

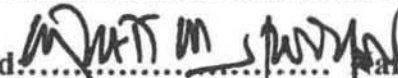
**ALCOHOLISM -
UNDERSTANDING NATURAL
RECOVERY**

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2001

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DECLARATION OF ORIGINALITY

I hereby declare that this thesis, unless
specifically indicated to the contrary,
is my own original work



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ABSTRACT

This qualitative study explored the process of recovery from alcoholism as experienced by individuals who recovered from alcoholism without formal treatment or intervention.

This study sought to reveal those factors that initiated recovery and those that maintained and supported it, including some of the strategies and skills used by respondents in self-resolution of their alcoholism.

Limitations of the study are discussed, as are the requirements for future studies of natural recovery. It is hoped that understanding some of the natural processes involved in recovery from alcoholism may lead to developing more informed and creative treatment approaches which will harness the strengths, knowledges and abilities of individuals.

Semi-structured interviews were conducted with 25 participants and their families across a broad range of age, gender, race and socio-economic status. Participants were selected from those individuals who responded to an article in the daily newspapers in Durban, Kwa-Zulu Natal, South Africa and who fitted the criteria of being alcoholics who had achieved two or more years of sobriety without formal treatment.

This study seemed to indicate that natural recovery was the preferred choice of some individuals struggling with an alcohol problem. This choice appeared to have been made because of negative associations with and perceptions of treatment, combined with a belief in the individual's ability to solve their own problems. Reasons for stopping varied, but seemed to be underpinned by a process of cognitive self-evaluation that precipitated abstinence. Maintenance of sobriety was achieved by a variety of skills, strategies and processes that corresponded, in the main, with similar international studies. There appears to be a strong relationship with spirituality in all stages of the natural recovery process. Finally, it appeared that individuals who possess a variety of personal and social resources appeared to be best suited to and equipped for the natural recovery process, although some exceptions were noted.

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FOREWORD

USE OF LITERATURE

Some of the references used to inform this study are acknowledged to be old, some from 1950, 70 and 80's. In the field of alcoholism, some works and studies are considered pivotal and seminal works, which are constant points of reference, even for modern studies.

TERMINOLOGY

The researcher is aware of the power of language, and its ability to create meaning, distortion and images that may either enlighten or create confusion and even harm. The language that is used in the field of alcoholism treatment can be particularly problematic. For the purposes of this study some terminology needs explanation and clarification.

Alcoholics, addicts, alcoholism and addiction

These terms are loaded with meaning and especially so in a study of natural recovery. The conventional imagery associated with these terms may evoke a self-defeated, fixed identity, rather than

the fluid identity that often characterizes self-remitters. For the purposes of this study, these terms will occasionally be used to describe those participants fulfilling the criteria for inclusion in the study. Definitions will be contained in the Literature Review Chapter of this report.

Drinker, drinking

This terminology refers to the act of consuming alcohol.

Bingeing

This refers to episodes of excessive drinking usually with serious consequences, preceded either by a period of abstinence or controlled drinking (Mooney, Mooney & Eisenberg, 1992).

Natural recovery

For the purposes of this study, the term, “natural recovery” will refer to the resolution of a drinking problem without exposure to formal intervention as previously defined. The term ‘resolution’ referred to abstinence or a marked reduction in drinking or drinking-related problems (Tuchfeld, 1981; Smart, 1975; Sobell, Sobell, Toneatto & Leo, 1993; Moos 1994; Ludwig 1985). An explanation for this terminology will be offered in the Literature Review section of this report.

Self-remitter

Refers to the individual who employs a strategy of natural recovery to overcome an alcohol addiction.

Participants

This term refers to the individuals taking part in this study. This terminology was preferred as it implied a voluntary partnership, which was reflective of the ethos and principles underpinning this study.

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CHAPTER ONE

INTRODUCTION

1.1 RATIONALE, PURPOSE AND THEORETICAL ORIENTATION

Alcoholism is one of the most pervasive and intransigent health problems facing societies today. 'Chronic' and 'difficult to treat' seem to be the way most clinicians would choose to describe this problem. It is one of the most widely researched behaviour patterns in Social Science. There are approximately 60 theories about alcoholism. These range from a view of alcoholism as a disease or psychiatric disorder to a view of alcohol problems as a self-inflicted bad habit (Guinan, 1990). Any study about alcoholism is particularly relevant in South Africa today, as the estimated economic cost of alcohol abuse to a developing country may be as much as ten billion Rand (Parry & Bennetts, 1998). This may be more now given the elapse of time since Parry's study.

The most widely accepted and used theory in alcohol treatment programmes in South Africa, as in the United States, is the disease concept of alcoholism (Parry & Bennetts, 1998; Guinan, 1990).

Practitioners whose view of alcoholism is informed by the disease-orientated approach suggest that all alcoholics are suffering from a disease that is treatable but not curable and the only way it can be arrested is by total abstinence (Mooney, Eisenberg & Eisenberg, 1992; Levinson & Straussner, 1978). Most treatment approaches support this view. Further, most practitioners stipulate that in order for successful recovery to take place, the alcoholic is required to be treated and thereafter, placed in a supportive maintenance programme, possibly for the rest of his/her life (Mooney et al, 1992; Polich, Amour & Branken, 1981). The alcoholic is traditionally viewed as a 'resistant' and 'hard to work with' client with a poor prognosis (Googins, 1984). Treatment outcome studies have traditionally not shown promising results. Studies revealed that 19% of alcoholics treated achieved total abstinence, 54% achieving only a reduction in drinking behaviour, and not total abstinence (Miller & Hester, 1986; Merikallio-Pajunen, 1996, Stinchfield & Owen, 1998). This had led researchers to observe that treatment professionals have

negative attitudes towards alcoholic clients and many are resistant to work in the field. This resistance is explained as a result of the frustrations created by ineffective methods of treatment (Guinan 1990; King & Lorenson, 1989).

In contrast to the above there is an ever-increasing body of scientific documentation and research which suggests that:

1. Alcoholics can and do recover, and some do so without formal treatment. Statistics show that 20% of alcoholics surveyed recover 'naturally' (Granville & Cloud, 1999; Ludwig 1985; Moos 1994; Polich et al 1980; Sobell, Sobell, Tonneato & Leo, 1993; Tuchfeld 1981; Tucker, Vuchinich & Gladsjo 1994).
2. Formal treatment does not reliably produce long-term recovery (Miller & Hester 1986).
3. Alcoholics that recover, do so in a complex set of personal and social circumstances, of which only one element is treatment, and that there are many factors other than treatment, which may have a stronger, or more enduring impact on recovery. That these factors may be the same factors that facilitate the 'natural' resolution of problems (Moos, 1994).

It was hoped that a qualitative study of the experiences of those individuals who have recovered from alcoholism naturally may enrich our understanding of the recovery process.

Although many studies have evaluated various treatment approaches, we remain uncertain about which specific treatment is best, about whether treatment is better than no treatment, and about the efficacy of non-professional treatments for alcoholism, the Alcoholics Anonymous (AA) movement being the best known of these.

Treatment for alcoholics is expensive and not always effective. If the proper combinations of social circumstances without treatment can lead to abstinence or controlled drinking then considerable savings in time, effort and money may be possible.

By deconstructing the natural processes, strategies, skills and supports used by alcoholics, treatment providers can provide better service by harnessing natural processes in developing more effective attitudes and responses to alcoholism treatment (Granfield & Cloud, 1999; Smart, 1975).

It is not the intention of this study to advocate for natural recovery in favour of treatment, but rather to explore the factors, events and strategies which are present in natural recovery in order to gain a deeper understanding of alcoholism and the recovery process. In view of the pessimism which surrounds alcoholism treatment a reason for optimism lies in the range of promising treatment alternatives available (Institute of Medicine, 1990). Research shows that individuals who are given their own choices in treatment do better than those who are assigned interventions by someone else (Mattson & Allen, 1991).

The fact that 20% of people with alcohol problems choose to help themselves to recovery sounds an optimistic note of hope for the future (Sobell et al, 1993). This study hopes to learn from this combined wisdom and harness it to inform our knowledge base.

1.2 ALCOHOLISM IN THE SOUTH AFRICAN CONTEXT

Any study on alcoholism is highly relevant in the South African context. Alcohol features prominently in our social and political history regardless of specific culture or other variables.

Historically it has been used as an integral part of the various religious ceremonies and feasts as:

- A means of political control.
- A social and recreational lubricant (Parry & Bennetts, 1998).

Empirical evidence presented by Parry & Bennetts (1998) supports the view that the number of people drinking at risky levels in South Africa is substantial, resulting in an increase in the development of alcohol related problems. In terms of future trends it was predicted that South Africa is likely to see a continuing increase in consumption and alcohol-related problems (Parry & Bennetts, 1998). It was stated that alcohol-related problems:

- Deplete national resources, human, material and financial.
- Have a negative impact on life expectancy.
- Negatively affect production and labour productivity by contributing to absenteeism from work, carelessness, and, in some cases, premature death.
- Incur considerable public expenditures and generally interfere with the attainment of national goals (Parry & Bennetts, 1998).

Parry further estimates that the economic costs to South Africa, may be as much as R10 billion rands a year (Parry & Bennetts, 1998). This amount will have increased as a result of inflation.

Future projections seem to indicate that South Africa will experience an increase in alcohol consumption and alcohol-related problems. Predictions are that S.A. will witness:

- Low-income groups move from a subsistence economy to a cash economy, continuing urbanization.
- Black communities moving away from wet-based sorghum beer to malt beer.
- The introduction of flavoured wine and fruit ales.

All of these factors will lead to an increase in consumption among young people (Parry & Bennetts, 1998). As consumption increases so will the incidence of alcohol-related problems and alcohol dependence.

Alcoholism treatment is expensive for the state and for the consumer. Even state subsidized clinics are beyond the economic reach of the majority of South Africans (Parry & Bennetts, 1998).

1.3 VALUE OF THE STUDY

It is hoped that this study will contribute to:

- a) An understanding of the natural processes involved in the recovery processes so that treatment providers could harness self-help processes in providing more cost-effective treatment.
- b) The empowerment of alcoholics in South Africa who do not have access to formal treatment, to enable their own resources and strengths to resolve alcohol problems.

A number of studies have been conducted in the United States of America and Europe to examine the phenomenon of spontaneous or natural recovery. Each study has focused on a specific aspect of the recovery process, e.g. cognitive processes, or motivation. There does not appear to be any study that has examined the phenomenon in its entirety. This study aims to document a description of the process of abstinence and recovery from alcoholism in an individual who relies solely on his/her own resources, strengths and abilities and on those social and familial resources to which he/she has access. The narrative will hopefully be enhanced both in terms of qualitative detail and research validity by corroborative detail from the families and significant others of the individuals concerned.

To the best of the researcher's knowledge no similar study has been conducted in South Africa. This provided further reason to pursue an exploratory and descriptive strategy to provide a basis and guide for future research.

1.4 THE OBJECTIVES OF THE STUDY

1. To establish contact with recovering alcoholics in the geographical area of Kwa-Zulu Natal, South Africa, who have achieved two or more years of abstinence, and who had not had access to formal treatment approaches.
2. To document, in qualitative detail, a rich description of :
 - The drinking behaviour, the physical, psychological and social functioning of the alcoholic prior to abstinence.
 - The circumstances, factors or processes that precipitated the motivation or readiness to stop drinking.
 - The present drinking/non-drinking behaviour of the alcoholic, the physical, psychological and social functioning of the alcoholic after two or more years of recovery.

- The key issues, life events and problems of adjustment with which the alcoholic had to contend during recovery.
 - The processes, strategies, skills and supports used by the alcoholic, which facilitated maintenance of the recovery process.
3. To document, in qualitative detail, a rich description of the process of abstinence and recovery, as witnessed and experienced by an involved significant other.

The experiences of close or involved significant others are included in this study in an attempt to provide a reliable documentation of events. To the best of the researcher's knowledge this type of information has not been included in any previous study.

1.5 SAMPLE SELECTION

Participants with two or more years of abstinence will be interviewed. Theorists are reluctant to stipulate a period by which an alcoholic can be identified as being successfully recovered. Instead they stress the concept of recovery as a process (Brown,

1985). Recent evaluators base their findings on a period of one year (Hoffman & Harrison, 1991; Stinchfield & Owen, 1998). For the purposes of this study, participants will be interviewed after two or more years of sobriety. The advantages of this are that:

- Sobriety will be considered to be stable. Success rates do drop alarmingly between one and two years of sobriety (Stinchfield & Owen, 1998; Hoffman & Harrison, 1991; McLellan et al, 1993).
- It may be that from this relatively long-term vantage, the intricacies and movements of change can be appreciated (Brown, 1985).
- Subjects with periods of sobriety longer than two years would contribute to the richness of experience.

1.6 WORKING ASSUMPTIONS OF THE STUDY

1. Some alcoholics are able to recover without formal treatment.

2. There are variables or events which motivate initial behaviour change (abstinence) and which serve as incentive functions in the natural recovery process.
3. There are variables or events which maintain behaviour and which serve as reinforcing functions in the natural recovery process.
4. Certain intra-personal, genetic, psychological, social or environmental variables or factors may predispose individuals to natural recovery.

1.7 RESEARCH STRATEGY

Although much has been written about alcoholism, specifically about the etiology thereof, there are few theories about recovery. Low success rates indicate that service providers continue to be baffled about the process of recovery.

A qualitative approach has been selected for the purposes of this study - even though it is acknowledged that qualitative research is criticized by some for its apparent lack of scientific process. Exploratory research is a means of discovering new insights, information and understanding into a phenomenon about which

little is known. It allows the researcher to add depth and richness to current investigations (Marlow, 1993).

