- **Attentional deployment** can be implemented in situations, which may not be altered through situation selection or situation modification, to assist in changing the individual's environment. Attentional deployment involves attempts to alter internal environments, through intentionally choosing to approach or avoid an emotional situation. Attentional deployment takes many forms, such as physically withdrawing one's attention, or internally redirecting of one's attention using distraction or concentration, or allowing others to redirect our awareness. After practising attentional deployment one learns that emotions decrease in intensity and are less emotionally activating over time (Harris & Lipian, 1989).
 - **Concentration** involves intentionally focusing on certain emotional states. This may be achieved through learning to be mindful of what one is presently thinking and feeling and naming thoughts and feelings one is currently experiencing (Linehan, 2014). Mindfulness is a skill that increases proficiency with attentional deployment (Mischel & Ayduk, 2011).

- **Distraction** involves paying attention to another aspect of the situation (Stifter & Braungart, 1995) or invoking cognitions such as thoughts or memories that will conflict with the present unwelcome emotional condition (Watts, 2007).
- **Thought suppression** may be used to deploy one's attention through focusing on particular thoughts and images as opposed to more emotionally activating ones. This strategy is mostly considered maladaptive (Campbell-Sills & Barlow, 2007).
- **Cognitive change** entails changing one's appraisal of a situation to reinterpret its emotional significance and reduce its emotional and physiological impact. This may be achieved by altering one's thoughts about a situation or by altering one's thoughts about one's ability to control the anxiety generated by the situation (Gross, 1998). Because psychologically relevant events or situations can be internal as well as external, cognitive change may be applied to both internal and external experiences of events (Gross, 1998). Strategies employing cognitive change include reappraisal, distancing, humour and downward social comparison.
 - **Reappraisal** entails changing the meaning of a situation by turning towards and engaging with an emotionally difficult stimulus (Gross & John, 2003).
 - **Distancing** involves engaging a third-person perspective to evaluate an emotional event more objectively (Ochsner & Gross, 2008). Distancing facilitates self-reflection, and processing of negative emotional stimuli (Ochsner & Gross, 2008).
 - **Humour** may be used to alter internal environment through decreasing the emotional intensity of a situation. This would constitute a cognitive change and is discussed shortly (Gross & Thompson, 2007).
 - **Downward social comparison** involves comparing oneself or one's situation to that of a less desirable one to alter one's interpretation of the situation to minimize negative feelings (Taylor & Lobel, 1989).
- **Response modulation** takes place subsequent to a response to an emotional cue occurring. It involves efforts to directly impact behavioural, physiological and experiential methods of responding to an internal or external emotional situation (Gross, 1998).

- **Physical exercise** may be used as an outlet for expressing difficult emotional experiences. Alcohol may also be used to dampen or modify the experience of emotional experiences
- **Emotionally expressive behaviour**, such as talking, serves to modulate responses (Gross & Thompson, 2007).
- **Venting** is considered a maladaptive emotionally expressive strategy.

2.9 Summary

In this chapter alcoholism and addiction have been described, and the global problem of addiction highlighted. Treatment options have been outlined, with special emphasis on AA and its TSP. Affect dysregulation has been examined with a view to how it might contribute to the development of addiction. Khantzian's SMH (1985) has been used to demonstrate the link between affect dysregulation and addiction. The process model of emotional regulation strategies, by James Gross (1998), has been used, to describe strategies that may increase individual's capacities to adaptively regulate their affect.

Finally, the aim of this chapter has been to highlight AA and its various offshoots such as Narcotics Anonymous, as options to simultaneously treat both addiction and affect dysregulation, and thereby to increase the chance of long term sobriety.

Chapter 3

Research design and methodology

3.1 Introduction

The aim of this chapter is to identify and describe the research paradigm and the research design used in this study. Criteria around participant selection are identified. Reasons are given for the instrument selection, i.e. the use of an in-depth semi-structured interview to collect data from the participants. Furthermore steps taken to analyse the data and identify emerging codes and themes are explained. This chapter also highlights ethical issues as well as issues of credibility, dependability, confirmability, transferability and reflexivity.

3.2 Research questions

The objectives of this study were to increase understanding about how:

- AA and the TSP may assist addicts in achieving and maintaining on-going sobriety; and
- To examine a possible link between AA and TSP and improved affect regulation.

The study focused on answering the following research questions:

- What do recovering addicts consider to be the most helpful elements of the TSP?
- What are recovering addicts' reflections on the role of the TSP in constructive affect management?

3.3 Research design

This study used an interpretive research approach within a qualitative paradigm and was primarily exploratory (Babbie & Mouton, 2005). According to Smith (2015), a qualitative design provides a rich, descriptive account of the phenomenon under investigation.

Berkwits and Inui (1998) note that the value of this research method is that it stimulates dialogue so as to produce rich and detailed data. An interpretive approach privileges the subjective experiences of participants. It is achieved by interacting with participants and conversing with them in an attempt to understand their insights and experiences. This allows the participants to be the experts on the topic at hand. In this study, the focus of the

dialogue with participants was their perceptions of the benefits of the TSP (Terre Blanche, Kelly & Durrheim, 2006).

3.4 Sampling

Both snowball sampling and non-probability, purposive sampling techniques were employed. Snowball sampling occurs when an individual participant is identified among a specific population and asked to select another person in the population (Goodman, 1960). Purposive sampling involves the deliberate selection of specific participants for the study to obtain the required information (Maxwell, 2012). Participants for this study were required to have had first-hand experience of the TSP and to have achieved recovery through their engagement with the programme (Henry, 1998; Cohen et al., 2007). The snowball sampling technique, which relies on referrals from initial subjects to generate additional subjects, was used to gather participants for this study. Snowball sampling may have presented a challenge with regard to confidentiality, as participants referred other participants to the study. However, as they were members of a TSP they already knew each other prior to the referral of the subsequent participant. The researcher adhered strictly to protecting participant's identity and confidentiality. Snowball sampling is inexpensive and made it easier to gather an appropriate sample for this study (Braun & Clarke, 2006).

In this study, the target population, or the overarching group from which participants were selected (Durrheim & Tredoux, 2014), consisted of addicts who had used the TSP to achieve sobriety. The sample consisted of eight subjects, seven male and one female, with a mean age of 47. As thematic analysis involves close, detailed and thorough scrutiny of data, a small sample is necessary (Braun & Clarke, 2006). Five participants were white and three were Indian. Each had attended a minimum of 50 twelve-step meetings, reported being abstinent from mind-altering substances for a minimum of three years and attributed their recovery to working the twelve- steps and attending twelve-step meetings. Some participants had been introduced to the twelve steps as inpatients in rehabilitation centres and continued attending twelve-step meetings as outpatients. Others encountered twelve-step meetings through word of mouth and through newspaper adverts, which led them to groups in their communities.

3.4.1 Method of recruitment

As the researcher in this study had worked in the field of addiction recovery previously, she knew key contacts who were able to assist in the sampling process. One contact was a long-standing member of an active Pietermaritzburg Narcotics Anonymous (NA) meeting, while others were long-standing members in other provinces. Key contacts shared information about this research and the researcher, with members of the NA fellowship. Those willing to be interviewed allowed one of the key contacts to pass their details on to the researcher. They, in turn, provided the researcher with contact details to other people they knew in the AA and NA fellowship who were also willing to participate.

Once contact had been made with each participant, the researcher negotiated suitable times to meet. Those living nearby were interviewed in person. Those living a greater distance were interviewed via Skype or WhatsApp video call. In all instances, participants appeared eager and willing to share their experiences.

3.5 Instrument selection

Semi-structured interviews were used in this research to encourage open-ended conversations with the participants (Silverman, 2013). The aim of using a semi-structured interview was to increase understanding of the participant's subjective experience of the TSP (Castillo-Montoya, 2016; Terre Blanche, Kelly & Durrheim, 2006).

An in-depth, semi-structured interview, lasting 60-90 minutes was used with each participant. Through one-on-one interviews, interaction and engagement were facilitated between the researcher and the participants (Seidman, 1991). According to Boyce and Neale (2006), interviews tend to elicit rich information. (Having spent time teaching steps one to four of the TSP in a rehabilitation clinic, and having observed inpatients and outpatients responding favourably to the twelve steps, the researcher had developed an interest in positive emotional changes through engagement with twelve-step treatment).

The interview schedule was developed based on theoretical work by psychologists in the field, such as Phillip Flores, Edward Khantzian and Ernie Kurtz. With this in mind, the semi-

structured interview questions were used to get deeper understandings of the psychological underpinnings of the TSP. The interviews focused on possible changes experienced with regard to managing difficult emotions, such as anger. Questions were broad and open-ended to stimulate conversation in the area.

3.6 Data collection

Details regarding the date, time, and venue of each interview were discussed and agreed upon individually. After meeting in person or online, participants were made aware of the voluntary nature of the study, as well as confidentiality and the option to withdraw from the research at any time. Participants signed a consent form (see Appendix 2). Members of the sample were coded using a number to protect their anonymity.

Data was collected using semi-structured interviews (see Appendix 4 for interview schedule). Data collection entailed audio recording individual interviews with each of the research participants. Interviews were then transcribed.

3.7 Data analysis

Thematic analysis was used to analyse data as soon as possible after it had been collected, to elucidate recurring ideas, which were identified as common themes (Silverman, 2013). Terre Blanche et al. (2006) elaborate on the value of thematic analysis in highlighting core themes and categories emerging from data. Thematic analysis identifies common themes and facilitates the grouping of these in an organised and clear manner (Aronson, 1995). Grouping the data into themes promotes the interpretation of the research aims and permits the data to be explained in rich detail (Braun & Clarke, 2006). Six phases of data analysis, as outlined by Braun and Clarke (2006) were followed. The steps suggested by Braun and Clarke (2006) are repetitive and need not be followed sequentially. The six phases include:

Phase 1: Familiarising oneself with the data

During the initial interviews, recording and subsequent transcription of them, the researcher developed a more three-dimensional understanding of the territory (Riessman,

1993). Data were transcribed verbatim to retain as much of the meaning as possible. Through the process of data collection and the interaction with participants, the researcher identified a few tentative themes. Through immersion in the transcripts, by reading and re-reading them many times, the researcher was able to gain a more global view. As noted by Braun and Clarke (2006), this is a vital process, necessary for establishing a firm foundation of understanding before beginning to break the data down into smaller parts. Mind maps were used during the reading and re-reading phase to track ideas and thoughts as they developed in response to the data. The use of different colour pens also served to bring the data to life (Braun & Clarke, 2006).