When 'how' and 'why' questions are being asked, when the investigator has little control over events, and when the focus is on a phenomenon within a 'real-life context', case studies are the preferred strategy (Yin, 1994). Yin further states that such 'explanatory' case studies can also be complemented by 'exploratory' and 'descriptive' case studies.

Descriptive data will be collected from each subject in order to record and report some objective data and to 'fill out and enhance' the full and rich description required.

1.7.1 Case Studies

A case study is an intensive description and analysis of a single individual. It has been stated that the power of the case-study method "lies in its ability to open the way for discoveries" (Shaughnessy & Zechmeister, 1990, p.145).

Other advantages of the case study method are that:

- They provide a unique means of studying behaviour.
- They are often characterized as exploratory in nature and a source of hypothesis and assumptions about behaviour.
- They are seen as interrelated with and complementary to other research methods (Shaughnessy & Zechmeister, 1990).
- They allow for the development of hypotheses and assumptions that may later be researched by more rigorous methodologies. A starting point for a researcher entering an area about which relatively little is known (Shaughnessy & Zechmeister, 1990).
- They provide a way to study a wider range of issues. Certain events are so infrequent that it is possible to describe them only through intensive study of single cases (Shaughnessy & Zechmeister, 1990).
- They provide a challenge to theoretical assumptions - can provide a case that violates a general theoretical proposition or universally accepted principle.
- They can provide tentative support for a psychological theory awaiting more carefully controlled procedures to validate.
- They complement nomothetic study of behaviour. The idiographic approach, or study of the individual, as represented by the case study permits the kind of detailed observation that reveals nuances and subtleties of behaviour

that the nomothetic approach may miss (Shaughnessy & Zechmeister, 1990).

This study is both nomothetic and idiographic in that a detailed study of many individuals enables both the subtleties and richness of the individual narrative and the determination of the 'average' or typical performance which applies to a group.

Information was therefore collected from each respondent and their family by means of unstructured interviews, placed into different arrays, making a matrix of categories and placing the evidence within such categories (Yin, 1994). This information was analyzed based on the theoretical propositions which informed this study (see section 2.5 of this study). The research questions and literature review guided the direction of the analytic process. It is hoped that this process would provide new insights and provide some answers to the 'how' and 'why' questions which present themselves in the recovery field.

Interviews were analyzed as more or less accurate descriptions and reports of reality. These descriptions were systematically grouped into different arrays or categories - providing a coherent organizing framework that explains aspects of natural or

spontaneous recovery as portrayed by respondents. This process uncovers the 'what' questions (Holstein & Gubrium, 1997).

1.7.2 The Active Interview

'How' questions were uncovered by a process of active interviewing.

Our society favours the interview as a means of generating information. Television, radio, newspapers, magazines, human-service-providers and researchers all use the interview as a technique to gather information. Ninety percent of all social science investigations use the interview in one-way or another (Holstein & Gubrium, 1997).

Interviews provide a way of asking people to talk about their lives. They are interactional in character. Traditionally, interviewers are concerned with obtaining a flow of valid, reliable information, while minimizing distortions. The interviewer is firmly in control, the appropriate questions will elicit the desired information. From a post-modernist, constructivist, post-structuralist perspective this method of obtaining data is questioned. The proponents of these perspectives hold that

meaning is socially constructed. Interviews are sound encounters in which knowledge is constructed (Holstein & Gubrium, 1997). Michael White refers to this process as ‘panning for gold’, as searching for the “little pockets of non-co-operation, moments of personal courage and autonomy, self-respect and emotional vitality beneath the iron grid of lived misery and assigned pathology” (in Wylie, 1994,p.38).

The process of interviewing was treated as :

- a social encounter,
- a means of producing reportable knowledge,
- A process in which both parties would be engaged in excavating the knowledge which provides answers to the ‘how’ questions (Holstein & Gubrium, 1997).

The researcher hoped to engage with the participants in this manner and to ask the kind of question that would uncover ‘new knowledge’s’ and ‘unique outcomes’ (Freedman & Combs, 1993).

1.8 POTENTIAL LIMITATIONS OF THE STUDY

Qualitative studies are often criticized because of the following:

- It is difficult to draw cause and effect conclusions. Researchers cannot control extraneous variables. Change can be attributed to many factors. At best only tentative conclusions can be drawn which need more rigorous scientific investigation.
- There is the possibility of bias in interpretation. There is a reliance on the inferences drawn as a consequence of the feelings and impressions of the researcher who was both participant and observer.
- There are possible biases in data collection. Sources of data can be biased. When information is based on self-report, there is always the possibility of distortion or falsification, by design or by nature of denial mechanism which is a symptom of alcoholism, or by selective or poor memory. The researcher was keenly aware of this possibility and sought to eliminate some of this bias by inclusion of interviews by significant and involved others.
- It is difficult to generalize from one case, it depends on the degree of variability in the population. In this study, people

were selected from a wide community of people of all ages, races, genders and income levels. For this study, therefore, 25 cases were studied in the hope that findings could be generalized, even tentatively, to highlight significant variables which would be put forward for further testing (Shaughnessy & Zechmeister, 1990; Silverman, 1997).

It seemed important in this study to question whether all participants were alcoholics prior to their natural recovery. Recovery might have been attributed to the presence of an alcohol problem, rather than an alcohol dependence or addiction. In other words, alcohol may have been abused thus creating life problems, but the individual may still have had the ability to control his or her alcohol use. Whereas, the alcoholic, or alcohol dependent individual is thought to be unable to exercise control, and therefore choice (this distinction is clarified in Chapter Two).

Due to the difficulties presented by administering retrospective interviews, questions were asked of the participants and their family about the extent of the problem. The researcher drew conclusions about the extent of the problem by eliciting responses to questions about 'loss of control' and the presence of

'harmful consequences' caused by drinking. It was noted that as participants relaxed and became more trusting of the process more information regarding the extent of the problem was released.

The sample recruited for this study were those who had access to an English language daily newspaper in Durban, Kwa-Zulu Natal, South Africa and access to telecommunication facilities. Therefore our sample was restricted to literate, English speaking individuals with access to telephones in a geographically specific population. In the future, a broader and larger study needs to be conducted throughout South Africa that would include all language groups and would include those without access to reading or telecommunication systems.

1.9 PRESENTATION OF THE STUDY

Chapter One provides an introduction to the study by outlining the contextual framework within which the study was conducted, the rationale and purpose of the study, the objectives and working assumptions of the study and a rationale for the choice of qualitative research strategy. The literature pertinent to the study is reviewed in Chapter Two. Chapter Three covers an overview of the research process. The results of the study are analyzed and

interpreted in Chapter Four. Conclusions and recommendations for further research form the subject of Chapter Five.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Literature on alcoholism is extensive. Literature on the subject of natural recovery is not.

The researcher has attempted to cover the wide range of literature on alcoholism as concisely possible in order to provide a comprehensive overview for the purposes of this study. Where authors have provided definitive theories on alcoholism and etiology, those have been included, despite the fact that this literature may not be recent. These are theories which are seminal and have stood the test of time and are in current use in the treatment of alcoholics.

Literature on natural recovery from alcoholism, though not as extensive as literature on alcoholism, provided a good

understanding of some of the factors and variables which enabled some individuals to self- remit.

Literature is included on the strengths perspective, systems theory, and cognitive behavioral and narrative therapy as these theories and perspectives have informed this study.

2.2 ALCOHOLISM DEFINED AND DECONSTRUCTED

What was clear from a review of the theories and models about alcoholism was that it was difficult to understand that there was not one specific pattern of behaviour that was regarded as typical to the alcoholic. Alcoholics differed in their styles of alcohol consumption and in the severity of the consequences of their drinking. Some were calm and contained, others acted out and caused chaos. Some kept jobs and were relatively functional and some did not. Some used alcohol daily, others drank in episodic binges. Some stayed dry between binges, others controlled their drinking between binges. Some drank large quantities of alcohol, others did not. Some drank only beer and others drank anything and everything. Some developed alcoholism early and rapidly and

others took years to develop the illness (Mooney et al,1992; Perkinson, 1997).

2.2.1 Definitions of Alcoholism

The simplest and most widely used definition was that “alcoholics are those people who are unable with any predictability to control their drinking, and/or whose drinking causes problems in major areas of their lives” (Black,1981,p.xiv).

Another more recently compiled definition was a collaborative effort approved by the Boards of Directors of the National Council on Alcoholism and Drug Dependence, Inc. (Feb 3, 1990) and the American Society of Addiction Medicine (Feb 25, 1990). This collaborative definition states:

- “Alcoholism” is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.

- “Primary” refers to the nature of alcoholism as a disease entity in addition to and separate from other pathophysiologic states which may be associated with it. “Primary” suggests that alcoholism, as an addiction, is not a symptom of an underlying disease state.
- “Disease” means an involuntary disability. It represents the sum of the abnormal phenomena displayed by a group of individuals. These phenomena are associated with a specified common set of characteristics by which these individuals differ from the norm, and which places them at a disadvantage.
- “Often progressive and fatal” means that the disease persists over time and that physical, emotional, and social changes are often cumulative and may progress as drinking continues. Alcoholism causes premature death through overdose, organic complications involving the brain, liver, heart and many other organs, and by contributing to suicide, homicide, motor vehicle crashes, and other traumatic events.
- “Impaired control,” means the inability to limit alcohol use or to consistently limit on any drinking occasion the duration of the episode, the quantity consumed, and/or the behavioural consequences of drinking.

- “Preoccupation” in association with alcohol use indicates excessive, focused attention given to the drug alcohol, its effects, and/or its use. The relative value thus assigned to alcohol by the individual often leads to a diversion of energies away from important life concerns.
- “Adverse consequences” are alcohol-related problems or impairments in such areas as: physical health (e.g. alcohol withdrawal syndromes, liver disease, gastritis, anemia, neurological disorders); psychological functioning (e.g. impairments in cognition, changes in mood or behaviour); interpersonal functioning (e.g. marital problems and child abuse, impaired social relationships); occupational functioning (e.g. scholastic or job problems); and legal, financial, or spiritual problems.
- “Denial” is used here not only in the psychoanalytic sense of a single psychological defense mechanism disavowing the significance of events, but more broadly to include a range of psychological maneuvers designed to reduce awareness of the fact that alcohol use is the cause of an individual’s problems rather than a solution to those problems. Denial becomes an integral part of the disease and a major obstacle to recovery.

The American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM) (1994) defined a Substance Abuse Disorder as follows:

1. Diagnostic Criteria for Psychoactive Substance Abuse

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
2. Recurrent use in situations in which it is physically hazardous (e.g., driving while intoxicated or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems (e.g., arrests of substance-related disorderly conduct)
4. Continued use despite knowledge of having a persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

11. Diagnostic Criteria for Psychoactive Substance Abuse Dependence

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

- A. Tolerance, as defined by either of the following:

1. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
 2. Markedly diminished effect with continued use of the same amount of the substance.
- B. Withdrawal, as manifested by either of the following:
1. Characteristic withdrawal syndrome of the substance.
 2. The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
- C. Substance often taken in larger amounts or over a longer period than intended.
- D. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- E. A great deal of time spent in activities necessary to get the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects.
- F. Important social, occupational, or recreational activities given up or reduced because of substance use.
- G. The substance use is continued despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is likely to have been caused or exacerbated by the use of the substance (e.g., keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking) (DSM-IV, 1994).

2.2.2 Models of Alcoholism

In 1996, there were approximately sixty models of alcoholism in existence (Merikallio-Pajunen, 1996). More may exist now. For the purposes of this study, the most widely accepted and most commonly used models are presented in an attempt to provide a multi-faceted view of alcoholism. These are presented briefly, with acknowledgement that each on its own is a relatively complex conceptual framework.

The Medical or Disease Model

This was one of the most widely used and accepted models which viewed alcoholism as a disease, with an accompanying set of recognizable symptoms, a progressive course and prognosis. The original view placed emphasis on the biological properties of the illness and placed the medical fraternity as the primary therapist (Brown, 1985). A revised view of the medical or disease model acknowledged the presence and influence of psychological and social variables in the disease and included other helping professionals in the treatment thereof (Diamond, 2000; Marjot, 1982).

This approach was criticized by some who maintained it did not explain the complexity of the phenomenon we call addiction (Diamond, 2000). Critics, such as Peele & Brodsky (1992) maintained that alcoholism should rather be viewed as a learned behaviour, which could be unlearned without pathologising labels.

The role played by the cognitive processes seem to indicate a greater sense of control than is evidenced in definitions of the disease model which emphasize loss of control and power as physical symptomology overtake the individual.

The Behavioural Model

The basis of this approach is the absence of physiological intolerance, which leaves some individuals without a biological protective mechanism against excessive drinking (Langley, 1985). More simply put, some individuals find excessive drinking a positively reinforcing experience. This model also included social learning principles to describe the development of alcoholism and its treatment. Marlatt & Gordon (1985) maintained that the alcohol-related behaviours of problem drinkers are acquired through observation of the alcohol-related behaviours of others, such as family members or the media. Treatment included

behaviour modification therapy, aversive conditioning and positive reinforcement (Brown, 1985).

The Psychoanalytical Model

The central tenet of this model was the controversial ‘alcoholic personality’. Proponents of this model maintained that there was a particular personality type which predisposed certain individuals to the development of an addictive disorder. While most practitioners would acknowledge having observed an addictive pattern of thinking, there was no clarity on whether this pattern of thinking and behaving predated the individual’s alcoholism or whether it emerged as a consequence or result of the alcoholism.

In this model there was an emphasis on subconscious conflict and the importance this placed on the alcoholic’s inadequacy in social and personal relatedness, poor ego-strengths and other personality defects (Brown, 1985).

The Social Model

The emphasis was placed on the alcoholic’s socio-economic status, ethnicity, sub-cultural moves and family interaction as

causative factors in the development of alcoholism. The Social model held that alcoholism developed in societies and cultures in which alcohol was freely available and which supported its use. Further it maintained that there were ethnic and socio-economic factors that predisposed some groups to the use of substances (Brown, 1985).

Family Interaction Model

This model held that some families were predisposed to the development of alcoholism by means of genetic heredity and the pattern of unhealthy relationships, behaviours and roles, which developed as a result of excessive alcohol use and the family's efforts to survive. This model used the term the 'alcoholic family' to describe a family in which the disease of alcoholism had affected the way the family system operated (Kritzberg, 1988).

This model was criticized for its deterministic nature. Although overwhelming evidence for the genetic transmission of alcoholism exists, many argue against this (Granfield & Cloud, 1999; Peele & Brodsky, 1992).

The Alcoholics Anonymous Model

This is not a formal model, but had to be included as one of the major treatment approaches. It was informed by the disease model and exists as a 12-Step recovery programme based on elements of peer-approval and peer-support. It was based on strong and enduring guiding principles and formed the basis of the Minnesota Model of treatment, (described later) and many of the treatment programmes in South Africa. There was both strong support and criticism for this approach. It was supported by those who are invested in the self-help nature of the programme and who admire the programme's endurance. Critics argued that its adherence to the disease model, use of labels, and non-support of other models, was simplistic, stigmatizing, and did not address the complete issues of the problem (Brown, 1985; Diamond 2000; Marjot, 1982).

Because so many models of alcoholism exist, it followed that there was much debate about its nature, cause and treatment. There was also evidence of professional rivalries. Different professions had investments in the particular model which gave them authority and power (Granfield & Cloud, 1999; Peele & Brodsky, 1992). It seemed relevant to highlight some of the

controversies and debates in the interests of a better understanding.

1. There was concern whether alcoholism was continuously distributed, or whether it was an all-or-none phenomenon with a specific cut-off point which separated alcoholic and non-alcoholic.
2. Some individuals appeared to be able to return to social drinking.
3. Some alcoholics did not appear to suffer harmful consequences and appeared stable and functional in their dependence.
4. It was sometimes difficult to distinguish between alcoholics and non-alcoholics.
5. The diagnosis of 'alcoholism' appeared to stigmatize people and make them resistant to obtaining help.
6. It seemed that viewing alcoholism as a disease:
 - disempowered people
 - provided them with an excuse to drink
 - enabled them to take advantage of the sickness
 - removed the individual's responsibility for their drinking behaviour (Granfield & Cloud, 1999; Marjot, 1982; Peele & Brodsky, 1992).

2.2.3 Types of Alcoholism

In attempt to understand the wide range of alcoholic behaviour, researchers categorized alcoholism into typologies. Theory developed by Jellinek in 1952 and 1960, remains significant and relevant in 2001 (in Glatt, 1974). Discussion about different types of alcoholism was relevant to this study as, in addition to assisting in the understanding of the nature of alcoholism, as it may have had implications in predicting the type of recovery chosen and the recovery outcome.

Jellinek's Five Types of Alcoholism

Jellinek preferred talking about alcoholics rather than alcoholism. He identified five types of alcoholism (Glatt, 1974).

1. Alpha Alcoholism: a purely psychological continual dependence or reliance on the effect of alcohol to relieve bodily stress or emotional pain.
2. Beta Alcoholism: where physical or psychological complications may have occurred without physical or psychological dependence on alcohol. This type of

alcoholism could rather be described as ‘heavy drinking’ due to cultural customs in conjunction with poor nutrition.

3. Gamma Alcoholism: a physically and psychologically addictive type of alcoholism where loss of control was evident.
4. Delta Alcoholism: a physically and psychologically addictive type of alcoholism where loss of control had reached the stage where the alcoholic was unable to abstain.

Jellinek viewed type 3 and 4 as the only type which constituted addiction in the strict pharmacological sense. He explained that the alcoholic’s craving, loss of control and inability to abstain was brought about by the affected metabolism, the development of tolerance and physical withdrawal symptoms.

5. Epsilon Alcoholism or Periodic Bingeing Alcoholism: this type of alcoholism was characterized by intermittent periods of abuse and loss of control associated with the individual’s state of mind, physical health, environmental, and social factors (Glatt, 1974).

More recent studies found that all alcoholics may be grouped into one of two categories and that these categorizations may be used

to predict treatment outcomes (Babor, Hoffmann, Delboca, Hardbrock, Meyer, & Dolensky 1993). It seemed that Type A and Type B appeared to have some correlation with Jellinek's Gamma and Delta Alcoholism respectively.

Type A was characterized by "later onset and fewer childhood risk factors, less severe dependence, fewer alcohol related physical and social consequences, less previous treatment for alcohol problems, less psychopathological dysfunction and less distress in the areas of work and family" (Babor et al, 1993, p1.).

Type B was characterized by "more childhood and familial risk factors, earlier onset, greater severity of dependence, poly-drug use, more serious consequences, more chronic treatment history, greater psychopathological dysfunction and more life stress"(Babor et al, 1993).

Finding in these studies suggested that the different typologies responded to different approaches (Litt, Babor, Delboca, Kaden & Cooney, 1993). Type A was found to have better outcomes with less structured interactional treatment. And Type B fared better with more structured coping skill programmes (Litt et al, 1993).

Some researchers predicted that, alcoholics who recovered spontaneously or naturally would in all probability be Type A alcoholics (Babor et al, 1993; Litt et al, 1993).

2.2.4 Stages of Alcoholism

Much of the literature referred to the passage from social drinking through to alcoholism as belonging on some kind of continuum (Brown, 1985; Glatt, 1974; Marlatt & Gordon, 1985. There was mention of a dividing line between ‘problem use’ and ‘addiction.’ Diamond (2000) proposed that a clear distinction might occur between substance abuse and substance dependence. That we may be dealing with two totally different phenomena, as different as “emphysema and lung cancer” similar in manifestation but differing in symptomology and progression (Diamond, 2000, p.15).

A substance abuser may have used alcohol excessively and harmfully, but once it had been determined that a problem existed, they were able to stop or resolve the problem in some way. Lockard (Diamond, 2000) called this the “point of common sense”. An alcoholic or addict seemed to be the person, who continued to use beyond “the point of common sense” (Diamond,

2000, p.15). This distinction could still be critically examined. If the alcohol abuser was not an addict, why would they need to stop using alcohol in order to resolve the problem? It seemed therefore that this line of questioning would lead us back to the different types of alcoholism outlined previously.

Progressive Stage Theory

Jellinek (Glatt, 1974) described a progression of identifiable symptoms and behaviour in increasing severity and distinguishing stages. This was seminal and crucial work, defining the progression and disease concepts of alcoholism.

Glatt (1974) described four symptomatic stages:

- The pre-alcoholic stage characterized by increased alcohol use.
- The pro-domal stage, characterized by increased tolerance and dependence.
- The crucial stage, characterized by physical and psychological dependence.
- The chronic stage, characterized by the loss of control and adverse consequences rendering the affected individual's life unmanageable .

Glatt (1974), refined Jellinek's work to trace the developmental progression of dependence and proposed a mirror image of recovery .

2.3 RECOVERY FROM ALCOHOLISM

In reviewing literature on recovery, it becomes clear that there is a language of recovery that needs to be understood before grasping the finer nuances of the concept of recovery. The various definitions and terminologies will be outlined in the following section.

2.3.1 Definitions of Recovery

Definitions of recovery ranged, on a continuum, from those which regarded any reduction in alcohol use as indicative of recovery, through to a complete cessation of alcohol use with accompanying improvement in life quality. Examples were:

Recovery involves abstinence or a marked reduction in the use of alcohol and a reduction in alcohol related problems (Smart, 1975).

“Recovery: the ongoing process of overcoming physical and psychological dependence on alcohol and learning to live in a state of total abstinence without the need or desire for those substances” (Mooney et al, 1992, p.577).

Recovery described the modification of the individual’s physical and mental state so that chemical substances were unnecessary for happiness and fulfillment.

Abstinence referred to the complete cessation of the use of alcohol (Mooney et al, 1992).

Sobriety was referred to as “a state of mental clarity reached through abstinence from alcohol and other drugs” (Mooney et al, 1992, p.577).

Sobriety also referred to the quality of the state of abstinence. It could best be understood in reference to the terms ‘wet’ and ‘dry’. A “wet” alcoholic referred to an active or drinking alcoholic who would not be in recovery. A “dry” alcoholic was one who was not drinking but unhappy and resentful about his/her status. Thus, an alcoholic could be ‘dry’ and not sober. This implied abstinence,

but there was no positive or perceived quality to the state of abstinence (Brown, 1985; Vaillant, 1983).

Relapse referred to a sustained return to a lower level of functioning following a period of adequate functioning. The person returned to a state that satisfied all the criteria for a diagnosis of alcoholism (Langley, 1985). Or as “The return by a person in recovery to the self-prescribed, non-medical use of any mind altering drug (including alcohol) and risk of the subsequent problems associated with such use” (Mooney et al, 1992, p.577).

Relapse was often preceded by negative thoughts, distorted perceptions and even non-specific physical symptoms (Langley, 1985, Mooney et al, 1992).

A ‘slip’ referred to a brief return to drinking behaviour (Mooney et al, 1992.p. 577).

2.3.2 Recovery as a Process

The alcoholism recovery process was not only viewed as a process which involved abstinence or a reduction in alcohol use but also to the construction and reconstruction of a person’s

fundamental identity, and of his/her place in the world. It was not seen as static, but as a process involving movement and change. Bacon (1974) was the first to speculate about the process of recovery as a mirror process reflecting the reverse image of alcohol addiction. He saw recovery as a progressive phenomenon in which the alcoholic experienced changes to his defensive structure, self-esteem and life-roles. He identified different needs and problems that challenged the recovering alcoholic at different phases. However, his work did not describe how people changed, or specify which therapeutic strategies were most useful at different stages in recovery (Brown, 1985).

2.3.3 Alcoholism Recovery Models and Approaches

The Dynamic Model of Recovery

This model proposed that recovery was a developmental process that was not a mirror image of the development of alcoholism as Glatt and Bacon suggested (Brown, 1985). What was lost in drinking did not appear to be automatically gained in abstinence. Recovery seemed to be a progressive and complex building process, structured in four stages or phases, each involving a series of stage associated tasks with the goal of reconstruction of a

person's identity and social roles. Learning and reconstruction seemed to be accompanied through behavioural change, cognitive re-organization and restructuring and involved a complex set of interactions between behavioural, cognitive and affective components. The stages outlined were:

1. The Drinking Stage - where the individual was still attached to alcohol. The tasks in this stage were to break down the alcohol efficacy belief system and denial.
2. The Transition Phase - where the tasks were accepting oneself as an alcoholic and emphasis on learning new 'recovery-based' behaviours.
3. The Early Recovery Stage - where these behaviours continued together with the exploration of affect and self.
4. The Ongoing Recovery Stage - where the alcoholic invested in new recovery-based behaviours, in the construction of a new identity as an alcoholic in recovery and in reconstruction of the past (Brown, 1985; Vaillant, 1983).

The Relapse-Prevention Model of Recovery

Gorski (1989), a leading pioneer in relapse-prevention in recovery expanded on this model to present a well-defined model of the recovery process. He outlined six stages of recovery:

1. The Transition Stage - developing an awareness of the need for change.
2. The Stabilization Stage - asking for help, and accepting medical or other assistance needed to abstain, e.g. detoxification.
3. The Early Recovery Stage – initial period of abstinence , including admitting and accepting the problem.
4. The Middle Recovery Stage - repairing social damage and establishing a sober lifestyle.
5. The Late Recovery Stage - dealing with character defects, childhood issues and self-growth.
6. The Maintenance Stage - maintaining effective daily coping strategies, in addition to continued growth and development (Gorski, 1989).

The Narrative Approach

Even narrative therapists, critical of the disease-orientated model, recognized the transitional and phasic nature of the recovery process (Diamond, 2000; White, 1997). White (1997) commented on the ‘migration of identity’ in relation to an alcohol problem. “An act of intentionally leaving one’s life behind in order to make a new life for oneself” (p.39). His view was that individuals pursued a desire to revise their relationship with a substance, and take up a journey in which the individual left behind the territory of life that was previously inhabited. His view was that the individual arrived at a new place where they experienced once again a sense of belonging. Having completed this journey, individuals emerged with a map that could be used as a basis of predicting experiences, and to inform others about the preparations that were needed (White, 1997).

It was this sharing of ‘maps’ and stories of recovery that provided synergy between this narrative model of recovery and the AA 12-Step view or philosophy outlined in section 2.2.2. White (1997) recognized that the stories told by recovering alcoholics provided the ‘maps’ needed by others in recovery. White credits the

founders of AA with great vision and understanding of the significance of the ‘rites of passage’ (White, 1997, p.41).

2.4 TREATMENT OF ALCOHOLISM

As this study focuses on those individuals who recovered from alcoholism without formal treatment, it seemed important to include a discussion on treatment for the following reasons:

- An understanding of the processes involved in informal treatment is central to a discussion on recovery from alcoholism
- Recovery during and after treatment would seem to be nurtured by similar factors that facilitate the resolution of problems without treatment (Merikallio-Pajunen, 1996; Moos, 1994).

2.4.1 Definitions of Treatment

Formal treatment was defined as:

“any intervention by recognized programmes or individuals whose primary goal was to treat individuals with alcohol problems” (Sobell et al, 1993, p.217).

This included in and out patient treatment facilities, Alcoholics Anonymous (AA) or similar self-help groups, professional counseling specifically for alcohol problems and treatment-orientated drinking-driver courses. Attendance at just one or two AA meetings was not considered to be treatment, as AA's philosophy did not consider attendance at one or two meetings as successful participation. Physician warnings were not considered treatment unless accompanied by advice or counseling. Visits to psychologists, social workers for reasons other than alcohol were not considered treatment. Even one session of professional counseling specifically for alcoholism was considered treatment as brief interventions had been found to be effective (Sobell et al, 1993).