Phase 2: Generating initial codes

Once familiar with the data, and having compiled a preliminary list of ideas about what the data contained, as well as what seemed noteworthy, coding began. This was done manually. Attention was given to every item of data, to observe if parts of it were repeated, and could later be used as themes, either within or across the data sets. Again, the use of mind maps and coloured pens was vital in bringing the data to life visually (Braun & Clarke, 2006). A systematic process was followed, where each piece of data was given the same amount of attention, and awareness was placed on pieces data that could be identified as repeated themes or patterns. Initial codes started to emerge once all the data, as a whole, had been read, re-read and ideas had been added to several mind maps. The initial codes reflected aspects of the data that the researcher found interesting. They referred to basic, verbatim extracts of data that could be coded broadly around the research questions pertaining to affect dysregulation (Boyatzis, 1998). This process helped to organise that data into logical and coherent groups (Tuckett, 2005). These initial codes were not necessarily the same as the themes, which were broader. The coding, which took place in this phase, was intended to ensure that the themes emerged in response to the actual data, and were not ideas generated from elsewhere, such as the researcher's preconceived ideas.

The researcher intended for the codes to be 'theory-driven', rather than 'data-driven.' Questions held in mind pertained to particular hypotheses around which data could be coded. Also of importance was an awareness that not every extract from the data needed to be coded, only those highlighting certain aspects of the data (Braun & Clarke, 2006).

Actual extracts of data were coded from each participant and then gathered together within each code across the data set. As recommended by Bryman (2012), the researcher coded for as many possible themes as possible. When extracts were coded, some of the surrounding data was included to provide a context. Individual pieces of coded data were collected under more than one theme in instances where they fitted. Later, some of the information that seemed redundant was uncoded. The final thematic map contained contradictions and inconsistencies. This was to be expected and was an important part of the coding experience.

Phase 3: Searching for themes

This phase marked the beginning of starting to search for themes by sorting the initial codes into possible themes and then examining how these might relate to one another. Here, the focus was on grouping the initial codes into themes and starting to see how they might form a single encompassing theme. Again mind-maps proved very useful in developing candidate themes, sub-themes and the coded data extracts within them. These themes formed the starting point of data interpretation. Here arguments about the benefits of the twelve-steps became clearer (Boyatzis, 1998). No information was considered redundant at the end of this phase in case themes needed to be modified in any way.

Phase 4: Reviewing themes

Having established what had been identified as the candidate themes, coded extracts were reviewed to see if they fitted under the themes in which they had been placed. In so doing, some of the themes changed, becoming more focussed or redundant. In some instances, two themes merged to become a single theme.

Once the candidate themes had been reviewed and become part of a map, each individual theme was reconsidered to see if it fitted with the map. This process necessitated reading and re-reading the data to code any more data into existing themes. It was a challenge to avoid summarizing the data extracts rather than identifying why they might be interesting or descriptive.

Phase 5: Defining and naming themes

This phase involved clarifying and explaining each theme and ensuring that each theme was accompanied by a detailed written analysis. In addition, the 'story' each theme told, in relation to the research question, was clearly explained.

Themes were revisited to ensure they were not too varied or complex. Data extracts within each theme were revisited and organized, provided with a coherent explanation and an accompanying account.

Phase 6: Condensing this data into a report.

Once the themes were established, the analysis and write-up began. Data extracts were selected to illustrate and support the themes. Themes were repeatedly linked back to the research question. The discussion focused on the implication of the information that had been highlighted by the themes.

3.8 Validity, reliability and rigour

When conducting qualitative research, trustworthiness and authenticity are considered important criteria by which to judge the study (Bryman, 2012). According to Babbie and Mouton (2005), trustworthiness can be measured using the following four principles:

Credibility, or internal validity, refers to the trustworthiness of the research (Tracey, 2010). Credibility may be compromised by anecdotalism when the researcher selects data extracts highlighting their interests instead of representing the data (Silverman, 2005). The researcher guarded against this by checking information with the participants and by avoiding the use of generalizations in this study, clarifying questions were used to determine whether the researcher accurately understood the information participants shared. Reference to literature supporting findings was included so as to increase the research credibility. Furthermore, the researcher used reflexivity, which included self-reflection and acknowledgement of her previously held beliefs.

Dependability, while similar to reliability, looks at the likelihood that findings will be consistent at other times (Bryman, 2012). It is important that the process used to obtain

results can be replicated (Ulin, Robinson, Tolley & McNeil, 2002). According to Babbie and Mouton (2005), resulting data should be consistent if process notes, raw data and data reduction corroborate the research steps. Dependability can be increased through including longer verbatim data extracts, instead of those rephrased by the researcher. In this study, the researcher has provided a detailed description of the research process so as to enhance dependability.

Confirmability and reflexivity deal with the possibility that another researcher may be able to replicate the study and obtain the same results Bryman (2012). This ensures that findings are reflective of the actual data, and not what the researcher is wishing to find. This issue was addressed through the researcher's efforts to remain open to emerging themes in this study. In addition, the supervisor of this research was called upon to assist in ensuring personal bias did not creep into findings. This gives other researchers an opportunity to examine the analysis decisions made. An audit trail was provided in this study through a detailed description of the research process.

Transferability, or external validity (Bryman, 2012), refers to the extent to which research findings may be transferred to other contexts. To ensure transferability, the researcher needs to state the assumptions that are fundamental to the research and provide rich data enabling the reader to connect personally with the research material. Transferability was addressed in this study by providing full and detailed descriptions of the twelve-step group context and the addict's personal experience of the twelve-steps, as experienced through the attendance of these groups. Readers may be able to identify personally with the experience of belonging to a group, e.g. a church group or a book club, as well as to experiences of individuals attending the TSP. By increasing the possibility of the reader being able to relate they will be better able to decide for themselves if the research findings transfer to their own experience/s and context (Tracey, 2010).

3.9 Reflexivity

When using qualitative research it is essential that the researcher be openly reflexive of their influence on the research findings.

Reflexivity refers to the researcher's awareness of their role in the research method and their responses to the data, (Willig, 2001). The researcher paid careful attention to her personal views and beliefs in the area of addiction to guard against their potential impact on the results of the study. The researcher attempted to reduce the impact of some of these factors by ensuring that good rapport was developed with the participants and that participants felt comfortable during the interview process.

The researcher was cognizant of the risk that her subjective views could compromise the confirmability of this study and the need therefore, to remain open, discerning and thoughtful so as to obtain reliable data (Camic, Rhodes & Yardley, 2003).

The researcher made use of a research journal where personal reflections were recorded. This technique is one put forward by Anney (2014) and involves documenting the data collection process, the data analysis procedure, and the researcher's own interests and background, all of which could potentially impact on their interpretation of the data. Anney (2014) argues that, in so doing, the researcher will be able to recognise how they might have influenced the study at various points along the way. The process of keeping a journal is vital in enabling self-reflexivity and assisted this researcher in recognizing when subjective views may have impacted the analysis.

Focusing on issues of reflexivity, the researcher ensured that interview questions were open-ended and encouraged participants to answer as honestly as possible. This compelled the researcher to focus on the views of the participants rather than her own. Issues of reflexivity were also noted during the process of analysing the data by identifying emerging themes.

Kerstetter (2012) points out that data can be observed through an 'insider,' 'outsider' and 'space-between' position. An 'insider' position involves the researcher acknowledging their particular knowledge of the topic under investigation, in this instance the TSP for recovery from addiction (Le Gallais, 2008). As previously explained, this researcher had experience working in a rehabilitation facility. Through taking an 'outsider' perspective the researcher strives to reduce personal bias and to view findings as objectively as possible (Kerstetter,

2012). As is the case with many researchers, it was necessary for the researcher to take a 'space-between' position recognising that an 'outsider' positioning would be difficult, given her existing knowledge in the field of research. By doing so, the researcher recognised that she may have influenced participants' responses to some extent (Kerstetter, 2012) but she nevertheless made every effort to produce results that were as authentic as possible.

3.10 Limits to the design

Thematic analysis is a very thorough, intricate and repetitive process, where one develops an in-depth understanding of the data. Richards (2009) highlights the importance of using a small sample since qualitative research can be very time-consuming to collect, transcribe and analyse. Therefore it is important that the sample is small (Lapadat & Lindsay, 1999). This researcher's interviewing style and attendant success in building rapport with participants facilitated more open sharing, which may have increased the value of the results obtained, albeit from a small sample. Due to the fact that a small sample was used, generalizability of the findings could pose a limitation, and for this reason, purposive sampling was used to enable the researcher to carefully select participants to increase the transferability of the findings.

3.11 Ethical considerations

The researcher adhered to the eight principals of the ethical code of conduct stipulated by Emanuel, Wendler and Grady (2008) who highlighted the importance of carefully assessing the ethical merit of a study so as to avoid exploiting or harming participants in any way.

3.11.1 Collaborative partnership

A collaborative partnership, based on respect, was formed with each of the eight participants, in an attempt to allow participants to feel open and enthusiastic about sharing their views openly with the researcher. In addition, meeting with the gatekeeper, a member of the target population, at the outset of this research, and discussing with him his views on the thesis topic, and possible value that may be derived from it, increased a sense of collaborative partnership.

3.11.2 Social value

The researcher aimed to address the question of a suitable, free and accessible treatment option for alcoholics and addicts. In addition, the researcher hoped to shed light on a psychological paradigm, rather than a medical paradigm for understanding the dynamics contributing to addiction.

3.11.3 Scientific validity

It is hoped that results from this research, i.e. the role of affect regulation in addiction, will be useful to clinicians working in this area. The researcher adhered to the six steps put forward by Braun and Clarke (2006) for analysing data when using thematic analysis. The qualitative research design was feasible as it facilitated the gathering of unbiased data, from the inside out, on AA members' views of the programme.

3.11.4 Fair participant selection

Participants were selected using purposive and snowball sampling in a bid to obtain a representative sample of AA and NA members. As long as participants who volunteered to participate in this study met the requirements of having been 'clean' for three years and attributed their recovery to their participation in a TSP, they were eligible to participate.

3.11.5 Favourable risk-benefit ratio

It was anticipated that there would be minimal risks of any sorts, to the participants, as a result of their participation in this study. The only indirect benefit included contribution to the field of research into recovery and addiction.