2.4.2 Formal Treatment Models and Approaches

The Minnesota Model of Treatment

The Minnesota Model was one of the most common approaches used in the treatment of alcoholism and drug abuse worldwide and was found to be used in clinics in South Africa. It was the treatment modality practiced at Hazelden, arguably one of the best

known and respected treatment facilities worldwide (Stinchfield & Owen, 1998). The basic assumptions of this model were:

- That alcoholism was a “no-fault”, multi-phasic, chronic and primary disease.
- The caring versus curing model was embraced. This concentrated not on the underlying cause of alcoholism but on the factors which stimulated, maintained and perpetuated the alcoholic behaviour.
- The Alcoholics Anonymous (12-Step) philosophy was embraced and membership of and attendance of AA community based meetings was encouraged during treatment (Alcoholics Anonymous, 1981).

The goals of treatment were:

- Complete abstinence from mood-altering chemicals and
- Achievement of an improvement in the alcoholic’s quality of life.

Treatment was offered in an in-patient setting by a multi-disciplinary team which included a doctor, nurse, psychologist, chaplain and chemical dependency counselor. The primary agent of change was group affiliation and practicing behaviours consistent with the AA’s 12-Step programme (Stinchfield &

Owen, 1998). This included labeling oneself as an alcoholic and acceptance of the position of powerlessness over alcohol. This powerlessness position, by necessity, meant that the alcoholic had to remain in a 12-Step support programme for life (Mooney et al, 1992).

The Alcoholics Anonymous Treatment Approach

Alcoholics Anonymous was founded, in 1935, by Bill Wilson. The programme consisted of 12 steps (see Appendix 6). At its foundation were enduring traditions and principles which guided its self-help meetings. These principles:

- Safeguarded anonymity,
- Ensured that the organization remained not-for-profit,
- Protected the principles from personalities and
- Guaranteed continuity (Alcoholics Anonymous, 1981).

This programme claimed that:

- Regular attendance at AA meetings would empower the individual to abstain from alcohol.
- By working the 12 Step programme the alcoholic could achieve continued sobriety, one day at a time.

There was a strong emphasis on the powerlessness of the alcoholic and on the need for a higher power to achieve sobriety. Relapses were dealt with in a non-punitive manner as a symptom of the illness (AA, 1981; Mooney et al, 1992; Perkinson, 1997).

Critics of the AA programme, maintained that the programme encouraged dependence, stigmatized the individual and did not allow for individual differences and needs in its treatment approach (Peele & Brodsky, 1992).

However, its broad acceptance by recovering alcoholics and endurance as a treatment modality seemed to have been recognized by most practitioners in the addiction field.

The Relapse Prevention Model

The more recently developed Relapse Prevention Model (RPM), developed by Gorski (1989), accepted a view of alcoholism which incorporated the seminal theories of Jellinek and Glatt (1974) and added additional pathogenic mechanics incorporated from behaviour, genetic, interactional and cognitive behavioural theory (Gorski, 1989; Langley, 1985).

The RPM called for adaptive transactions between persons and their environments. It contended that traditional approaches to alcoholism treatment often failed, because they ignored the transactional nature of recovery and over-emphasized interpersonal, psychological, genetic and personality trait factors (Gorski, 1989).

Poor adaptation implied the development of stress. Germain, Morcheubaum, Lolmau and Rose (Langley, 1985) developed a transactional model of stress based on the discrepancy between the demands made of an individual and the individual's capacity or ability to meet that demand. Coping responses were usually activated to restore the balance. It was claimed that effective coping would reduce stress, while ineffective coping would lead to increased stress (Langley, 1985).

Gorski (1989) refined this theory and developed the RPM based on the following premise:

On experiencing a stressful event or high risk event, the alcoholic either:-

1. Perceived an ability to cope with the demands of the situation and generate the coping skills necessary to deal

effectively with it. In this case, relapse was unlikely and recovery possible.

2. Perceived an inability to cope with the demands of the situation and experienced stress. In this case relapse was possible (Langley, 1985; Gorski, 1989).

Gorski (1989) went on to identify high-risk situations in which relapse was possible and developed a programme to teach individuals ways to cope with these situations, thus developing a sense of self-efficacy and confidence (Gorski, 1989).

This model was widely used in alcoholism treatment and had been incorporated into 12-step programmes worldwide.

The Life Processes Model

Peele and Brodsky (1992) were outspoken supporters of the Life Processes Model that placed itself firmly in opposition to the disease model, arguing that it:

- Stigmatized people for life.
- Failed to differentiate between the worst alcoholics and those with minor dependence.

- Created a dependency on AA programmes and groups and trapped alcoholics in a world inhabited by fellow alcoholics.
- Ignored the rest of a person's problems in favour of blaming everything on the alcoholism.
- Attacked a person's feelings of self-control and set up alcoholism as a self-fulfilling prophecy (Peele & Brodsky, 1992).

Proponents of this model further argued that:

- People do not necessarily lose control of themselves whenever they are exposed to alcohol.
- Alcoholism does not always last a lifetime. The view 'once an addict – always an addict' was regarded as pessimistic and harmful and offered only two alternatives which were either staying addicted until death; or abstaining for life while attending groups (Peele and Brodsky, 1992).

Supporters of this model believed that most people were more resilient and resourceful than the disease model gave credit for and that most people with an addictive habit, either moderated or eliminated their habit over the course of a lifetime and that they

did this without having to identify, and perhaps, stigmatize themselves as an addict (Granfield & Cloud, 1999; Peele & Brodsky, 1992).

Further, they believed that, if most people could give up addictive habits then, the idea of the inevitable progression of alcoholism was the exception rather than the rule, and calling alcoholism a progressive illness came from looking at a few individuals who had progressed to severe addiction (Peele & Brodsky, 1992).

These theorists viewed treatment for addictions as setting people up for failure by emphasizing their loss of control (Peele & Brodsky, 1992). This view seemed to be supported by the treatment matching study implemented by Miller and Hester (1986), which found that in two studies in which alcoholics were randomly assigned to AA, other treatment facilities and to no treatment, that those who were assigned to AA or treatment did no better and actually suffered more relapses than those who were not treated at all (Miller & Hester, 1986). Vaillant's (1993) study reported similar findings (in Moos, 1994). In addition, it was argued that attending AA sessions and claiming that one suffered from a disease made people feel worse as they were rewarded for,

or received support for, sharing their symptoms (Peele & Brodsky, 1992).

Motivational Enhancement

Influential theorists Miller (1986) and Rollnick (2000) maintained that enhancing the individual's motivation for initiating behaviour change was an essential factor in the treatment and recovery process. These researchers outlined a method of interviewing which encouraged the alcoholic to engage in a process of self-evaluation and taking responsibility for their problem (Miller & Hester, 1986; Rollnick, 2000)

2.5 NATURAL RECOVERY FROM ALCOHOLISM

Several terms were used to describe the resolution of an alcohol problem on one's own, e.g., spontaneous remission, natural resolution, spontaneous recovery, natural recovery. These terms were used interchangeably to denote the same phenomenon. However some researchers debated the terminology as being semantically and conceptually imprecise, that they were euphemisms for our ignorance of the process at work (Sobell et al,

1993). The term ‘spontaneous’ did not mean that remission occurred for no reason at all, or that it was unexpected or strange, or that it was instantaneous (Smart, 1975). Hirschberg & Barasch (1995) preferred to speak of a healing ability that was part of a lifelong process, occurring due to a “native internal proneness” (Hirschberg & Barasch, 1995, p.20). This implied a natural process which arose from within most individuals which predisposed them to possess the ability to heal themselves (Hirschberg & Barasch, 1995).

The general concept of natural recovery was well known in medical literature. It arose from western medicines apparent bewilderment, limitation and lack of scientific explanation for some recovery processes. Researchers such as Granfield & Cloud (1999), Hirschberg & Barasch (1995) and Weil (1995), maintained that individuals had an innate, intrinsic capacity within themselves to experience natural healing as common occurrences and not as rare events.

For the purposes of this study, the term, “natural recovery” will be preferred, in acknowledgement of these natural processes, and would refer to the resolution of a drinking problem without exposure to formal intervention as previously defined. The term

'resolution' referred to abstinence or a marked reduction in drinking or drinking-related problems (Ludwig, 1985; Moos, 1994; Smart, 1976; Sobell et al, 1993; Tuchfeld, 1981).

As a result of the traditional emphasis on the etiology of alcoholism, little research had been conducted into the phenomenon of natural recovery.

Controversy over the occurrence of natural remission had been fuelled by two extreme points of view. One view was that certain types of people who use alcohol were constitutionally predetermined to develop an irreversible disease which required treatment if a cure or remission was to occur (Mooney et al, 1992; Vaillant, 1983). The other view was that only a few people who used alcohol fell into this category and others, the majority, who had destructive patterns of alcohol use 'naturally' resolved such problems without any exposure to treatment (Hirschberg & Barasch, 1995).

Studies of minimum intervention have documented that extra-treatment processes may account for as much change in alcohol-related behaviours as do some treatment regimens (Tuchfeld, 1981).

Researchers seemed to search for the explanation of spontaneous remission by resorting to delineating alcoholics into addictive and non-addictive types of problem drinkers, claiming that non-addictive drinkers only may be capable of resolution without exposure to treatment. However, empirical evidence suggested that untreated resolutions occurred despite diagnoses of addictive severity (Tuchfeld, 1981).

It was found that most alcoholic abusers did not seek treatment (Sobell et al, 1993). The question was then asked, “ what happened to these people?” Did they all deteriorate into a degrading death, or did some recover on their own. It appeared that the process of natural recovery was recorded as long ago as 1800 (Smart,1975). Rush (in Smart, 1979) reported that several individuals recovered from alcohol problems on their own, as alcohol treatment were then unknown. A century later another well-documented study revealed cases of self-change where problem drinkers became long-term abstainers or moderate drinkers. More recently a Canadian national survey showed that natural recoveries from alcohol problems seemed to be the predominant pathway to recovery. Eighty-two percent recovered

without treatment, while 18% reported using formal treatment, including AA (Sobell et al, 1993).

Smart (1975) documented a review and analysis of studies conducted in Europe, USA and Canada since 1942 and up until October 1975. He concluded that most of these studies included information from alcoholics who did not apply for treatment. He surmised that they perhaps did not apply because their symptoms were controllable or because their self-evaluation was that their prognosis was good. He also mentioned research that showed that alcoholic symptoms and heavy drinking appeared to decline with age.

His further conclusions were that most studies found that natural recovery among alcoholics did occur, that it was not certain whether natural recovery equaled or exceeded that of any type of treatment, although research did indicate that recovery rates may be close, that reasons for natural recovery were not well understood and that further investigation was needed (Smart, 1975).

Since 1975 several researchers have focused their studies on understanding the nature of natural recovery. Ludwig(1985),

Moos(1994), Sobell et al (1993), Tuchfeld (1981) and Tucker, Vuchinich & Gladsjo (1994) were among the researchers that discovered that people with alcohol problems existed in an environment, where forces, both personal and social, and which may or may not include treatment, had a lasting impact on improvement and recovery. Further, that even recovery sustained after treatment was not due entirely to treatment, but may have been nurtured by the same set of personal and social forces which maintained the resolution of problems without treatment (Ludwig,1985;Moos, 1994; Sobell et al 1993; Tuchfeld, 1981 & Tucker, Vuchinich & Gladsjo,1994).

In studies on natural remission, researchers identified and made a distinction between factors that initiate the recovery process and those that help to maintain it (Moos, 1994; Sobell et al, 1993; Tuchfeld, 1981). These factors were as important in motivating individuals to enter and remain in treatment, as they were in motivating recovery without treatment. Hirschberg & Barasch (1995) outlined the process of natural recovery as being precipitated by a combination of “avoidance-oriented” and “approach-oriented” conditions. They explained that:

- Avoidance oriented conditions were a set of negative consequences associated with substances (e.g. work,

financial stressors, physical problems) that resulted in motivating the individual to discontinue substance use.

- Approach conditions were defined as being the pull of the positive consequences of sobriety, such as hope for a better life, stable work & home environments, and financial security (Hirschberg & Barasch, 1995; Sobell et al, 1993).

Moos (1994) also identified approach and avoidance coping mechanisms and predicted that self-remitters were likely to rely more on approach coping mechanisms than avoidance coping mechanisms.

Research indicated that one of the central factors in initiating and maintaining behaviour change was the concept of cognitive appraisal and evaluation. This was identified as the process whereby subjects weighed up the perceived costs and benefits of continued drinking and decided that the adverse consequences outweighed the benefits. Cognitive evaluation was seen to be central to the change process for alcohol abusers who changed with or without formal treatment (Moos, 1994). Ludwig (1985) maintained that it was not stressful events that precipitated behaviour change, but rather the meaning or interpretation of such events.

Studies also showed that other factors in people's lives influenced the resolution of alcohol problems (Moos, 1994). These factors included the socio-economic status, the environment, or the social role of a person that played an important role in initiating and maintaining recovery (Tucker et al, 1994). It was also clear that the individual had to perceive these factors as linked to alcohol abuse in a way that aroused a need for change (Moos, 1994).

2.6 CONCEPTUAL FRAMEWORK

The social work profession seemed to experience a growing need to move away from the traditional emphasis on problems and pathologies. There seemed to be a need to place more emphasis in discovering and using clients' strengths in social work practice (De Jong & Miller, 1995; Saleeby, 1992). Assumptions underpinning the strength's approach, and the notion that client's 'meaning' and 'expert' knowledge of their own lives need to be privileged over traditional social work theories and scientific labels, provided a compelling rationale for the 'natural recovery approach (Focault, 1980; White, 1991).