Risks to participants of feeling traumatised by remembering painful events linked to their using, were minimized as the open-ended questions permitted participants to engage with the material at a level with which they felt comfortable. Participants were made aware of the option of counselling, at the Child and Family Centre (see Appendix 3) in the event that the interviews triggered significant emotional distress.

3.11.6 Independent review

Approval of the study was issued by the Registrar's Office at the University of KwaZulu-Natal (UKZN). Ethical clearance was granted by the Humanities and Social Sciences Research Ethics Committee at UKZN (reference number, HSS/1217/019M, see Appendix 6).

Gatekeeper's permission was granted by a long-standing NA member (see Appendix 5).

3.11.7 Informed consent

Participants were provided with an information sheet (Appendix 1) providing detailed information about the study, and what would be required from them. Participants were informed of the details of the study and signed consent was obtained (see Appendix 2)

3.11.8 Respect for participants

The mental health and wellbeing of the participants were monitored by the researcher during the interviews to ensure no emotional distress was incurred and that participants felt valued and respected, and that their contribution was appreciated. Confidentiality was ensured through identifying each of the participants using a number from 1-8. Participants understood that they could withdraw from the study at any point. Research results were disseminated via email. Participants wishing to engage with the researcher following this were made aware that this was acceptable.

3.12 Summary

This chapter focused on the research design and methodology used to conduct this study. It elaborated on the manner in which participants were selected, and the collection of data. In addition, cognisance was taken with regard to the limitations encountered in both the research design and the collection of the data. The reasons supporting the use of a qualitative research design, and a thematic analysis of the data have been highlighted and the steps taken in order to arrive at the codes and themes residing in the participants' transcripts. The results of the thematic analysis are presented in chapter five.

Chapter 4

Results

4.1 Introduction

This dissertation explored what eight participants of AA/NA and its TSP found to be the most helpful elements in the programme. Having established the common elements, identified by the subjects as beneficial, this study went on to examine if some of the success of the TSP can be attributed to the ability it enhances in participants to regulate their emotional lives more effectively. With this in mind, subject's interviews were thematically analysed to extract the key elements in their experiences of the TSP.

4.2 Themes emerging from the transcripts

4.2.1. Twelve-step recovery programmes of AA

4.2.1.1. A programme for life

4.2.2. Regular attendance at meetings

4.2.2.1. Social network

4.2.2.2. Connection

4.2.2.3. Interpersonal skills

4.2.2.4. Feedback

4.2.3. Understanding addiction as a disease

4.2.3.1. Shame

4.2.4. Acceptance of a Higher Power

4.2.5. Service to others

These are discussed below.

4.2.1 Twelve-step recovery programmes of AA

4.2.1.1. *A programme for life*

The transcripts suggest that the most curative and transformative part of this programme for participants is that it provides members with a new model for living. The following extracts were chosen to illustrate the on-going (lifelong) and challenging nature of recovery.

Participant 5 explained the manner in which the steps fulfil the role of providing on-going and continuous support:

Well the thing about the twelve steps [is that] it's a never-ending process. So it's like you do step 12 and then you start with step 1 again. So I would say a lot of the steps are very similar to CBT; it's just [that] they use a different language. The steps teach you to become aware of your unhelpful coping skills. We learn to not make snap decisions, to sleep on it, to not walk around with a credit card or with a lot of money on you. Russell Brand puts it very clearly when he says 'if you're not working a program, you're being worked by your own unconscious programme.

Participant 7 explained that the TSP is more than just a treatment model. It also provides tools that assist one in changing one's life:

Recovery is definitely not the Disney picture, you going to get the girl and the house and a big car. It's more like you going to manage a somewhat shitty life a bit better. The steps are very practical. The steps are about getting you through your day. It's about structure. Waking up in the day, and having like a schedule so you don't feel overwhelmed and shit like that.

The TSP is seen by members of the fellowship as providing a template through which one can access more positive behaviours. As participant 2 observed:

Me being an addict and an alcoholic is a gift. I had to face some stuff in my life because of the steps. Everyone should use the steps.

Participant 3 echoed the advantages of working the twelve-steps as a means of gaining insight into oneself:

The twelve steps helped me realise that the problem wasn't really the alcohol. The problem was me. I realised that giving up alcohol is only the start of it. I had to realise this to be able to do the rest.

Participant 6 concurred with this sentiment of learning important things about oneself, and of learning to take greater responsibility for one's actions, through walking the steps, saying:

When I got to the TSP it immediately changed my life. In the TSP lies the belief that all problems that a person experiences, the solution is within themselves. It does not lie with the other person.

Participant 2 explained that the benefit of being part of a TSP is that sober living is modelled by more longstanding members, increasing newcomers confidence in their ability to manage abstinence:

These people have showed me how to change my life and how to live the way I now do.

Participant 1 added that he now felt able to confront, rather than avoid, problems:

Through the TSP I learnt how to accept that life is about moments of joy and moments of pain. You know if you get clean, life is not a bed of roses. Life is still coming with all its challenges and you've got to face this because that is your life. You cannot run and forget about it. So I had to learn to find solutions to the problems that I faced.

4.2.2 Regular attendance at meetings

While all respondents in this research were unanimous in their appreciation of the TSP, all concurred that the two central ingredients comprising the TSP, i.e. regular attendance at meetings and working each of the twelve-steps, were in and of themselves noteworthy. Meetings were seen to provide a competing behaviour for members, one to rival that previously spent using. In addition to meetings providing a safe place, away from temptation of relapse, they also facilitated in the development of a greater sense of accountability, among members:

Going to meetings gave me structure and something to do in the time that I would otherwise have been using. Meetings help to keep me clean because I now have a sense of accountability. I didn't want to go there and say I'd relapsed. I felt I'd be letting them down and myself. (Participant 3)

All participants spoke about the value they found in regular attendance of meetings, and of being a part of a unique programme, for addicts and run by addicts. Participant 8 explained this saying:

It's a fellowship for addicts and alcoholics only, and there's a pride that we are run by ourselves. That's why we don't have doctors and psychologists. It's the concept that the therapeutic value of one addict helping another one is without parallel.

Participant 2 noted how through spending time with others who could relate to one another, without judgment, a sense of identification and an ensuing ability to share openly and honestly developed:

AA says to look for the similarities rather than the differences. I would sit there and I'd listen to someone else sharing. I would think: "That's exactly the same as me. That's how I am. That's not lekker hey, I must change." I share and someone else thinks: "cheez I can relate to that".

For participant 4, the process of identification in meetings assisted him in being able to recognise his familiar patterns of thinking and behaviour when in active addiction and to see them as irrational and illogical:

Addiction is self-generated chaos. It's total insanity. Meetings are where you identify with that insanity. No person except those in AA/NA can identify with that.

4.2.2.1. Social network

Participants were unanimous about becoming part of the fellowship of AA, and the sense of community this provided. Participant 2 explained the value of being in the company of others saying:

Towards the end of my using I was very withdrawn and isolated. I pushed everybody away. The groups play a huge role. Sometimes I don't feel like going to a meeting, but I promise you, as I leave that meeting, I feel great. Even if the guy shared and I didn't take a lot out of his share, just being there, seeing people in recovery that I know, it's just lekker. I feel lekker.

Participant 5 noted that through being part of the fellowship, he was afforded protection from feelings of loneliness and isolation:

The fellowship is central to me. There were many times that I felt lonely. Now my source of friends and company is the group.

4.2.2.2. Connection

All participants reported feeling deeply lonely, isolated and ashamed because of their addiction, and noted that these feelings were alleviated through connecting with others:

Participant 3 clarified the importance of connecting with others in order to recover:

The underlying message of AA for me is [that] you can't do this on your own. Going to meetings is useful for connecting with people.

Meetings provide an antidote to loneliness as members come to identify with and relate to one another:

Hearing other addicts at meetings – it's as if someone else is telling my story (Participant 6).

Participant 8 observed that she benefited from the sense of connection and structure provided through becoming part of the fellowship:

You become a member of the fellowship. Then when you pass a certain point you start to sponsor other people and you become part of this tree of support. I've got a sponsor and now I became a sponsor, and one day my sponsee will sponsor someone. It keeps people connected.

Participant 2 highlighted the importance of connection in recovery, citing an important 1970s experiment by a Canadian psychologist Bruce Alexander, which he called Rat Park:

In an experiment called Rat Park, there was one rat in a cage, given cocaine water and ordinary water. It drank the cocaine water until it died. Then a second Rat Park was built a rat park, with many rats together and the rats don't drink the cocaine water. So because recovery is about connection, if you're not going to get that connection, you're going to isolate yourself and use. So the culture of recovery is about forming a social network with like-minded people who promote recovery.

Participant 2 elaborated on the importance of becoming part of a sober social network in order to protect oneself from the temptation to use:

The culture of recovery is forming a social network with people that promote recovery. The culture of addiction is the opposite, isn't it? It's forming an informal social network of users. I want recovery. For me to have recovery, I need to get into the culture of recovery. If I wanted to get into religion I'd go to church. I go to the meetings because there are like-minded people there, all working their recovery. The fellowship keeps me in recovery. It's about you knowing you can't do it alone. There's an AA slogan that says: You alone can do it, but you can't do it alone.

Participant 3 highlighted that for him a consequence of getting clean was losing many of his friends and that the groups were central in introducing him to a new group of people, supportive of recovery:

It provided me with a group of sober friends. I couldn't hang out with my friends 'cos they were all drinking and drugging. (Participant 3)

Participant 5 expanded on the importance of being able to exchange one's using friends for clean friends, so as not to jeopardise one's recovery:

So the drug team, the people I used to use with, they were replaced. That negative social network was replaced by a positive social network.

4.2.2.3. Interpersonal skills

While all participants described arriving with their interpersonal relationships in tatters, all described learning constructive interpersonal skills from the TSP. Participant 8 detailed some of these basic interpersonal skills learnt in meetings:

There are a lot of benefits in attending meetings. There's some reparenting, we learn socialising skills. It's learning that you have to be quiet now cos someone else is talking. Or learning that you've got to move your chair over to let someone fit in. There is no calling a person out because there is no cross talk.

Participant 5 observed the importance of learning to be assertive without being either aggressive or passive, both common among people suffering from addiction:

We don't always agree. But [we learn] to be able to say 'I need to disagree' and say sorry afterwards. You are allowed your own opinion, and I'm allowed to have mine. It gives us tools to manage conflict.

Participant 5 assessed the strengths of the group process, reflecting on his increased levels of empathy and awareness of the needs of others:

There is a lot of gossip that goes on in meetings. There are group dynamics. In some ways we have to act out our sense of self. We have to deal with our character defects within the group. We use the program to explain to others, "hey this is how the program tells us how we should behave and so you shouldn't be fighting with this person. That person has his or her own problems. Go and apologise."

Participant 5 highlighted some of the interpersonal challenges faced during meetings, and how beneficial it was for him to have a safe place to improve these skills:

There are group dynamics. Within the group you get newer members competing with one another. In some ways we have to act out our sense of self. We have to deal with our character defects within the group.

Participant 6 emphasized the rich learning that takes place through receiving feedback from fellow group members:

In our life experiences at some point we might experience what others have experienced. When they are relating their experiences we might not have experienced that at this point. But a lot of the lessons we all experience at one time or another. E.g. there is one member who gets very frustrated in traffic. We keep telling him "You need to calm down." So when I'm in traffic I think of that guy. In lots of other respects, experiences shared become lessons for all of us. And that is why the group is so important.

Participant 6 also highlighted the collective wisdom obtained through being part of the fellowship:

At all times somebody or other is having some sort of challenge. The group becomes a reservoir of insight and understanding and a source of knowledge for all of us, to embrace what they are experiencing. It becomes a library of information for other members in the group. That is why group therapy is so important.

Participant 1 articulated the value he experienced in groups as a result of the emphasis of the TSP's philosophy on focusing on similarities among members rather than differences, and how, in his view, this facilitates increased tolerance of others:

In NA there are relatively few problems between members. There is harmony. And it shouldn't be. But all these people saying we are the same and saying there is a need to find a solution. This makes it harmonious.

Participant 7 described recognizing positive changes in his social interactions subsequent to joining the programme, and how this strengthened his sobriety by reducing interpersonal conflict:

Since being in the programme I have better relationships, there's less chance of getting the shit kicked out of me in a situation. I can hold down a job. I don't get so angry. Often if I fucked up with anger then the using came because the only option was to use because I'd trashed up my life again. Even though I didn't relapse, I've kind of dismantled everything. And then picking up is almost like a face-saving thing. Like you know: "Oh well I might as well use now cos I fucked it up again"

The above transcripts highlight the central role played by the experience of belonging and connection obtained through attending TSP groups and the resulting development of more effective social skills.

4.2.2.4. Feedback

An important therapeutic function of TSP meetings was attributed to the feedback received from others. Participants highlighted the value of understanding how others experienced them, in an environment perceived as tolerant and accepting. Participant 2 described how this helped him:

It was in groups that I heard how others experienced me, particularly my anger. I couldn't have otherwise known these things. If I didn't share honestly then how would I have gotten feedback about myself? To be able to sit there and hear: "You know what M, you are arrogant, and you use anger for control." Sitting here and I must listen to this.

Participant 8 recognised how her sense of self-worth, which had been severely eroded during her time of using, grew as a result of attending and receiving positive feedback from others:

So when I'm in a meeting, listening, it's feedback that makes me feel worthwhile

Participant 4 noted that as a result of group feedback, he felt assured of having a place where he could seek guidance and support in his everyday life:

I'm just thankful for the meetings because it's given me life. The only way I can deal with my life is with the fellowship. If I've got a dodgy idea, another person in the fellowship might say, "That's dodgy. Don't do that."

4.2.3 Understanding addiction as a disease

Participants in this dissertation were unanimous in the sense of relief they reported upon coming to understand, as a result of working step 1, that they suffered from a disease, namely a disease of addiction. Participant 4 attempted to convey his understanding of the disease of addiction, saying:

The best way to even try understanding, and it's a weird thing, [is that] it's like an allergic reaction. That's the only thing I can describe it as is as an allergic reaction to something. Cos it affects you straight away. Who would have rat poison every day of their life on purpose? No normal human being stuffs whatever chemical into their body.

Participant 3 believed the most useful thing about seeing addiction as a disease is accepting the seriousness and chronic nature of the siltation, and the need therefore for on-going treatment.

Alcohol has got characteristics of a disease. AA says it is a disease. I actually don't think it makes a difference what it is. The fact is that if I drink my life completely falls apart.

As a consequence of realising that they suffered from a disease of addiction, participants shared that they now realised they were not to blame or responsible for their addiction, nor was the disease confirmation that they were intrinsically bad. Participant 1 captured this profound shift in self-understanding he experienced upon learning that he suffered from a disease of addiction:

I think the first and most important thing was, that despite all my education, and all my perceived intelligence, I had never worked-out that the reason I do all these things is because I have a disease. I'm an addict. I need a programme of recovery. I say to myself: "Ja you are bad. You did all these things. But your life can change, because others have changed."

The TSP described the disease of addiction as chronic, progressive and that the necessary treatment is abstinence. Participant 5 articulated the importance for him, in managing this disease through on-going commitment to group attendance despite living far away and having been sober for many years, saying:

Although I work 240km away, I come down for the Saturday meeting. I've been doing that for 15 years.

Participant 2 described his understanding of having a disease of addiction that primarily impacts his thinking, which he describes as having been irrational and insane.

The TSP keeps me in recovery, because my brain has been hijacked. My brain is rewired. So I need a program to help me through recovery. I've got to remind myself that I have the disease of addiction. If I say to myself 'X you're an addict,' it reminds me that I've got a disease of addiction; and it can kill me.

Participant 1 described understanding the difference between his diseased self and his sober self, saying:

When I get angry and resentful I know it's that mad addict, who wants everything now, that is running my brain. He doesn't need drugs to do that. He

just wakes up and runs riot. And now I know when I'm getting angry and open my big mouth, I realise that's my addict, egotistic person. There is a way I need to say what I want to say, but I need to think about what's irritating. It's taught me how to think because, as an addict, I am not thinking.

As part of the behaviours that characterise addiction, addicts are often seen as arrogant and proud. Participant 7 clarified how these traits diminished as he became more humble and learned to apologise to others, through working the steps:

Letting go of pride, what they talk about in AA as "bullshit pride and ego." When I mess up I can always apologise, you know. If I did not deal with it. I can go and apologise to people, the same day or the next day, and say 'you know I was a bit over the top' and I can apologise, or at least talk about it whereas you know in active addiction I would hold onto that need to be right

4.2.3.1 Shame

Participant 3 explained how understanding his addiction as a disease enabled him to stop seeing it as a moral failing or something he had a choice over, thereby decreasing his sense of failure and in return reducing his need to use:

I believe that for a lot of people, the fact that it is a disease takes away a lot of stigma. It's not that there is something wrong with me, it's that I've got a disease. I've got a disorder or a disease and I don't have to be ashamed about it.

Participant 7 recognized that once he understood it was his addiction that caused him to hurt others; he could forgive himself for events of the past that previously he had avoided through using:

Being in the programme, you start to see patterns in your life and you start to see how most of your relationships turned out the same, even though there might have been different people involved. And then you start to get some awareness and that's where you start a process of beginning to let go of some of some aspects of your personality and hopefully become less selfish and self-obsessed.

Subsequent to coming to understand addiction as a disease, participants in this study reported being able to dis-identify themselves as being bad. They reported this to be crucial to their recovery, as it mitigated against their experience of shame, which previously had led them to use. Participant 8 highlighted the toxic nature of shame, linking it to a sense of isolation common among addicts:

Meetings help to reduce shame. At the height of using I had a tremendous sense of isolation. Unbelievable loneliness, profound loneliness, even though it was by my own hand. Unbelievably so. I guess it's just because of shame. Shame reduction is enormous because the things that I thought made me the worst person on the planet; you start to hear, that "oh, you also stole your mother's wedding ring".

Participant 6 emphasized that understanding he has a disease that he needs to treat with abstinence has allowed him to respond more appropriately to cues, rather than resorting to anger:

Often when I have acted out in anger, when the anger subsides, I feel this terrible shame come over me and that's when I'm vulnerable. So not using stops the shame that follows the anger.

Participant 5 reflected on the relief afforded through understanding one is suffering from a disease, especially as he no longer needed to feel self-sufficient:

I don't need to be shameful that I can't handle my issues. As a using addict, I didn't have the ability or the courage. Now I don't have to be man enough. I understand that I'm fragile, that I can break and hurt. We need help and we need guidance at times and we need support and emotional support. It's about opening myself up when I am in emotional pain.

Through feeling accepted in a group, participant 3 reported being able to be more vulnerable, and to be able to share his uncomfortable feelings of fear, embarrassment and anger:

Meetings are a place where I can feel, I can actually open up about my shame, anger, depression, anxiety, and character defects without being judged by people.

The groups provide members with a safe space that they know they can return to, no matter what. As participant 8 observed:

It's easy to come back to meetings. It's the only place where you can steal from your mother, come there, tell people and they pat you on the back and say come back tomorrow.

Participant 2 described reducing his shame by recognising that the past is over, it is only the present and future that he can ensure he does not regret, saying:

I live with the belief that there is nothing that I can do about what I have done - therefore I feel no shame. There's nothing that I can do about what I did. Nothing. There is more use in saying: I don't want to be that person again. There's no way I'm going back there.

Participant 5 articulated having the opportunity to be able to process his feelings of shame and guilt about his actions in the past, as a result of participating in the programme, stating:

I had to deal with all the guilt and shame. It was difficult for me to realise the harm and damage I was causing. And so I had to talk about all these things. As a using addict it was difficult for me to talk to someone in recovery in the first year. Once I came to my Step Four I had to talk about it to my sponsor. It was the shame; it was the guilt, and anxiety to an extent. I had to deal with emotions. And we tell people if you don't deal with these issues you will go back and use.

Participant 7 added to this, recalling his sense of isolation:

By the time I got clean I felt very isolated, very shameful, a lot of self-blame. And being in a twelve-step fellowship for a long time you get to know that there are people who have don't like similar stuff to you.

4.2.4 Acceptance of a Higher Power

All participants reported the experience of being able to surrender their will to a power other than their own, termed the Higher Power, to be a profoundly useful tool. Participants understood this power to be more benign than own power, which, to date, had led them to chaos and pain. All participants identified their higher power as residing in both fellowship and the twelve-steps. They were unanimous in the serenity achieved through nurturing a spiritual part of themselves. Without exception, all reported being atheists when entering the programme and all participants noted that once they began working the programme, their sense of spirituality grew. Participant 4 summed this idea up saying:

Part of the programme is about giving up. We need to surrender to win. It's a total paradox. But it's the only way it's going to help. I was in control every single bit of the way and that generated chaos.