2.6.1 The Strengths Perspective

The term ‘strengths perspective’ was first used in 1989 (Saleebey, 1992). The strengths perspective was based on the assumptions that:

- People and environments possess strengths that could be marshaled to improve the quality of client’s lives.
- Practitioners should respect these strengths and honour the way in which clients chose to use them.
- Clients were motivated by consistent emphasis on their strengths as named and defined by the client.
- Workers and clients could engage in a co-operative process of exploration of client’s strengths.
- The worker was not regarded as an ‘expert’ on what the client needs. Rather the client was regarded as ‘expert’ on his/her own life.
- Focusing on strengths, de-pathologised and de-victimized the client and placed emphasis on how clients managed to overcome and survive difficult situations in the past (De Jong & Miller, 1995; Saleebey, 1992).
- Human beings were resilient i.e. they were able to survive and thrive despite dysfunction and problems. Researchers had isolated resilient characteristics as social competence,

autonomy and a sense of future and purpose (Early & Glenmaye, 2000).

These assumptions were grounded in philosophies, practice and principles of a post-structural notion that the clients 'meaning' must count for more in the helping process than social work theories and scientific labels. This seemed to indicate a major paradigm shift away from traditional views of 'the helping professions' which viewed themselves as the 'experts' and clients as passive recipients of expert treatment. Increasingly there seemed to be a shift toward the notion that in most people there existed a repository of knowledge and skills which if accessed, could provide the best resolution to problem situations (Focault, 1980 & White, 1991).

The strength's perspective seemed to be underpinned by the work of the philosopher, Focault (1980). His work was largely dedicated to the analysis of the 'practices of power'. His intention was to expose the operations of power at the micro-level and at the periphery of society – in clinics, prisons, family systems, hospitals etc. According to him it was at these sites that the workings of power were most evident, in subjugating and alienating people (Focault, 1980). Professional disciplines had

been successful in the development of language practices and techniques which encouraged persons to believe that they were “privileged to speak with authority beyond the range of their personal experience” (White, 1991, p.142). White (1991) inspired by Foucault’s (1980) theories, proposed an alternative way of being as a professional, a context in which the ‘client’ was privileged as the primary author of “knowledges and practice” and the professional as co-author, thus deconstructing so-called ‘expert’ knowledges. This way of being, honoured and respected the client’s frame of reference and involved the client in co-authoring their preferred choices and ways of being in the world (White, 1991).

This approach informed and seemed to have synergy with the objectives and scope of this study, which sought to honor and privilege the stories of ordinary people’s efforts to resolve their difficulties with alcohol by seemingly accessing their own resources and internal knowledge about their own situation without resorting or deferring to ‘so-called’ ‘experts’.

2.6.2 The Narrative Approach

Works by White (1997) and Diamond (2000), informed by the strengths perspective and by the work and philosophies of

Focault (1980), documented an approach to alcoholism, which allowed people to explore their relationship with alcohol, and the ways that it affected them as people. This narrative approach avoided stigmatizing and pathologising labels, and privileged the individual as author and expert in his or her own life. These Narrative theorists viewed the individual's relationship with alcohol and their efforts to change their relationship with alcohol as a migration from one way of being towards another preferred way of being (Diamond, 2000; White, 1997).

CHAPTER 3

METHODOLOGY

3.1 PARTICIPANTS

3.1.1 Recruitment & Screening

Natural recovery, by definition, takes place outside of the health and welfare system, which is normally a source of subject recruitment in clinical research. For the purposes of this study, the researcher relied on media-based solicitation procedures that recruited alcoholics who had resolved their problems with alcohol without access to formal treatment. This purposive availability sampling method carries the risk of sampling error. However, previous studies on natural recovery evaluated the representatives of media-solicited samples in relation to their community populations and found no evidence of selection bias (Granfield & Cloud, 1999). However, media-based recruitment has the potential to produce representative samples (Sobell, et al, 1993; Tucker, et al, 1994). In this study, all respondents meeting

specific requirements were used, giving the researcher a cross-section of participants, somewhat reflective of the South African population.

In this study, four Kwa-Zulu Natal newspapers with a multi-lingual readership and a national magazine were approached (see Appendices 1 & 2). Two daily newspapers responded. An article and a letter to the editor were placed in these two publications requesting the participation of these individuals who had successfully overcome an alcohol-problem for two or more years, without access to any formal treatment (see Appendices 3 & 4). Participants were asked to reply telephonically.

A brief telephonic-screening interview was implemented which included questions about treatment history, the period of sobriety and willingness of a family member or involved significant other to be included. Evidence of an alcohol problem was ascertained based on:-

- a) alcohol dependence symptoms (e.g. severe shakes, tolerance, loss of control) or
- b) alcohol-related negative consequences (e.g. drunk driving, job loss, family problems).

These criteria were adapted from the definitions of alcoholism as previously outlined (Tucker et al, 1994).

At this brief telephonic interview it was clarified that participation was voluntary and that participants confidentiality would be assured and that anonymity would be protected. Participants were not paid. The researcher was willing to interview participants at their homes or at the researcher's office.

For purposes of this study, "family" was defined as any member or members of the participant's family or significant other/s, who were involved with the participant prior to and during the natural recovery process. Sample 1 included "recovered" participants, Sample 2 included family or significant others.

Forty-three people responded to the study. Twenty-six individuals and their spouses, family member/s or significant other/s were selected as per the selection criteria and participated in the study. One participant was excluded as he had received treatment. A profile of these individuals will be presented in the Results Section of this study.

3.2 MATERIALS

Participants and a member or members of their family or significant others, were interviewed individually in one or two 1.5 hour sessions, held concurrently. Participants received a verbal description of the study and gave verbal consent to the procedure. Informed consent was tacitly implied by their voluntary response to the advertisement and subsequent presence at the interview.

The interviews were conducted by the researcher. Reliability concerns were addressed by the audio taping of all interviews. Consent was elicited for this procedure prior to the start of the interview.

The interview consisted of two components (see Appendix 5). The first was structured in order to elicit certain identifying data and included family history details. The second component was semi-structured and committed to certain themes, developed to aid the unfolding of the story of recovery. The interview themes explored were:

- Participant's drinking patterns.
- Pre-contemplation about their drinking problem.
- Their reasons for stopping drinking.

- The methods used to achieve abstinence.
- The strategies, skills, abilities and strengths used to maintain sobriety.
- Their attitudes to treatment and reasons for not submitting to treatment.
- Difficulties experienced in recovery.
- Appreciation of sobriety.
- The unique abilities or characteristics that enabled them to succeed where others may have failed.

This semi-structured format allowed the researcher freedom to follow instinct and hunches in an effort to obtain the detailed description needed to enhance analysis-interpretation. Theories informing the composition of the interview structure were selected and adapted from various international studies of natural recovery previously discussed in chapter two (Ludwig, 1984; Moos, 1994; Sobell et al, 1993 & Tucker et al, 1994).

Family interviews explored similar themes to obtain corroboration and included their perceptions of the recovery process (see Appendix 5).

3.2.1 Reliability and Validity

The researcher attempted to ensure that the data-gathering instrument (the interview guide) measured as accurately as possible what it was intended to measure (Marlow, 1993). Research conducted by other researchers in the same area of interest, together with a review of the relevant theory and consultation with other professionals in the field guided and informed the questions and themes to be explored, thus hopefully developing a credible measuring instrument.

This instrument was tested in a limited pilot study where the guide was used in an interview to establish whether the instrument reliably gathered the information required. Data was obtained from two sources, from the participant and a significant and involved other. Interviews were recorded on audiotape, thus ensuring accurate reporting of information.

3.2.2 Limitations of the study

As outlined in Chapter 1, the research strategy included the use of the case-study methodology. Problems that can arise when using a case-study approach are:-

1. Information is gathered retrospectively and using recall must inevitably carry distortions (Marlow, 1993).
2. Respondents respond differently to different people, as do researchers in a mutually reactive effect (Marlow, 1993).
3. Factors such as the time and place of an interview must be taken into account.

In response to these concerns regarding reliability, the researcher included the evidence of a second source (a family member or significant other) in an attempt to counter distortions, memory lapses and reactions to the researcher.

However, the retrospective nature of this study must be noted and its effect, the possible loss or distortion of detail accepted as a limitation. For example participant No. 12 noted:

“that’s all I remember, perhaps you would have got more out of me if you had asked me in the first year.”

In mitigation, however, the loss of detail must be weighted against the possibility that perspective is gained by the passage of time.

3.3 PROCEDURE

3.3.1 Interviews

As previously mentioned the interview was conducted by the researcher. Eighty percent of the interviews were conducted at participant's homes. Twenty percent elected to be interviewed at the researcher's office. All interviews were recorded on audiotape and transcripts were written out by the researcher. The researcher attempted to conduct the interviews in as consistent a way as possible through the use of an interview guide (see Appendix 5). An active-interviewing technique was used as a means of "opening the way for discoveries" (Shaughnessy & Zechmeister, 1990, p 145).

3.3.2 Data Analysis

The primary strategy in analyzing data for this qualitative study was:

- To identify trends in terms of similarities and differences in the data.
- To identify patterns and connections that may, in turn enable us to develop hypothesis, which, eventually may lead to theories about recovery (Marlow, 1993).

The descriptive account of the aggregate of data collected, which consisted of raw data, observation and impressions of participants could be referred to as a case-study (Marlow, 1993).

Categories emerged from the data obtained which could be described as researcher-constructed categories, derived from patterns identified by the researcher in the data, these categories appeared to provide a complete overall picture of the research topic (Marlow, 1993). This strategy is outlined in Yin (1994) as developing a descriptive and causal framework for organizing case studies (Yin, 1994).

In addition, two general analytic strategies were employed. One relied on theoretical orientation to help focus attention on certain themes and data. It was argued that theoretical propositions help organize case analysis and define alternative explanations to be examined, thus exploring causal relations and answers to 'how' and 'why' questions. The second strategy was to develop a descriptive framework for organizing case studies (Yin, 1994). The natural recovery process could be described as a series of decisions and events. The researcher could therefore focus part of the case study on the number and types of such decisions and

elements. This framework helps organize the case study analysis and may help identify the appropriate causal links to be analyzed (Yin, 1994).

3.4 ETHICAL ISSUES

Without the objectivity of statistical analysis and the stringent rules which govern statistical significance, qualitative research is open to personal and professional judgments and bias (Marlow, 1993). It seems important to acknowledge this and it is hoped that this acknowledgement would serve to make researchers humble and cautious in interpreting and analyzing data.

In this study, the researcher has approached participants from the perspective of respect for the authorship and strength which has been evident in these stories of courage and struggle. This approach and perspective has been informed by the post-structural philosophies of Foucault (1980) and the narrative approach of White (1991) as previously mentioned in the Literature Review chapter of this report. This approach honours the individual's story and struggle and exhorts the researcher to be careful and sensitive around issues of consent, confidentiality and respect.

Research procedures can impact on participants and cause stress and psychological harm (Cozby, 1993). It was the desire of the researcher to encourage strengths and to do no harm. There remained a possibility that recalling their stories of recovery may have 'upset' or disturbed the equilibrium of some participants. The researcher offered counseling and/or support if this was needed at any time. No participants expressed a need for this. Most related that they felt empowered by the telling of the story and the possibility of helping others.

The issue of informed consent was dealt with as participants were informed prior to taking part in the study about the purposes of the study, who would be involved and the procedures that would be used. The researcher attempted to be as transparent as possible about the process (Cozby, 1993). These issues were addressed in detail during a telephonic screening interview prior to making arrangements for the first interview.

The importance of the participant's rights to privacy, confidentiality and anonymity were acknowledged and addressed (Cozby, 1993). This also took place in the initial telephone-

screening interview and again at the time of the first interviews. Permission was also obtained to record the interview. Participants were asked to use first names only. No street addresses were used. In analyzing and preparing the final report, participants were identified numerically.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 INTRODUCTION

In this chapter the data collected is presented, analyzed and tentatively interpreted in accordance with the purposes of this study.

The chapter begins with a profile and discussion of the sample interviewed and then moves on to present information regarding the extent of the drinking problems experienced by the participants prior to natural resolution. Finally the participant's experience of the progression of the natural recovery process is presented and discussed, linking the data from this study with other similar international studies.

Note: In the following tables some percentages may not total 100 where participants have responded to more than one category.

4.2

IDENTIFYING THE SAMPLE

TABLE 1: SAMPLE PROFILE

AGE AT TIME OF STUDY	NUMBER OF PARTICIPANTS	PERCENTAGE
30 – 39	1	4
40 – 49	12	48
50 – 59	5	20
60 – 69	7	28
GENDER		
Male	19	76
Female	6	24
OCCUPATION		
Professional	3	12
Self-Employed	5	20
Managerial	6	24
Admin / Sales	3	12
Artisan	4	16
Homemaker	1	4
Retired	3	12
RACE		
Black	2	8
Mixed Race	2	8
Asian	6	24
White	15	60
MARITAL STATUS		
Married	17	68
Divorced	4	16
Cohabiting	2	8
Single	2	8
Widowed	0	0
RESIDENTIAL AREA		
Durban and Surrounding Areas	22	88
Pietermaritzburg	2	8
Eshowe	1	4
RELIGIOUS AFFILIATION		
Yes	12	48
No	13	52

Most people (68%), interviewed were between 40 – 59 years, were white males (76%), and married (68%) (See table 1). Most had professional or business orientated occupations. This profile is reflected in similar studies in Europe, Canada and the USA (Granfield & Cloud, 1999; Sobell, et al, 1993; Tuchfeld 1981; Tucker, et al, 1994).