Through the process of relinquishing power, individuals reported feeling less omnipotent and self-centred. Participant 1 reported learning that in order to retain her/his sense of

serenity it was necessary to adhere to the tools learnt through participating in the TSP, and important in this regard is the higher power. This is achieved through accepting that her/his way is a destructive way and in order to experience serenity, it is necessary to surrender to a higher power:

I can now find solutions that make everybody else's life serene. I've had to learn to surrender, to live in the real world and accept things are not going to happen, as I want them, but rather they're going to happen as they are meant to. Now, I can look at things and say there is nothing I can do. Knowing the boundaries of what I can do and what I can't do.

Participant 2 explained the process of being able to surrender his perceived power to something other than himself:

People taught me about a power greater than me. They explained it in a way that I understood. They said: "Listen, maybe you don't believe in God or a traditional religion. There has to be a power that's bigger than you. You cannot be the power that's greater than everything. Your power is destructive. And this power that is bigger than you, it can help you." And for me it made sense that this power was the TSP. They brought it to something that I could say: "Fine, that is rational. There's this programme. If I follow this programme, uh, then my life is going to change. And that is my higher power."

Commonly, people who depend on mind-altering substances and behaviour are attached to the belief that they are in control of their lives and in control of those around them. With this in mind, the process of letting go and handing over to the Higher Power contributes to being a source of calm. Participant 3 observed:

Before I surrendered to a higher power I used to try to control everything. Now I can think about letting go and recognising that "okay, you're human, you sometimes don't feel that good. It's ok. You're not going to die. You're ok." I let go of resentments, blame, pity, woe is me. I let go of all that shit.

The big thing that NA/AA did for me was put me on a spiritual path that I was always interested in but I was using drugs to get me to a place of feeling connected with things and I think it's part of spirituality, being connected.

Participant 3 thus highlighted the role that spirituality played for him as providing an internal sense source of support, unlike drugs, which were previously thought, by him, to fill the same need.

Participant 7 observed that, in his view, the treatment for the disease of addiction is spirituality:

Some kind of spiritual awakening does take place with abstinence. Not necessarily the Hollywood version but there is a level of self-acceptance and a deep, deep sense of knowing.

Participant 5 also described the need for spirituality, and of relinquishing control to a higher power, as necessary in treating addiction:

'Surgery of the spirit.' It's where I admit weakness, I admit I have been over-powered and I hand over. Admitting that I'm weak is a paradox because that is the moment I become strong. It frees me in a sense.

Participant 6 also likened the acceptance of a higher power into his life, to that of a psychic change saying:

The TSP talks about a psychic change, a psychic moment, which leads to a spiritual kind of acceptance. Only spirituality can assist you as an addict. Once you are addicted there's no way in which you can, on your own, overcome that way of life. You need a power greater than yourself.

Participant 5 attributed his recovery to the role played by the higher power, saying:

So, no serenity, for me, without me saying to myself that it's that force that is responsible for being clean. So I'm not in control of my sobriety. I'm in control of everything else. I am in control of my actions. So I'm not saying I can do this because my HP told me to do this.

Participant 8 described the benefits attained through handing over his will to a Higher Power, were a greater capacity to moderate feelings:

*Acceptance and letting go. What is also important is when I'm wrong I promptly admit it. And I have found that helpful in regulating feelings...
Fear, as I grow in this programme was replaced by acceptance. Life is going to turn out as it is meant to be and that's ok. It's fine.*

4.2.5 Service to others

Consistent with much of the feedback already detailed in this chapter, participants all presented an understanding of themselves, when not managing their 'disease of addiction', as self-centred and self-interested. All expressed experiencing immense relief and satisfaction through serving others. For some, it was a necessary therapeutic step in the

programme seen as a profound and sustaining experience and for others, it was perceived more as a requirement. According to Participant 8:

Service for me is my favourite aspect of the twelve steps program because you take a group of selfish, self-centred and self-absorbed people and then all of a sudden they're arranging meetings for themselves. Someone's opening the room. Someone is bringing the milk. Someone is putting out the chairs and it's like this miraculous transformation of selflessness of sharing and support. That's the concept of this fellowship – it's by us, for us, and it only works because of service.

Participant 7 described his motivation for engaging in acts of service, more for their therapeutic value to himself, than from an intrinsic urge to help others:

I think service is really important. In NA they say basically the spiritual symptom of your illness is self-obsession. And so service is helpful in a number of ways. One of them is to sort of neutralise the self-obsession by focusing on helping others. Service also brings out all your character defects, cos you hopefully going to be collaborating with people. Service also leads to power struggles and people wanting to do it their way. So it also teaches you how to collaborate with people in a slightly more boundaried way. It's often very challenging and presents many opportunities for growth. You've got 10 control freaks in a room they going to argue about the time you spend.

Participant 2 highlighted his understanding of his behaviour while in active addiction as selfish and stated that, for him, the solution to this was performing acts of service:

The success of recovery is realising that this is not about me. It's about becoming selfless instead of selfish. This program is about service. I was so selfish in active addiction. Service is the antidote to selfishness. The success of recovery is realising that this is not about me.

Participant 1 interpreted service as a repayment of debt resulting from the support he received upon entering the programme:

This place has given me life. And I owe this to other addicts; I owe it to others to get what I got. Give them what I can to get what I got.

Participant 6 explained his understanding of the logic underlying service, as helping others, promotes a more positive sense of oneself, thereby increasing one's ability to remain sober:

In the programme, almost everything is paradoxical. The more I receive, the more I give, and the more I give, the more I receive. For me, to keep what I have, I have to give it away. It's crazy, yes. It does not make sense, but it does if you're

in the programme and you have a problem like I have. So, the more I help, the more I help myself.

Participant 6 also concurred with other participants' interpretation of addiction as selfish, and of acts of service providing an important antidote to this:

I think addiction is a very selfish thing. With service, instead of it all being about you, it's about other people. Service has taught me to be humble. Recognising that it's not all about me and my big ego. When I focus on others, it makes me feel useful and part of something, connected.

Participant 4 acknowledged how difficult he found performing acts of service to be but, nevertheless, recognized its curative power:

Service is very, very humbling and it's also painful. It was freely given to me. I needed a listening ear when I came in. So I've got to be that listening ear to others. Before doing service I was not useful. Not to anyone. It didn't matter how useful I tried to be, my addiction was in the way. I didn't feel worth anything but helping to stack chairs or get coffee or help people helped.

Participant 5 understood service as operating as a strategy aimed at promoting and maintaining on-going sobriety:

Being of service, that's one of the things that keeps me clean. I think it is marvellous. You see, as addicts, we are exploitative. Trying to manipulate society. Service is also a form of giving back, of showing gratitude for what I've learnt and discovered within the fellowship, that it saved my life and having made my life simpler in so many respects that I just want to share it with everyone.

Participant 6 described service as a technique used to reinforce sobriety through inviting individuals to behave in a kind and considerate manner, and in so doing, developing a greater sense of dignity and self esteem. Again, the paradoxical nature of the programme was highlighted in this extract:

The secret to recovery in AA is that the most simple and effective way of staying sober is to help another person. If you can do that, then you got it. Then that's it. The program tells me that I'm going to stay sober, not through joining AA, but only if I take care of others who have the same condition. The program tells you... that you got to serve someone else to serve yourself. So I'm taking care of you to take care of me. So it's a selfish, self-serving program. But you don't have to know that. When people say, "Hey, I've got to thank you so much..." I tell them: "Look the truth is I am in taking care of myself. The fact that you are a beneficiary, well that's great, but I must thank you."

4.3 Summary

This chapter offers a summary of themes emerging from participants that emerged using thematic analysis. Recurring codes, clustered into larger themes included the value of the TSP as a whole, the benefits of regular attendance at meetings, the significance of coming to understand one's addiction as a disease, the importance of surrendering one's control to a higher power and the value of involving oneself in service to others. Results suggest that many of these processes helped participants to manage their levels of emotional arousal and activation. When this was the case, they were able to behave in a more considered manner, than when in active addiction.

These themes are discussed in Chapter 5, along with literature to support these results.

Chapter 5

Discussion

5.1 Introduction

This chapter focuses on interpreting and evaluating the research findings in relation to the existing literature and the theoretical framework i.e. affect dysregulation. The objectives of this study were to increase understanding about how:

- AA and the TSP may assist addicts in achieving and maintaining on-going sobriety; and
- To examine a possible link between AA and TSP and improved affect regulation.

This study was suited to a qualitative method of investigation as the TSP is an action-based, experiential form of treatment and not easy to grasp from a theoretical perspective alone. A qualitative methodology also privileges the participants' perspectives. A quantitative approach would not have provided such rich data regarding the participants' lived experiences.

Findings from this study revealed overwhelming consensus among the participants with regard to identifying helpful elements in the programme. Many of these elements were also reported to increase participants' capacity to manage their feelings more effectively. Furthermore, the findings of this research were supported by the literature review.

This study considered the following questions:

- What do addicts consider to be the most helpful elements of the TSP?
- What are addicts' reflections on the role of the TSP in constructive affect management?

Findings in relation to these questions are discussed below.

5.2 Main findings

5.2.1 Key elements of the twelve-step programme (TSP)

Participants in this study reported the TSP, to be valuable, if not essential, to their recovery. A significant contributor to this sentiment was the long-term support all had enjoyed in the programme. As observed in *The Twelve Steps and Twelve Traditions of Alcoholics Anonymous*, the TSP provides a new 'way of life' (Alcoholics Anonymous, 1993). Due to recovery being understood, in the TSP, as more about getting sober than about attending meetings, the lifestyle changes that members learnt translated to a lifestyle supportive of recovery, an important element within the TSP supported by McIntire (2000).

Participants in this and many other studies found the TSP to be essential in increasing their motivation to become sober and assisted them in developing greater confidence in their ability to achieve and manage sobriety. This increase in abstinence self-efficacy has been identified by a number of researchers as an outcome of TSP treatment (Kelly et al., 2010; Morgenstern et al., 1997). Participants noted that their motivation increased in response to what Yalom and Leszcz (2005) termed an "installation of hope" and inspiration derived from being in the company of individuals, in the TSP, who had achieved and sustained their sobriety over many years.

Another important factor contributing to the reported success of the TSP was the frequency with which participants were able to attend meetings. All participants agreed that in the early stages of their recovery, which for some spanned a few years, attending several meetings a week was an imperative. This finding was supported by Leshner (1997) who noted that substance abusers that stay in treatment for longer, demonstrate greater improvements. Respondents explained that regular attendance at meetings served to ensure accountability and the majority of them admitted staying sober, especially in early recovery, to avoid having to report using at a meeting. The fact that participants were kept busy with a competing behaviour was also described by participants as vital to their recovery.

All participants reflected with pride that the success of the TSP lay in its principal of one addict, helping another addict, to recover. This point highlighted for participants the possibility of successful recovery, without the involvement of professionals. This strength has also been noted by Bekkeringa et al. (2016).

The TSP provides scaffolding and structure for self-change promoting a healthier and more stable lifestyle (Melemis, 2010). All the participants commented that the structure inherent in the programme stood in stark contrast to the chaos manifested in their lives prior to entering the programme. Participants explained that structure ensured a secure and predictable environment. The value of structure in recovery has been widely recognised (Krystal & Raskin, 1970). Alcoholics Anonymous (1993) states, “AA does not teach us how to handle our drinking. It teaches us how to handle our sobriety” (p. 554).

Participants reported valuing the practical nature of the programme facilitated through working each of the steps (Narcotics Anonymous, 1998). Of particular interest was the gratitude expressed by participants towards the fellowship and the programme for facilitating their recovery and also for their increased sense of humility which enabled them to be more able to identify their wrongdoings in relationships, and to be take responsibility and accountability of their perceived failures.

All participants recognised the meetings as a vital therapeutic tool (Yalom & Leszcz, 2005). Personal feedback received during groups was identified as being effective in assisting them in developing greater self-knowledge, insight and empathy, findings supported by Borkman (2008). Participants noted that the groups provided a useful forum in which to practice corrective behaviour in response to the constructive feedback received from the group. All participants recognised that while receiving feedback was, at times, a painful experience, it was of great value.

Participants described meetings as a place where many social skills were learned that facilitated stronger and more respectful engagements with others. Examples they cited included being more aware of others, waiting their turn, not interrupting one another, pouring tea and coffee and providing others with transport to meetings. Previous studies

into TSPs have also emphasized the value of basic social skills transmitted at the meetings (Makela et al., 1996).

An important element recognised by all of the participants in this study was having access to a sober social network of people who shared the same goal of abstinence that made recovery possible. Participants explained that during active addiction, their social circle was comprised principally of fellow substance users. This finding supports research conducted by Kaskutas et al. (2002); White (2012); McIntire (2000) and Laudet et al. (2006).

Participants explained the immense relief they derived from learning, in the TSP, that they suffered from a chronic, progressive and life threatening disease of addiction, that symptoms of this disease were selfishness and reckless behaviour, and that there was treatment available for this disease. This concept has been more widely accepted (AMA, 1987). They noted being able to embrace this treatment of abstinence, through working the steps and attending meetings. They all observed that subsequent to this realisation they no longer perceived abstinence to be associated with a sense of deprivation, but rather to promote sobriety and serenity. Participants considered these qualities to be precious and not to be easily jeopardised.

In summary, participants shared similar views on what they found to be the most helpful aspects of the TSP.

5.2.2 The role of the TSP in developing constructive affect management

Affect dysregulation has been identified by a number of theorists as a core ingredient of addiction (Flores, 1988; Khantzian & Mack, 1979; Kurtz, 1982). Many theorists have also argued that addiction can be seen as a symptom of affect dysregulation (Flores, 2007; Katehakis, 2009; Krystal, 1988; McDougall, 1989).

Participants in this study were unanimous in acknowledging that upon entering the TSP they all experienced difficulty managing their feelings. This phenomenon has been recognised by Putnam (1992). Mostly they reported valuing the numbing effect of their DOC. In addition,

they all admitted to having previously relied on their DOC order to manage difficult affective states (Khantzian, 1985).

Through involvement in AA, all participants in this study reported learning more adaptive strategies to manage both their addiction and their emotions, decreasing their tendency to avoid them through using substances (Katehakis, 2009). TSPs have been recognized as a tool for decreasing affect dysregulation, promoting psychological growth and development and effectively treating addiction (Kelly et al., 2010; Mack, 1991; Zemore, 2017).

5.2.2.1. Strategies

Seligman (1972) drew attention to the power of changing thinking when he identified the role of repetitive negative thoughts in depression and how through changing cognitions affect can also be changed. Schore (2016) explained that emotional dysregulation short-circuits the thinking part of our brain, adding that people generally demonstrate a wish to be able to exercise control over their experience of emotions.

In order to regulate affect, it is first necessary to be able to reduce emotion to allow the brain to access thinking (Chapman et al., 2006). Participants reported that subsequent to working the TSP they were able to respond to stimuli, rather than reacting. This is supported by Kurtz (1982) who suggests that AA ‘works’ by changing the ways of thinking of its members. Participants noted gaining greater control over their emotions, through several strategies, obtained in the TSP. These are discussed in the light of Gross’s (1998) process model.

a. Situation selection

Situation selection is the first of five strategies identified in the emotional regulation process model by Gross (1998) used to regulate affect. All participants emphasised the importance of carefully selecting physical environments, or situations that supported their recovery, by decreasing cravings. Through attending meetings participants automatically selected a safe situation, and safe people to surround themselves with. In addition, through frequent

attendance at meetings, participants decreased the time available to engage in substance abuse. As the AA slogan reminds them: *Time spent in meetings is time not spent using.*

Participants in this study reported that simply through selecting a situation supportive of sobriety they felt more in control of their lives, and that this, in turn, had a ripple effect, increasing both their motivation for recovery and their sense of wellbeing. This phenomenon is supported by the findings of Ryan and Deci (2000). Participants reported experiencing lower levels of stress as a result of selecting to attend meetings and that this, in turn, increased their level of happiness. These findings support those of many other researchers (AA, 2001; DeLucia et al., 2016; Diehl & Hay, 2010; Humphreys, 2004).

Participants emphasised that in addition to selecting to attend TSP meetings they also adhered to the TSP suggestion of avoiding the three Ps-familiar people, places and playthings, and in so doing selecting situations that would not act as triggers to use. These included people with whom they had previously used, places where they had used and playthings or equipment needed for their drug usage such as a particular pipe. A helpful AA slogan cited by a participant with regard to avoiding places was: *If you spend enough time in a barbershop, you are bound to end up getting a haircut.*

Participants recognised that as a result of selecting a situation, such as a TSP meeting, they ensured they would spend time with a sober peer group. The curative effects of group therapy, which were a product of their careful situation selection strategy, were unanimously applauded. Some of the reasons for this included the importance of the experience of affiliation, cohesiveness, and social support, being able to down-regulate difficult emotional reactions through discussing them in meetings, and having an opportunity to learn to identify and to communicate feelings more directly, a finding also documented in research by Kaskutas et al. (2002) and Spickard (1990).

b. Situation modification

Situation modification involves taking practical and behavioural steps to alter an external situation in which one finds oneself to decrease the risk of experiencing cravings, or feelings

that might put one's recovery at risk. Participants reported valuing the opportunity of having a situation, i.e. a group, where they could practice modifying ways of behaving to achieve more favourable results. This value of the TSP has been recognised by Flores (2007).

Before selecting to attend TSP meetings, participants recalled struggling with impaired social interactions, all common experiences among those with SUDs (Koole, 2009; Treece, 1984; Zeman et al., 2006). They noted that an effective way of modifying their social skills was spending time with the TSP social network. They recognised that the experience of feeling connected to others enabled them to modify their emotional arousal more effectively. This is in line with studies recognising that people with more adaptive affect regulation strategies tend to enjoy greater social adaptation (Fabes et al., 1999).

A great deal has been written about the therapeutic value of articulating thoughts and feelings (Kelly et al., 2009; Krystal, 1988; Pollner & Stein, 1996). Participants in this study reported benefiting from learning to identify, name and express feelings within group situations. Participants described that as a result of talking and sharing their life-stories in groups they felt an increased sense of trust and belonging to other members of the fellowship, which provided them with a greater sense of containment. Similar findings were reported by Pollner and Stein (1996).

Participants also reported the emphasis in the TSP, on performing acts of service to newcomers, provided them with an activity they could use to modify their physical situation, as was calling a member of the fellowship or their sponsor in order to modify a situation that they anticipated being challenging, a strategy identified as effective in modifying situation perceived to be potentially activating (Ochsner & Gross, 2008).

c. Attentional deployment

Unlike situation selection and situation modification, which rely on external rather than internal strategies to regulate affect, attentional deployment is an internal strategy used to regulate emotion. Two attentional deployment strategies include concentration and distraction. Participants reported an increased capacity to concentrate their attention on

their current experiences through practising meditation and prayer, as stipulated in step 11. This enabled participants to be able to focus on being in the present and to be better able to accept and tolerate their feelings at any given moment without needing to alter them. This skill was noted to be very important in learning to respond, and not react, to thoughts and feelings. Distraction as a means of decreasing arousal and craving was noted by participants who were able to deploy their attention away from their using social network towards a sober social network, a strategy recognised to increase emotional support (Longabaugh et al., 1998).

Through becoming involved in the TSP, participants reported being able to distract themselves away from their previous rumination and worry about obtaining and using their DOC towards attending to other members of the fellowship. Participants recognised the value of engaging in acts of service as a means of distracting themselves from thoughts of using, and from rumination and worry. Participants reported strenuously suppressing negative thoughts arising that glamourized their previous drug use, and increased their cravings, referring to this as ‘stinking thinking.’ This cognitive strategy is designed to immediately divert attention away from certain thoughts, and depending on which context it is used in, may be of differing value (Campbell-Sills & Barlow, 2007; Wegner & Zanakos, 1994). Participants in this study highlighted the value of slogans as a tool to deploy their attention away from using. Makela et al (1996) drew attention to the value of slogans to refocus attention on sobriety.

Slogans cited by members of this study as beneficial include:

*One is too many and a thousand is never enough; and
I alone can do this but I can't do it alone.
One day at a time*

Other elements within the programme cited as beneficial in managing challenging feeling states through attentional deployment included ‘playing it forward.’ Participants described using this strategy to distance themselves from their cravings. This entailed envisaging situations that inevitably occurred after using. In so doing, they would be reminded of the inevitable chaos that ensued with relapse.

d. Cognitive change

Cognitive change is a strategy that operates internally, and involves using cognitions to reappraise the meaning of a situation so as to alter its emotional significance and reduce its emotional valence. Here one can either alter one's thoughts about a situation; or one can alter one's thoughts about one's ability to control the challenges the situation presents (Gross, 1998).