The average age of participants was 50 years while the modal age was 40-59 years. This may reflect the length of time it takes for an individual to develop an alcohol problem and to reach the point where problem resolution is considered. This seems to be reflective of Jellinek's Progressive Stage theory of alcoholism (Glatt, 1974).

Participants were drawn predominantly from Durban and surrounding areas.

In other studies, respondents who had resolved their alcohol problem showed relatively greater marital and occupational stability before resolution (Sobell et al, 1993; Tucker et al, 1994). This appears to be true in this study as 68% of the respondents were married and most were employed at the time of initial abstinence. This may have contributed to recovery.

Tucker (1994) cautioned against using demographic indices as a tool in predicting which problem drinkers will achieve stable recovery with or without treatment. Environmental contexts appear, though, to be influential in the natural and treated recovery population.

Participants with alcoholic parents

Fifty-two percent of participants had one or more alcoholic parent. Eight percent had two alcoholic parents. This leaves 48% of participants who have no alcoholic parents.

This appears to lend some support to the view that not all addiction is genetic or hereditary. Some may, in fact, be habitual (Granfield & Cloud, 1999; Peele & Brodsky, 1992).

TABLE 2: NICOTINE AND OTHER ADDICTIONS

	NUMBER OF PARTICIPANTS	PERCENTAGE
Nicotine addiction	11	44
Resolved nicotine addiction	5	20
Non smoker	6	24
Gambler	2	8
Cannabis	1	4

Equal numbers of participants in this study smoked and did not smoke. One could infer that an addiction to nicotine need not necessarily be a hindrance to the resolution of an alcohol problem.

Tuchfeld (1981) found that a relationship between smoking and abstinence did exist. He further proposed that the cessation of smoking might have coincided with a commitment to a new lifestyle.

Twenty percent of participants had successfully resolved a nicotine problem by using natural recovery. It could be inferred that the same process, which facilitated natural recovery of nicotine addiction, could have facilitated natural recovery from alcohol addiction (Granfield & Cloud, 1999). It may be useful to further explore the link between nicotine and alcohol addiction and recovery and the processes involved there with.

4.3 DRINKING HISTORY

All twenty-five participants were assessed by the researcher for the presence of an alcohol problem, which would fit with the criteria

as listed in the definitions of alcoholism previously outlined. Each respondent had to show evidence of:

1. Excessive and inappropriate alcohol consumption and loss of control.
2. Physical dependence and consequences (e.g. delirium Tremens (DT's), memory loss, liver damage, blackouts).
3. Psychosocial consequences (e.g. relationship, family or job losses, aggression).

All twenty-five respondents showed evidence of alcoholism. In retrospect, the researcher believes a standardized test should have been used. This was avoided, in favour of a less structured and less threatening approach. In some ways this approach appeared to elicit more honest responses. Participants appeared to relax and share more detailed descriptions of how severe their problems had been. However, in an expanded future comparative study, comparing self-remitters with treated alcoholics, standardized measures should be used. Of interest were the varieties and types of drinking patterns recorded, giving credence to Jellinek's work so many years ago (Glatt, 1974).

Perhaps the complexity of patterns of alcohol dependence is best described in these two vignettes: -

Case 11

"I had been drinking since the age of eighteen – a slow, slow process. ...only beer... up until a year before I gave up, I was a reasonable person. In my mind I thought I was. I thought my behaviour was normal. I never lost a days work through booze. Then we came to this Utopia called South Africa. The price of booze was so cheap. There were no pubs, they were called 'ladies bars'. They're soulless places. This was where the trouble started. So I bought booze and brought it home. The novelty of being in the sun, on the beach, the novelty of the braais we thought we were in heaven then I got to the stage of 'bottoming out' you reach that stage when you know you've got to give up you start to turn nasty. The smallest thing you build into a mountain. I drank twelve quarts over a weekend and kept a stash of about six quarts in the boot of the car that no-one knew about – so I would never run out."

This participant drank excessively on a daily basis, had to make sure he never ran out, was still functional at work, his family, though supportive were isolated and he was aggressive towards them.

Case 18 tells a more devastating story: -

"to cut a long story short I was drinking all the time. I took drink to work, I used to keep it in the boot of my car and I used to shake terribly and the only way I could calm myself down was to have another drink and I used to nip out

to the car park and down a couple of beers. After work I was starting to shake again and I would have one or two beers while sitting in the car.”

A sad story continues of continual drinking day and night, to avoid delirium tremors or the shaking and symptoms of withdrawal.

Case 2, in contrast, reports: -

“I used alcohol as a crutch. I drank openly in front of my husband. I was aware of drinking too much ... a half of a bottle of whisky a night. I was never abusive or violent. It helped me relax after work while cooking.”

This participant seemed to retain some control of her alcohol use. This was totally corroborated by her partner who never viewed her drinking as a problem. Yet she was diagnosed an alcoholic by her general practitioner and had to be detoxified prior to an elective surgical procedure.

It would seem to appear that the type or severity of dependence did not seem to be too important in predicting which individuals were able to resolve a drinking problem naturally.

TABLE 3: AGE OF ONSET OF PROBLEM DRINKING

YEARS	NUMBER OF PARTICIPANTS	PERCENTAGE
11 – 19	6	24
20 – 29	8	32
30 – 39	2	8
40 – 49	1	4
Unspecified	8	32
TOTALS	25	100

The unspecified category indicates those participants who were vague about when alcohol began to be a problem. Fifty-six percent of participants developed a problem prior to the age of 30 and 24% before the age of 19. This seems to support the view that there is a tendency to develop alcohol problems at a young age (Parry & Bennetts, 1998).

TABLE 4: DURATION OF PROBLEM PRIOR TO STOPPING

YEARS	NUMBER OF PARTICIPANTS	PERCENTAGE
10 – 19	7	28
20 – 29	11	44
30 – 39	6	24
40 – 49	1	4
TOTALS	25	100

These results would seem to indicate that this group appeared to be in a state of problem drinking for over 20 years before successfully overcoming their problem. It would be interesting to explore whether this result could be attributed to the length of time it takes for self-resolution of problems, and, if compared with a treated group, problem resolution may have been achieved sooner. This result would seem to have implications regarding the amount of damage and consequences that could accrue in 20 years and may then be a strong argument for treatment.

TABLE 5: LENGTH OF SOBRIETY

LENGTH OF SOBRIETY	NUMBER OF PARTICIPANTS	PERCENTAGE
1 year	1	4
2 years	3	12
3 – 4 years	5	20
5 – 10 years	8	32
10 – 19 years	6	24
20 – 29 years	2	8

Sixty-four percent of the sample had over five years of sobriety at the time of the study. Only one participant (4 % of the sample) had just less than two years of sobriety.

4.4 PRESENT DRINKING STATUS

All participants but two were sober at the time of the study. As previously explained, the state of sobriety refers to a condition of complete abstinence. The two participants who were not sober, were not under the influence of alcohol at the time of the interview, but admitted to using alcohol occasionally in a controlled manner and this, could not be considered to be sober in terms of the terminology used in this study. These two participants did describe a considerable reduction in their drinking behaviour. They described taking an “occasional drink” every “now and then”. These were included in the sample as previous studies had included self-remitters who had achieved a marked reduction in their drinking behaviour (Moos, 1994; Sobell et al, 1993; Tucker et al, 1994).

However most self-remitters (92%) interviewed, made the decision to abstain from future use. Those who reduced their intake developed strong personal rules limiting use. Others who eventually decided to abstain had previously attempted to control use but were unsuccessful and appeared to believe that the only way to resolve their alcohol problem was through abstinence. This would appear to indicate support for the Disease Model’s view of

recovery through complete abstention (Mooney et al, 1992). Eight percent of participants were able to moderate their drinking patterns but reported that strict controls were necessary to achieve this.

TABLE 6: RELAPSES

RELAPSES	NUMBER OF PARTICIPANTS	PERCENTAGE
Yes	2	8
No	21	84
Not applicable	2	8
TOTALS	25	100

Alcoholism is described by many as an illness characterized by relapse (Gorski, 1989). This result, therefore, is noteworthy and deserves further investigation, as it may indicate a possibility that self-remitters suffer fewer relapses. This result seems to substantiate the findings of Miller & Hester (1986) and Vaillant (1983), that alcoholics who had no treatment, suffered fewer relapses than did those who attended Alcoholics Anonymous (AA) or other treatment programmes.

4.5 ALCOHOLIC IDENTIFICATION AS A PRE-REQUISITE FOR RECOVERY

In this study 80% identified themselves as alcoholic and appeared comfortable with identifying themselves as such to close friends and family. Much Disease Model orientated research postulates that the alcoholic is required to openly identify him or herself as an alcoholic before recovery can take place (Granfield & Cloud, 1999). Opponents of the Disease Model argue that this is not necessary. They assert that it leads to a view of a person as essentially flawed (Granfield & Cloud, 1999).

4.6 TREATMENT AVOIDANCE ISSUES

TABLE 7: REASONS FOR AVOIDING TREATMENT

REASON FOR AVOIDING TREATMENT	NUMBER OF PARTICIPANTS	PERCENTAGE
Negative Images	12	48
Treatment doesn't work	5	20
Don't need it	11	44
No access	3	12
Belief that God can heal	4	16

Granfield & Cloud (1994) found three main reasons why self-remitters avoided treatment. These were:

- 1) An aversion to traditional forms of treatment and a fear of embarrassment and stigmatization.
- 2) A belief that treatment was not needed and a belief in one's own ability to solve one's problems.
- 3) A belief that treatment doesn't work.

The self-remitters in this study appeared to substantiate these findings and to have an optimistic view of their problem and their ability to resolve the problem themselves. Forty-eight percent appeared to share the views expressed by the critics of the Disease Model regarding the stigmatization of going for treatment, some believing that any association with alcoholics, even alcoholics in recovery, would not be conducive to their own recovery (Granfield & Cloud, 1999; Peele & Brodsky, 1994).

This study also reflects their findings, but includes two more. These are that:

1. Participants had no knowledge of, or financial access to treatment programmes.
2. Some participant's belief was that 'God' could 'heal' where programmes could not.

Participants having no knowledge of or access to treatment facilities is possibly unique to a country like South Africa where treatment programmes tend to be accessible to those with financial and literacy resources (Parry & Bennetts, 1998).

The spiritual aspect as a reason for circumventing treatment was not mentioned in other studies. However this does not seem surprising when taking into account the level of spiritual awareness and belief evidenced by participants of this study in other stages of the recovery process.

4.7 FAMILY PARTICIPATION IN STUDY

TABLE 8: FAMILY PARTICIPATION IN STUDY

	NUMBER OF PARTICIPANTS	PERCENTAGE
Family participated	18	72
No family available	4	16
Non participation	3	12

Most participants were willing to allow one or more family members to participate in the study. Four participants had no family available for participation. Three participants did not allow

the researcher to have access to their family. One participant stated it was due to a 'cultural reason' and two other participants evaded the issue, however it emerged that these partners were, in fact, alcoholic or heavy drinkers and did not want to participate in the study. Possibly the study could have been perceived as being threatening. In similar studies a 71% collateral involvement rate was recorded and similar reasons for exclusion were outlined (Sobell et al, 1993; Tucker et al, 1994).

There was a high level of corroboration of data by family member's who participated in this study. Only one family (parents) felt that the participant's recovery was not going as well as had been recorded. They did agree that there was a high level of resolution but that the length of sobriety was in question.

Partner's sobriety

Fifty-two percent of participants reported their partners were sober. Twenty-eight percent reported that their partners drank socially, while 12% expressed concern that their partners drank heavily or were, in fact, 'alcoholic'.

This result appears to be consistent with research findings that indicated a stable home environment is conducive to recovery (Ludwig, 1985; Moos, 1994; Sobell et al, 1993, Tuchfeld, 1981).

4.8 THE PROCESS OF NATURAL RECOVERY

Overview of the literature on natural recovery seems to make a distinction between variables that motivate initial behaviour change and those that maintain it (Hirschberg & Barasch, 1995; Sobell et al, 1993; Tucker et al, 1994). This proved to be true of this study where various stages in the natural recovery process emerged: -

1. Pre-contemplation of change.
2. Initiating change.
3. Maintaining change.

4.8.1 Pre-contemplation of Change

Evidence from previous studies suggested that the process of recovery begins long before the actual decision to stop (Moos, 1994; Sobell et al, 1993; Tucker et al, 1994).

In this study, 72% of participants admitted to engaging in a process of pre-contemplation. Some for periods longer than two years. In this process, some had tried to give up or cut down on their drinking and there was some indication of a stabilization of the social context prior to the final decision to stop using alcohol. Tucker et al (1994) found that self-remitters were more stable socially before and after resolution.

Most participants identified several influences that emerged over time and described a combination of long-term and short-term influences where:

- Mundane events played a role and participant's experienced a build-up of negative events.
- A final event that may or may not have been perceived as important eventually triggered change (Sobell et al, 1993).

CASE 12

"It became a habit to fall asleep at 10pm. I woke up at 3am, sober, with a bottle and a glass next to me and I'd get up and drink. That was the day I realized there was a problem. Then I rationalized – what was the difference between 3am and 3pm? So it's okay If there was no wine at my girlfriend's then I had to go to strange places to purchase it after hours One day I thought I must start cutting down. I tried four or five times to stop. I never got it together. The longest period was three days. I gave it three serious attempts

over about nine months. Then on Valentines day, I was incredibly abusive to my girlfriend at a restaurant. She couldn't take it any more and that was that".

CASE 15

"I knew something was happening to me but I had no control. I couldn't go to any social functions. I was becoming a liability and I still hadn't reached rock bottom".

CASE 9

"My father and brother both collapsed and died as a result of alcohol-related problems. I thought that I must do something about myself too as it might happen to me with the type of work I'm doing."

It appeared that for most participants there was a cognitive process of getting ready to stop and for some, even a 'cutting down' in their drinking as a prelude to the initiation or resolution.