Humphreys (2004) and Morgenstern et al. (1997) have noted that decreasing the stigma around addiction is an important tool for recovery. In line with this, the strategy of greatest value to the participants was observed to be reappraisal of their addiction as a disease, in step 1, and becoming abstinent. Flores (2007) suggests that although the original disease concept of AA may be more metaphorical than scientific, its value lies in the fact that it requires abstinence for successful recovery. Participants reported that subsequent to becoming abstinent they developed greater insight into their feelings and their responses to them, promoting greater emotional maturity. In addition, through abstinence, participants recognised that they benefited from escaping the withdrawal–relapse cycle, which previously had perpetuated their continued substance use (this was also noted by Khantzian and Albanese, 2010, and Maremmani et al., 2006). During active addiction, more drugs had continually been required to escape the negative feelings of withdrawal. Despite having used mind-altering substances to cope with intense feelings, participants observed that their capacity to manage feelings had actually deteriorated (Rado, 1933).

Adams and Robinson (2001) identified that in order to treat addictions it is necessary to find tools to reduce shame. Participants recognized that coming to learn that they suffered from a disease of addiction freed them from the stigma and accompanying sense of shame, which, all participants agreed, had served as a strong trigger for craving.

Through the emotional regulation strategy of reframing and reappraising their addictive behaviour as a disease, participants reported being able to cut through the pervasive denial that had enabled their addiction (Kurtz, 2008). Participants all reported finding this cognitive change immensely powerful and an imperative to their recovery.

A strategy of distancing as a means of changing cognitions was reported to be employed by participants when they described engaging a third-person perspective, typically that of their sponsor or members of the fellowship, to gain greater objectivity of an emotional cue (Ochsner & Gross, 2008). This mobilises self-reflection (Ochsner & Gross, 2008).

Participants were unanimous in their enjoyment of humour shared among members of the fellowship and how this served to effectively de-escalate difficult thoughts and feelings.

Downward social comparison (Gross, 1998) is a cognitive change strategy that involves the comparison of oneself with someone perceived to be in a less favourable position. Several participants reported using this strategy by engaging in acts of service and particularly focusing on supporting and integrating newcomers into the fellowship. Through engaging in this, participants were reminded of where they had come from, the desperation they had felt, and that they were one drink away from a less favourable position themselves.

Participants reported developing increased self-efficacy in their ability to tolerate negative thoughts and to trust that, with time, difficult feelings would pass. They described being able to respond to emotional cues in a more considered and flexible manner. Considered and flexible emotional responses have been found to yield optimal outcomes, particularly interpersonally (Cole, Michel & Teti, 1994). Participants recognised that subsequent to working the TSP, they were less impulsive and better able to delay gratification. These findings support Flores's (2007) observation that AA teaches participants how to "develop the ability to postpone, modify and even forego gratifications whose demands previously seemed overpowering" (p. 192). These behaviours all required cognitive skills, which according to Dodes (1990) will previously have been weakened through drug use.

Addicts in this study all reported struggling with feeling lonely and isolated, but nevertheless also avoiding being vulnerable or dependent on others (Zeman et al., 2006). Through surrendering their power to a higher power, steps two and three, participants reported changing their cognitions about their ability to change things, recognising that they were not able to exercise acceptance. In addition, through depending on a higher power, participants reported being more able to be vulnerable and depend on other group

members. Through surrendering to a higher power, participants were able to accept the experience of depending on something other than themselves and to open themselves up to receiving support. This acceptance has been recognised by Flores (2007) as important to recovery.

Participants were unanimous in the value of written exercises, included in steps four, eight and ten, in assisting them in being able to think more clearly and logically about their feelings. Committing thoughts and feelings to paper was reported to be an effective strategy in gaining a clearer perspective on matters. Participants reported that as a result of feeling seen, heard and responded to in groups they felt calmer and more emotionally contained. The TSP also taught participants to contemplate the needs of others and to empathise. These skills have been identified as important in engaging cognitive responses to affective overload (Bateman & Fonagy, 2004).

e. Response modulation

Response modulation takes place once an emotion has occurred, unlike the previous four strategies, which are designed to prevent, delay or alter an unwanted emotional situation. Participants reported modulating their responses to emotional cues through phoning their sponsor to assist with processing difficult matters, or by bringing them to a meeting to discuss.

Participants found working step nine, which requires individuals to make amends and apologise to people harmed through their using, and step ten, that invites reflecting on one's behaviour on a daily basis and apologising to others immediately, to be an effective way of deescalating emotional responses that might previously have resulted in relapse. Participants expressed gratitude, relief and increased serenity after working this step. AA explains that in doing so, regrets and failures diminish and, the addict can begin to see that repair in relationships is possible (1993).

5.3 Conclusion of the study

Participants reported that by acquiring affect regulation strategies from the TSP, they were able to manage their feelings effectively and to diminish cravings and triggers to relapse. These findings were supported by findings in research by Choopan et al. (2016). The TSP was demonstrated to be a complex psychosocial treatment that promoted connection among its members, thereby reducing isolation and strengthening affect regulation Khantzian and Mack (1999).

Chapter 6

Conclusion

6.1 Introduction

This chapter summarises the main findings from this study, along with limitations and recommendations for further research and practice.

6.2 Main findings

This study paid particular attention to elements in the TSP reported by participants to be helpful to their recovery from addiction. Special interest was paid to extracts from participants' transcripts that referenced more constructive ways of regulating their affect.

This research was suited to a qualitative method of investigation as the twelve steps are an action-based, experiential form of treatment and not easy to grasp from a theoretical perspective alone. A qualitative methodology also privileged the participants' perspectives and a quantitative approach would not have provided such rich data regarding the participants' lived experiences.

Affect dysregulation has been shown to be one of the most powerful causative elements leading to the development of addiction (Khantzian, 1985). Conversely, an ability to regulate affect is known to be one of the major pathways to abstinence (Khantzian & Mack, 1994; Krystal, 1988; McDougall, 1989; Wurmser, 1980). Khantzian's SMH (1985), which carefully combines an understanding of addiction and affect regulation, served as the theoretical framework through which to understand ways in which participants regulated affect through drug dependence, and how, the TSP, through its provision of affect regulation strategies, facilitated recovery among study participants. James Gross's (2007) process model of emotional regulation was used to assist in identifying different strategies used to regulate emotions.

Research highlighted the benefits of interpersonal relating in providing comfort and support, which promotes increased affect regulation (Schoore, 2016). AA, and its TSP was

reported by participants to be a valuable means of treating addiction primarily through its provision of an interpersonal environment (Khantzian, 1993) that incorporated curative aspects of group therapy (Yalom & Leszcz, 2005), and where affect could be regulated.

A key ingredient that was also reported by participants was having access through the fellowship to a sober social network of people with whom they could identify, and with whom they felt a sense of belonging (Litt, Kadden, Kabela-Cormier & Petry, 2009). Recovery was found to improve through increasing spiritual awareness, reframing addiction as a disease and diminishing shame and self-loathing (Kurtz, 2002; Kelly et al., 2009). In addition, acts of service, as stipulated in the programme, were identified as particularly useful as a remedy to selfish behaviour characterised by addiction (AA, 2001; Melemis, 2010).

Participants in this study reported developing improved relationships with others (Kelly & Beresin, 2014), a greater capacity to self soothe and thereby decrease emotional activation, and an increased capacity to engage cognitive skills through which to more carefully navigate their feelings and behaviour (Bateman & Fonagy, 2004; Varona; 2017). Participants identified being more able to respond to emotional cues instead of reacting, to think more flexibly and less obsessively, to delay gratification and to empathise with others. They all concurred with having gained these strategies through participating in meetings and working the steps. These findings suggest the efficacy of the TSP may, in part, be attributed to the affect regulation skills learnt in the programme.

6.3 Limitations to the study

Given the small size of the sample, findings from this research cannot be generalised to persons who vary from the sample on the basis of race, age, gender and culture. It is hoped, however, that the results are transferable to other contexts that are similar to the sample in this study. Further research in this area could include qualitative investigations using larger samples. From the literature reviewed it seems that the TSPs have cross-cultural validity (Vederhus, 2017). However, the racial composition of the participants in this study was white and Indian, and including a more racially diverse sample may have increased the strength of the findings of this study.

Gender-specific groups or a comparison across gender of elements within the TSP identified as beneficial may have yielded different results. The gender composition of this study was one female and seven males. The female participant noted that, in her view, recovery for men and women is different as women frequently have families and children to tend to and are less able to commit as much time to attend groups. She hypothesised that women are more shamed for their addiction than men. This requires further investigation.

Given the lack of published literature on TSPs in SA, the researcher had to mostly rely on international and quantitative studies in the literature review, as few South African or qualitative studies could be found.

Further, the use of a semi-structured questionnaire may have, to some extent, led responses, given the key questions asked. Despite this, an attempt was made to counteract researcher bias by keeping the questions as open-ended as possible. Lastly, the nature of qualitative research is such that the researcher is at risk of influencing the direction the research takes, despite efforts taken to mitigate against researcher bias. This too was a risk in this study.

6.4 Recommendations

6.4.1 Recommendations for research

The recommendations for research relate to the limitations of the current study. Prior to introducing TSP's into settings such as psychiatric institutions or making them available to more of the population, it is important to understand more clearly the underlying reasons for their success. This may be achieved through increasing research into AA and its TSP in the South African context as, to date, it seems not to have been extensively researched locally. In addition, research comparing feedback from TSP in SA and elsewhere may be useful to assess if programmes are, in fact, universally consistent and if different contexts report the same benefits. While future research could compare the actual TSPs in different locations, it might also be useful to compare feedback from TSP participants nationally and internationally to assess if the experience among South African participants is generalizable and transferrable to other countries and vice versa. In addition, comparing responses to TSP

of different ethnic groups might yield important results. Project MATCH, a multisite research study assessed, AA effectiveness for white, African-American, and Hispanic ethnic groups, their findings suggested that different ethnic groups may attend more or less frequently, but that AA involvement for all predicted higher abstinence outcomes (Tonigan, Connors & Miller, 1998). Studies of TSP using different genders might shed light on whether gender differences play a role in identifying beneficial elements in the recovery process. This study could be repeated using a significantly larger population to lend greater weight to the findings.