4.8.2 Factors or reasons that precipitated problem resolution

Following on from the process of pre-contemplation described above, participants were able to identify specific reasons, events or factors which precipitated their final decision to resolve their drinking problems.

TABLE 9: PERCEIVED REASON FOR RESOLUTION

PERCEIVED REASONS	NUMBER OF PARTICIPANTS	PERCENTAGE
Physical health factors	11	44
Doctor's intervention	5	20
Family / friend's intervention	4	16
Family consequences	11	44
Self-evaluation (hitting bottom)	7	28
Job consequences	4	16
Financial consequences	1	4
Spiritual experiences	3	12
Extraordinary events (arrests, death, aggression)	7	28
Family / friend's support or belief	2	8

Categorization of reasons for stopping drinking would appear to offer little information about the actual cognitive process involved in the self-remitters decision. It would appear that the meaning ascribed to these events might offer a more concise understanding of the motivation for recovery (Ludwig, 1985).

It would seem that events and circumstances forced the individual to take a hard look at themselves and it is this process that motivates a change in lifestyle (Ludwig, 1985). Sometimes this appears to be a rapid process of sudden conversion initiated by an extraordinary event, but in most cases seems to be a long-term process of behaviour change (Ludwig, 1985; Tucker et al, 1994).

Recovery appears to conform to an incremental process of commitment.

Physical health factors

Consistent with other studies, this result seems to indicate that natural recovery might be connected with health concerns preceding initial abstinence (Ludwig, 1985; Sobell et al, 1993; Tuchfeld, 1981; Tucker et al, 1994). In this study many participants experienced serious threats of death in the face of continued drinking.

CASE 18

“What did worry me was the shaking and I couldn’t eat. The only time I could eat was after work. I had to have one or two beers and then I would go to the club and have something to eat. I would take about an hour to get my food down – taking small mouths full of food at a time. There were times I would go for three or four days without a bite to eat and I still wasn’t hungry.”

CASE 1

“Two years ago I lost my appetite and went to see the doctor. He did tests and found my liver was packing up. The doc said “you’re drinking too much – it’s your liver – the next time I see you I’ll send you to rehab or you will be history!”

CASE 3

“In the last few years I drank eight pints of beer, two bottles wine and a third of a bottle of whiskey every day. I drank till I passed out. Then I got a hellova fright. I coughed up blood one morning. The alcohol made me snore so much I ruptured a blood vessel! The doctor did tests and told me my liver had taken a hellova beating and that I was developing cirrhosis.”

Twenty percent of participants responded to the doctor’s brief intervention. This is consistent with recent research, which proposes that brief interventions can be effective in the management of alcohol problems (Rollnick, 2000). Tucker et al (1994) proposed that heavy drinkers who present for help in general medical settings such as hospitals, clinics, emergency rooms and private consulting rooms, who have not sought help specifically for alcohol-related problems, may comprise a receptive group.

Family consequences

Sixty percent of participants identified family consequences as being a factor that precipitated abstinence. This is also consistent with findings from other studies (Hirschberg & Barasch, 1999; Sobell et al, 1993; Tuchfeld, 1981).

CASE 15

“One day I was drunk, I saw my son’s face ... his disgust. It touched my soul. I had lost his respect. I had to get it back. I realized my son and my family meant more to me than a bottle of booze.”

CASE 22

“My wife used to say: “I wish there would be just one night when you would come to bed without the smell of booze on your breath” ... then the crunch came. The bubble burst. In October 1976 my marriage was on the rocks. My wife was leaving me and there was absolutely nothing I could do about it. I had failed in every respect and the person I suddenly realized meant the most to me was leaving and I was powerless to prevent it. My whole life had collapsed around me and in my extremity it began to dawn on me. I was stripped naked of all my pretence and for the first time in my life, felt absolutely helpless and vulnerable. It was at that stark moment of truth that I made the best decision I have ever made or am likely to make.”

CASE 24

“When I had my second child my Muslim partner would not accommodate my drinking and made me stop. After the second year of the child’s life, we found out he was deaf. I involved myself totally in his rehabilitation Now he’s a feisty kid. I can’t afford to have a hangover – I need to take care of myself so I can take care of him.”

What was interesting in this study was that it was those families who continued to support the problem drinker that had the most

influence. It was the self-remitter who perceived the disappointment or hurt experienced by their family and made a connection between this disappointment or hurt and their drinking. It was often what was unspoken that was most effective, as in the case of participant 15, whose interpretation of a look on her son's face did more to precipitate change than any words could have.

Extraordinary events

Twenty-eight percent of participants decided to stop drinking as a result of an extraordinary life event. These included arrests, aggressive incidents, embarrassing or frightening incidents, the death of a friend in an alcohol-related incident and even a famous political leader's assassination. These were often combined with other factors. Sobell et al (1993) found that it was usually a build up of negative events, capped by an extraordinary event "the straw that broke the camels back", which precipitated action.

In previous studies it was found that the perception of a crisis may seem irrational to the outside observer, but to the participant the logical connections seemed evident (Tuchfeld, 1981).

Cognitive evaluation

Studies indicate that the reason for abstinence is related more to the perception or evaluation of the situation than to the actual events or external circumstances themselves (Ludwig, 1985). The process of cognitive evaluation appears to be a key factor in recovery with or without treatment (Sobell et al, 1993; Vaillant, 1983).

Cognitive appraisal seems to involve the weighing of costs and benefits and concluding that the pain of adverse consequences is not worth the perceived benefits of drinking. Or, put another way, the pain of the consequences is worse than the pain of stopping (Hirschberg & Barasch, 1995; Ludwig, 1985; Sobell et al, 1993). This process appears to be rapid for some who are motivated after facing severe problems and more gradually for others who sense they are beginning to lose control to change, motivated not by a problem, but by a hope for a better life and the possibility of change (Ludwig, 1985; Moos, 1994).

CASE 19

"I took a good look in the mirror, as the saying goes. I had tried to stop drinking and the people at the hospital tried to send me away. There was something the psychiatrist said to me, he said, "you're an alcoholic" which did strike a note of

truth. There was a piece of lawn outside the hospital where all the 'blue trainers' (methylated-spirits drinkers) used to hang out 'those are alcoholics – I am not an alcoholic'. He said 'those are alcoholics who have reached the point of no return'. The housemother at the children's home said to me, "you are missing the best years of your kid's life. I am actually enjoying what should be your right." My husband was also getting tired. These are the chords, which struck home. I was now 29, I took a good look at my life and thought 'No'."

CASE 23

"I didn't want my kids to see me drunk. I looked down the road and saw where I was headed."

CASE 9

"It wasn't for me. I was trying to force this thing on me – it was just not right for memy life was not supposed to be as a drunk."

The term 'hitting rock bottom' popularized by Alcoholics Anonymous (AA) literature, seems to be another way to describe the process of cognitive evaluation. Hitting rock bottom consists of three converging events: -

1. The intersection of pain and understanding the moment of cognitive appraisal where the alcoholic evaluates his life

position negatively and attributes this to his drinking (Moos, 1994).

2. The ownership of being out of control and powerless over alcohol.
3. The individual is no longer prepared to live with the person he has become.

AA literature describes it as the situation where the individual experiences such profound shame, humiliation and loss, is believed to motivate the individual to seek resolution of their drinking problem (Lockard, 1993; Mooney et al, 1992). The concept of hitting rock bottom would appear to be a relative one, which has different meanings for different people.

It also seems clear that intrinsic to the concept of 'rock bottom' is the acceptance of a position of powerlessness and loss of control and supposed 'surrender' to a problem, whereas for the self-remitter it appeared that the process of cognitive evaluation helped them reach a point of decision and empowerment and taking control.

Perhaps these processes are similar, except that some people are able to solve their own drinking problem and some cannot. One participant seemed to instinctively recognize this when he said: -

CASE 13

"I admit this may not be the right journey – but it is my journey. I've never tried to hide my problem, I've admitted it. If I can't do something about it, I'll have to go to AA."

Spirituality

Although spirituality and religion played a greater role in the process of stopping and maintenance of recovery, 12% of cases cited a spiritual experience as being a catalyst for recovery. This aspect will be discussed in more depth later in this chapter.

CASE 10

"I was in the bedroom at 2.45am, my daughter was lying next to us (my wife and I) in the bed. Suddenly this voice came through my daughter who was fast asleep. "Daddy, you must stop your drinking." It was a very clear voice. My wife is a witness (wife nodding head "I was shocked!"). I woke up and came into the lounge, fell on my knees and said 'Jesus I accept you as my personal savior. You can take me now', I was crying, praising and worshipping until 6.30am, making a helluva noise. I had no sleep; I had a bath and went to work. I finished work and came home and slept like a baby. From that day on, praise

God, I never touched liquor. I never uttered a swear word. I never touched a cigarette. I never had any withdrawals at all.”

CASE 21

“A friend at work took me twice a week to church meetings. I started praying about my problempeople started praying for me. I continued drinking but the amount was halved. One night I was feeling very bad about my kids – that the home was falling apart – I started praying and felt an incredible peace. I felt a warmth in my body. From that day I stopped drinking. My friends were amazed as they felt I was so bad I should have needed rehab.”

The role spirituality plays in recovery is unclear and arguable, yet spirituality appears to be an integral and indispensable part of recovery (Johnsen, 1993).

Other studies have acknowledged spiritual, mystical and transcendental experiences as a basis of recovery (Hirschberg & Barasch, 1999; Johnsen, 1993; Ludwig, 1985; Tucker et al, 1994). This discussion will continue in content on subsequent stages of the recovery process.

4.8.3 Abstinence Strategies

Previous studies did not provide data on how self-remitters achieved abstinence. This intrigued the researcher, as it appeared

to be an important issue. In many cases, self-remitters were at a stage of physical dependence where medical detoxification should have been necessary.

TABLE 10: METHOD OF WITHDRAWAL

METHOD OF WITHDRAWAL	NUMBER OF PARTICIPANTS	PERCENTAGE
Immediate withdrawal of alcohol	19	76
Gradual withdrawal of alcohol	6	24
Experienced withdrawal symptoms	12	48
No withdrawal symptoms	13	52
No medical assistance	20	80
Medical assistance	5	20

Seventy-six percent of participants elected to stop alcohol use immediately. Twenty-four percent decided to cut down, gradually.

CASE 17 described a creative approach: -

“I was drinking ‘hot stuff’, vodka, brandy and sorghum (Zulu Beer) all day with my friends. I was so weak I couldn’t eat. I saw my doctor and he told me to stop. The first week was difficult. I also gave up smoking. I couldn’t do both. I was shaking, I couldn’t write so I used alcohol. I then cut down, I drank beers and Zulu beer and then after a few weeks I drank only Zulu beers and then I stopped.”

This seemed a unique and instinctive solution as this participant gave himself gradually diminishing doses of alcohol, a principle widely used in alcohol detoxification, using tranquillisers rather than alcohol (Mooney et al, 1992).

Forty-eight percent, of the seventy-six percent who decided to stop using alcohol immediately experienced withdrawal symptoms. Six (24%) cases reported experiencing severe withdrawal symptoms without access to medical assistance. An experience, which is referred to as going 'cold turkey' in addiction literature (Mooney et al, 1992). Fifty-two percent did not experience withdrawal symptoms.

Only 20% of participants received medical assistance of a minimal nature. There were no hospitalizations. One participant received two doses of nitrous oxide (an agent useful in the treatment of withdrawal symptoms and commonly used in dentistry). One participant received one antabuse tablet (Disulfuram which causes a allergic reaction if used in combination with alcohol) this in no way alleviates withdrawal symptoms (Mooney et al, 1992).

Twenty-four percent elected to gradually withdraw their use of alcohol and this probably contributed to these participants not experiencing withdrawal symptoms.

These results seem to indicate that :

- Physical withdrawal symptoms need not be a factor impeding resolution of an alcohol problem where there is sufficient motivation, and that
- There may be implications for treatment facilities that have large budgets for medical departments.

TABLE 11: STRATEGIES USED BY SELF-REMITTERS TO ACHIEVE INITIAL ABSTINENCE

STRATEGIES	NUMBER OF PARTICIPANTS	PERCENTAGE
Pouring drink down sink	1	4
Complete isolation	2	8
Avoiding contact with alcohol	2	8
Spiritual assistance	8	32
Gym	1	4
Replacing alcohol with another non-Alcoholic drink	1	4
Testing willpower	1	4
Friend / family support	3	12
Made a decision	3	12
Read himself to sleep	1	4
Forced himself to eat	1	4
Antabuse	1	4
Reading about alcoholism	1	4
Had beers on standby, in case	1	4

The list above reveals a wide range of fairly imaginative strategies to achieve abstinence. Einstein once said, “Imagination is more important than knowledge” and in the case of these participants this would seem to be true (Hirschberg & Barasch, 1995, p xii).

CASE 11

“I loved going to gym, I used to go to gym as an excuse to go out and get booze. So I really went into gym full tilt – that helped. I kept a pint pot (flask), which I keep on me all the time filled with milk and I sit with a cup of cold, flavoured milk. It’s like a dummy (pacifier) you’re so used to sitting with something in your hand. For a number of years you cannot do without – so I chose that. It also helps me sleep, I think.”

CASE 12

“I read lots and lots of books about it. I taught myself about alcoholism, reading about other people who have been through a rough time and come out of it and how they did itI needed to talk about it constantly. My wife had to listen, to the same thing over and over again. I needed to get it out of my system.”

Why the strategies used to stop drinking were not researched in previous studies is unclear, but it seems an important omission as it would appear to be this first step that is often difficult for those contemplating abstinence. Those who advocate that alcoholism is a disease appear to place a lot of emphasis on the necessity of

medical detoxification and yet in this study only 8% received any medical assistance.