6.4.2 Recommendations for practice

Addiction is a notoriously difficult condition to treat and has massive social, economic and health implications (Donovan, 1986). TSP's have been shown to be as effective as professional interventions (Project MATCH, 1999). Therefore, the TSP can be of immense value to professionals working in this area. On the basis on the results of this study and on recommendations by Kelly et al. (2009) it is imperative that professionals take cognisance of the strengths of the TSP to utilize it in conjunction with their own treatment, through referring their patients to TSPs or to adopt beneficial elements from the programme into their own treatment.

Research has confirmed that AA is a tool with universal applicability (Del Boca & Mattson, 2001; Kelly et al., 2006; Alcoholics Anonymous, 2001; Mäkela, 1996; Bekkeringa et al., 2016). Service providers should alert their patients to AA as it can be accessed every day of the week and at high-risk times, such as evenings, weekends and public holidays and does not require an appointment (Kelly et al., 2009; Villa, n.d). In instances where there are no professionals available to treat addiction, initiatives to start TSPs should be encouraged

Research has shown that AA plays a significant role cross-culturally, partly because of the values it espouses, such as altruism, honesty, gratitude and becoming open to spirituality (Vederhus, 2017). Gomes and Hart (2009) have alerted service providers to the need to embrace this model of treatment because of the lifestyle changes it advocates. Given that addiction is a chronic disorder characterised by high rates of relapse, AA, as a free service,

removes significant barriers to lifelong treatment, and needs to be seriously considered as a cornerstone of addiction treatment (Humphreys et al., 1997; Kelly et al., 2006).

Since addiction has been shown to manifest where individuals struggle to manage their emotions, and the TSP has been shown to assist in improving affect regulation strategies, alternate treatment programmes should emphasise emotional regulation (Kelly et al., 2009).

6.5 Summary

This study suggests that elements of the TSP treatment paradigm that foster greater relational connection and an improved capacity for affect regulation are core to the established success of the treatment approach. Given the high correlation between affect dysregulation and addictive pathology, it could be expected that TSP initiatives are likely to significantly improve the prevalence of addiction.

This research highlights the dual efficacy of the TSP in treating both addiction and affect dysregulation. This is a vital piece of information, as affect dysregulation is considered to play a significant role in contributing to, and perpetuating, addiction. Conversely, an ability to regulate affect is known to be one of the major pathways to abstinence. Therefore, treating affect dysregulation is more likely to yield longer periods of abstinence.

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APPENDIX 1

Information Sheet

Date: July 2018

University of KwaZulu Natal, Department of Psychology

To Whom It May Concern

Formal Title of Dissertation: Counting the steps to recovery: Personal reflections of addicts on what they consider to be the most helpful elements of the twelve – step programme.

Invitation to participate in study

My name is Susan Spencer. I am a clinical psychology masters student from the University of KwaZulu-Natal, Pietermaritzburg campus. I am currently completing a research project for my Masters degree, in clinical psychology at University of KwaZulu-Natal (UKZN). My supervisor is Dr Carol Mitchell.

You are being invited to participate in this study examining personal reflections of participants on what they consider the most helpful elements of the TSP to be. This information will be obtained through the use of semi-structured interviews. I hope that the study will generate useful information regarding individuals' experiences of twelve-step model, possibly highlighting shared experiences.

Study Procedures

If you decide to participate in this study, you will be asked to participate in a semi-structured interview, either face to face or using Skype, to ascertain your opinion of what you may perceive the consider the most helpful elements of the TSP to you. Interviews should take approximately 60 minutes.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number HSS/1217/018M).

Possible Benefits

There will be no direct benefits to participants.

Possible Risks and Debriefing

The study is unlikely to involve risks or discomforts.

However in the event of difficult emotions being stirred up as a result of your participation in these interviews, emotional support is available from the following sources:

Child and Family Centre - Pietermaritzburg 033 260 5166

Lifeline <http://lifeline.co.za>

WeDoRecover wedorecover.com or 081 444 7000

SANCA <http://www.sancanational.info>

AA www.aasouthafrica.org.za

Confidentiality

Using a pseudonym or number instead of your name will ensure your confidentiality. This research may be used for academic purposes, for example, published in academic journals, or for presentations. Any additional identifying details, that become apparent, will be amended to further ensure the confidentiality of the participants.

The recordings of the interviews will be transferred to a password-protected computer and the recordings will be deleted from the device.

Written information generated during the course of this research will be shredded.

Hardcopies pertaining to this research will be safely stored in a secure place, arranged with the supervisor of the research project, for a period of five years. Participants are entitled to receive feedback regarding the findings of the research in the form of a brief summary. The summary will include the major findings of the research. Please contact me via email if you would like a copy of my report suespencer65@icloud.com.

Voluntary

Participation in this research is voluntary. You may withdraw from this research at any time without incurring any negative consequences.

Queries

Should you have any queries or concerns please contact me on suespencer65@icloud.com or contact my supervisor Dr Carol Mitchell, mitchellc@ukzn.ac.za, Tel: 0332606054 or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

APPENDIX 2

Informed Consent

I have been informed about the study entitled:
Counting the steps to recovery: Personal reflections of addicts on what they consider to be
the most helpful elements of the TSP. This study is being conducted by Susan Spencer.

I understand the purpose and procedures of the study, which is to participate in an hour-
long interview about my experiences of what I consider to be important elements of TSPs.

I have been given an opportunity to answer questions about the study and have had
answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at
any time without affecting any of the benefits that I usually am entitled to.

If I have any further questions/concerns or queries related to the study I understand that I
may contact the researcher at or 0837892946.

If I have any questions or concerns about my rights as a study participant, or if I am
concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Signature of Participant

Date

Additional consent to audio and/or Skype record:

I hereby provide consent to:

Audio-record my interview (during a face-to-face interview): YES / NO

Skype record my interview (an automatic notification of this will appear on your screen at the outset of our Skype interview): YES / NO

Signature of Participant

Date

APPENDIX 3

Letter counselling provider - Child and Family Centre



24 July 2018

To whom it may concern

This letter serves to provide the assurance that should any research participant in the study by Ms Susan Spencer (Psychology masters student) require psychological assistance as a result of any distress arising from the research project titled: ***"Counting the steps to recovery: Personal reflections of addicts on what they consider to be the most helpful elements of the twelve-step programme"***, the service will be provided by Psychology Masters students and/or intern psychologists at the Child and Family Centre, University of KwaZulu-Natal, Pietermaritzburg Campus.

It is acknowledged that Ms Spencer's project is under the supervision of Dr Carol Mitchell.

Yours sincerely,

Dr Phindile L. Mayaba
Director: Child and Family Centre
University of KwaZulu-Natal
Pietermaritzburg Campus

CHILD AND FAMILY CENTRE

School of Applied Human Sciences

Discipline of Psychology

Postal Address: Private Bag X01, Scottsville, Pietermaritzburg 3209, South Africa

Telephone: +27 (0)33 260 5166/6368 **Email:** moyabap@ukzn.ac.za **Website:** psychology.ukzn.ac.za

Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

APPENDIX 4

Interview Schedule

Interview questions are a basic guide and probing questions may be used to explore further emerging issues.

- Introduction of self and brief explanation of personal interest in twelve-step model from having worked on an addiction unit previously;
- Overview of research;
- Discussing and completing informed consent forms;
- Inquiry around participant's willingness to volunteer to participate in this study;
- Semi-structured interview guide: to be used with participants regarding their experience of the TSP.

Biographical details

Age:

Gender:

Drug of choice:

Time in recovery:

Number assigned to participants and first name of whom this correlates to:

Months/years clean:

Research questions

- I understand that you have participated in the Twelve-Step program. Please can you tell me something about how you came to it?
- In your whole experience of the programme what did you find the most useful?
- We know recovery, in and of itself, is a process. What do you think, in TSP, has helped you most to remain in recovery?
- What are your thoughts and experiences of having to introduce yourself in TSP as an alcoholic?
- What are your thoughts and experiences about the aspect of the programme that concentrates on service to others?
- If you had to compare yourself, in terms of your ability to control your feelings, before and after working the TSP, what would your thoughts and feelings be on this?

- What do you feel was the most important emotion that you had to deal with?
- Some people who have addictions feel that anger and rage are the most important emotions to manage and deal with. Is this your experience?
- When you are able to manage or control your rage and anger, what do you think the benefits are for you?
- How has participating in regular groups changed your sense of being alone with some of the feelings you've mentioned?
- What feelings and emotions do you think lead you to using?

APPENDIX 5**Gate Keeper Letter**

Narcotics Anonymous
Pietermaritzburg Group

Contact Us

082 907 2725

riaz.jogiat@gmail.com

19 September 2018

Dear Sue

RE: PERMISSION TO CONDUCT RESEARCH

Gate Keeper's permission is hereby granted for you to conduct research with participants from Alcoholics/Narcotics Anonymous for your research, entitled:

Counting the Steps to recovery: Personal reflections of addicts on what they consider to be the most helpful elements of the Twelve Step programme.

As discussed, I am a long standing member of Narcotics Anonymous in Pietermaritzburg. I am happy to put you in contact with other addicts who, like me, have achieved sobriety through working the Twelve Steps at Alcoholics and Narcotics Anonymous group meetings.

These people will then be able to put you in touch with other addicts in recovery who attend or have attended Alcoholics or Narcotics Anonymous meetings.

Yours sincerely

RIAZ JOGIAT
SECRETARY

APPENDIX 6

Ethical Approval



27 September 2018

Ms Susan D Spencer 962112454
School of Applied Human Sciences – Psychology
Pietermaritzburg Campus

Dear Ms Spencer

Reference number: HSS/1217/018M

Project title: Counting the steps to recovery: Personal reflections of addicts on what they consider to be the most helpful elements of the twelve-step programme.

Full Approval - Full Committee Reviewed Application

With regards to your response received on 19 September 2018 to our letter of 04 September 2018, the Humanities and Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Professor Shenuka Singh (Chair)

/px

cc Supervisor: Dr Carol Mitchell
 cc Academic Leader Research: Dr Maud Mthembu
 cc School Administrator: Mrs Priya Konan

Humanities & Social Sciences Research Ethics Committee
 Professor Shenuka Singh (Chair)/Dr Rosemary Sibanda (Deputy Chair)
 Westville Campus, Govan Mbeki Building
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Website: www.ukzn.ac.za



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APPENDIX 7

The Twelve Steps of Alcoholics Anonymous

Step 1

We admitted we were powerless over alcohol—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 Him.

Step 4

Made a searching and fearless moral inventory of ourselves.

Step 5

Admitted to God, to us, 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 Him 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 Him, praying only for knowledge of His 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 alcoholics, and to practice these principles in all our affairs.