This study also seemed to indicate that self-remitters can be resourceful in generating their own natural resources to achieve their goal. This view is shared by those who advocate for the life processes model who argue that people are able to draw on their 'common-sense', problem-solving mechanisms, coping skills and support systems and do not have to resort to medical or other treatments (Granfield & Cloud, 1999; Peele & Brodsky, 1992).

Spirituality

As previously mentioned, spirituality appeared to be an integral part of recovery for 32% of participants.

CASE 11

"I did ask God for help and I'm not religious. I don't go to church but I did ask for help. I know I needed help somewhere along the line. I couldn't do it on my own so I did ask for help mentally and I got it, that's all I can say. I stopped."

CASE 12

“I prayed to God ‘you are the only person who can help me.’ The next morning I woke up absolutely cured of any desire – absolutely I credit God for that and I continued to pray.”

CASE 21

“One night I started praying. I felt an incredible peace. I felt a warmth in my body. I asked for prayer because I believed I could be cured. From that day there was an incredible change in my life. In July 1981, I stopped drinking.”

There appears to be no shortage of anecdotal data about personal accounts of the dimension of spirituality (Johnsen, 1993). In this study evidence was shared by people of different religions and no religion at all. In other words, some subscribed to a formal religion, such as Christianity, Hinduism or Islam, and others had a spirituality which involved belief in and communication with a God, or Higher Power of their understanding, but did not belong to any formal religion.

The challenge in any exploration of this dimension would lie in gathering scientifically appropriate data (Johnsen, 1993). There appears to be an increasing openness to the acknowledgement of spiritual beliefs or experience as a key variable in the mind, body, and spirit equation. A variable, which seems to be beyond

scientific measurement, but occurrences of which will not disappear (Hirschberg & Barasch, 1995).

Participants spoke about a spiritual experience which appeared for some to have a physical manifestation of heat or warmth. In previous studies, this sensation of warmth did not register in objective measurements of body temperature (Hirschberg & Barasch, 1995). Benei offered an explanation of a synesthetic crossed-sensory perception or nerve-endings which perceive heat being stimulated by healing energy of some sort, different from heat, but which overlaps it in some way in order to stimulate the nerve endings (Benei, in Hirschberg & Barasch, 1995 p.146).

In attempting to find an explanation for the perception of spiritual healing, Nordenstrum proposed that the “process of healing was initiated wherever sufficient energy is captured to push the system to the point from which it naturally evolves to a self-organized critical state.” In other words an energy barrier is overcome which facilitates healing (in Hirschberg & Barasch, 1995, p.149).

What seems clear that in these discussion, scientists are reaching the edge of knowledge as they seek answers to the question ‘What is God?’ Whether God is a spirit infusing a place, extra-biological

energy, love, stimulation of the healing system will probably remain a mystery, as each person's soul is unlikely to even be scientifically researched or understood. As an objective observer, participants appeared to be genuine in their stories and, with one exception, tended to downplay the dramatic value of their narratives.

Most models of recovery allow for a spiritual component to recovery. In the Alcoholics Anonymous programme, only the first step is about the substance, alcohol. All the other eleven steps are spiritual or psycho-spiritual in nature (Mooney et al, 1992). In the Life-process model, the role of spirituality is acknowledged as intrinsic to the strengths and resources harnessed by individuals to achieve sobriety and as part of the coping strategies used to maintain sobriety (Granfield & Cloud, 1999).

4.8.4 Strategies, Skills and Processes Used in the Maintenance of Sobriety.

Previous studies found there was a distinction between variables that motivated initial behaviour change and those that maintained it (Ludwig, 1976; Moos, 1994; Sobell et al, 1993, Tucker et al, 1994).

**TABLE 12: STRATEGIES, SKILLS AND PROCESSES USED IN
MAINTAINING SOBRIETY**

STRATEGIES, SKILLS & PROCESSES USED	NUMBER OF PARTICIPANTS	PERCENTAGE
SOBRIETY		
Avoidance of alcohol-related activities, cues and people	10	40
Non-avoidance of alcohol-related activities, cues and people	5	20
Development of alternative activities	12	48
Physical activity	3	12
Life-style changes	8	32
Spirituality	13	52
Community-orientated activities	6	24
RELATIONSHIPS		
Support from friends	2	8
Support from church	6	24
Support from family	6	24
OTHER STRATEGIES		
Placing time-limit on sobriety	3	12
Counting days	1	4
No access to money	2	8
Battle plan	2	8
Reading alcohol-related literature	4	16
Structured routine	8	32
Willpower	2	8
'Addicted' to craving	1	4
Replacing alcohol	7	28
Assertive responses	3	12
Aversive thoughts	7	28
Medication	2	8

Avoidance of alcohol-related activities, cues and people; and lifestyle changes.

Forty percent of participants avoided the temptation to drink or to return to a prior pattern of drinking. This included avoiding friends who used alcohol, bars, work functions, and social and

sporting functions such as “braais” (South African barbecues) and rugby games. In some cases, participants used this strategy for a period of time and were able to relax after a while.

CASE 1 put as much distance between himself and alcohol as he could, even shunning recovering alcoholics.

“If I went to the shopping center – I’d park the car the farthest I could away from the bottle store. I did not accept any invitations to any functions in my industry. In fact, I did not go out at all. I even stayed away from friends who went to AA. I wouldn’t go near them. I cut myself off from any mention of it, even articles in magazines. I shut the door; if I didn’t do that I would be reminded of it. I didn’t want to hear any sad stories. I often feel I should go and talk to these people, but then I feel it’s best to do what’s best for me.”

For CASE 2, this was not entirely of his choosing. He described what happened at his bowling club.

“You know I was virtually sent to Coventry because I didn’t drink. They never said anything but they turned their backs and started chatting amongst themselves and I found myself sitting on my own – laterally. Terrible isn’t it? So I said to my wife ‘I’m leaving the bowling club’ and I told her why, and she left as well.”

Avoidance strategies were recorded in other studies on natural recoveries (Granfield & Cloud, 1999; Sobell et al, 1993; Tucker et al 1994).

Non-avoidance of alcohol-related activities

Some individuals made it almost a point of pride, not to avoid alcohol-related situations and almost enjoyed putting themselves to the test.

CASE 2

“I allow alcohol in the house. Of course. My husband drinks. I will even pour drinks though I prefer not to. I can’t stand the smell. I go out socially. I find people don’t pester me. I tell them I’m on too much medication. It’s my choice and not others people’s problem.”

CASE 12 seemed to enjoy the challenge.

“I have to have it in front of me. I have to challenge myself. I have to have it in the house. If it is not there – then I’ll probably want it.”

CASE 18 said:

“After I stopped, I used to still go to the pubs for the company. It never worried me. I used to keep drink in my flat for my drinking friends. The beers in my car used to roll around for months after I stopped.”

Development of non-alcohol related activities and life-style changes

Forty-eight percent of participants reported actively pursuing non-alcohol related activities such as reading, studying, art and work. Twelve percent committed themselves to a strenuous physical exercise regime that included running and gym.

CASE 9

“I worked a lot and when I came back from work, I did exercise and kept it up. I trained and regained my fitness. I studied to further my career.”

CASE 3

“Five o’clock is drinking time, so I find something else to do. I read, do crossword puzzles or work on the computer.”

CASE 18 was particularly adventurous.

“I took up fishing, boating and parachuting. Eventually I even took flying lessons and got my pilot’s license. What else do you do on weekends? Before I was quite happy in the pub. I still went to pubs and discos and went out with girls. But staying in a pub on a Saturday afternoon just wasn’t on – I was bored. I started doing all these things, not to take my mind off drink, but to keep me occupied.”

Previous researchers commented on successful natural recovery being dependent on the availability of non-alcohol related leisure activities (Ludwig, 1985; Tuchfeld, 1981). Embracing these activities seem to lead to changes in life-style and social activities (Moos, 1994; Sobell et al, 1993). Granfield and Cloud (1999) referred to strategies which assist in maintaining sobriety including changing environments, finding alternative forms of leisure and recreation and engaging in meaningful work. They propose that these strategies are responsible for individuals 'feeling good' in their recovery, which appeared to increase their motivation to maintain sobriety (Granfield & Cloud, 1999).

Spirituality

Fifty-two percent of participants reported an increase in spiritual activity during their recovery. Some used prayer or meditation and 24% attended church and church support groups.

CASE 19

"All my strength comes from above. I ask others who had a problem, 'you're praying, right?' You can't pray with one hand and hold the bottle with the other. You need two hands to pray. You have to put the bottle down."

CASE 21

“My solution is in prayer meetings. Even my children started coming to meetings and to church. I’ve even started talking to other church groups about my healing.”

CASE 10

“My household goods were all stolen one day. Normally I would have gone to drink but I started praising god and God’s presence helped me. The insurance replaced our goods but they came back to steal the goods a second time – but I interrupted them. We were saved. Whatever I have is from the Lord. If I thank Him every day – He is going to bless me.”

CASE 14

“Now I use my home for house-church. There are no temptations. I can even sit with people who drink – no problem.”

There have been studies indicating a trend towards using prayer and meditation by those abstaining from substances. These studies have not claimed causation but have established an association between the use of prayer and meditation (Hirschberg & Barasch, 1995; Johnsen, 1993).

Ludwig (1985) reported in his study that self-remitters seemed to acquire an inner-strength from their spiritual beliefs that appeared

to play a role in people's ability to resist temptation and experience a reduction in craving.

From this study, it appeared that the acquiring of spiritual experience and beliefs seemed to assist individuals in the process of forming a new identity and adopting a new lifestyle with norms and values more congruent with non-alcohol related activities.

Community-orientated activities

Twenty-four percent of participants found that helping others helped them stay sober. Almost all participants expressed an interest in being able to help others suffering from the same problem. This need appears to be an attempt to make a negatively perceived event have a positive meaning (Granfield & Cloud, 1999; Hirschberg & Barasch, 1995).

CASE 21

"I began working with hobos and down and out alcoholics, for the church. I ran a type of shelter. It went very well. I began talking to other alcoholics, lecturing and counseling. I became really involved."

CASE 9 shared that he had helped other members of his family by advising and sharing his 'knowledge'.

“I feel good about what I have achieved. Both of my brothers are not drinking. The eldest one stopped on his own last year. The other one, the doctor told him to stop. I have been a good influence on both of them. I am the youngest but when you see us together, it seems I am the eldest. I told my brothers “it is like being in a jungle - you can come out if you want to. If you want to stay there - you can.” I was always there for them. I also helped some of my friends.”

It was clear that for this self-remitter there was a newly ascribed status among his family and community for having successfully overcoming his problem and he enjoyed using this influence for good.

Many participants mentioned the term ‘giving back’. The impression gained was that there was an acknowledgement of the potential harm they had caused and the help and support they had received. Helping others seemed to be a way to pay this ‘debt’, which appeared to be important in the formation of this new identity. This need is evidenced in the 12th Step of the AA programme, which encourages the recovering alcoholic to help other suffering alcoholics (Mooney et al, 1992).

Support from family, friends and church

Fifty-six percent of participants received support from their family and the church. The influence of a supportive social context, especially a positive family milieu is one of the most notable factors linked with positive outcomes in treatment studies and in natural recoveries (Moos, 1994). It was found that families with fewer stressful life circumstances, who had more cohesive and well-organized family environments had better recovery outcomes than those without (Moos, 1994).

CASE 25

"My husband was very much around me for the first six months. He wouldn't let anyone else pour me a drink. He always made sure he poured me a coke in a clean glass and made sure of where the glasses were at all times. He said, "The last two years have made up for all those drinking years. Everything you did is forgotten." After five months I sat my family down and said 'I'm sorry.' There were many tears. I said, "There are many things I don't remember. If there are things I did, please tell me now." It took us a couple of months to work things through – but we did it."

CASE 19

“My husband was wonderful. He bought me a new house so I would feel more secure and would get me away from my old life. We’ve been together 30 years and we’ve had no problems.”

Her daughter recalls, “My father is a strong man. He put up with my mom’s nonsense when she got into alcohol; it was hard for my father. But he has been a fantastic support for her.”

In this study it seemed that family support was important. This challenges some of the addiction wisdom, which encourages concepts such as ‘detachment’ and ‘tough love’ (Mooney et al 1992). It may emerge that families and friends who stay and support their impaired family member may also be effective in providing a supportive environment for recovery.

Other Strategies, Skills & Processes

This section of results is characterized by individuality and resourcefulness. Some strategies used have not been documented or recorded in other studies. Such innovation seems worth recording.

Placing a time-limit on sobriety

This strategy was used by 12% of participants.

CASE 18

"I did think "I'll give it up for a while and see how it goes." I just never entertained the idea of drinking again. The way I feel now, I have no inclination to drink again."

CASE 11

"The terrible thing about giving up is saying, "I'm never going to have another drink again." You cannot face life if you say that. That's what you're supposed to say. This is how I stopped drinking, I said "when I'm 80, I'm going to have a party that you've never seen before – I'm going to get absolutely *-!@! I'm gonna have a Chivas Regal party. I'm going to have gorgeous girls all over the place and I'll pay for the whole thing." I'm saving up for it now. I'm 60 now and I've got 20 years to go (laughs). When I gave up, that gave me the strength. I'd put a goal in my mind. It's too much to think of forever."

This thinking seems to be supported by addiction literature, which states that one of the reasons alcoholics deny their problem is because they cannot face ever having a drink again. In the AA programme one of the popular slogans is 'one day at a time' implying that more than that will be too much to handle (Mooney

et al, 1992; Perkinson, 1997). This self-remitter seemed to instinctively generate a creative solution to that dilemma.

Using the ‘Battle’ metaphor

Two participants used a ‘battle’ metaphor. CASE 12 spoke of a war between good and evil.

“I mentally drew a battle line. There’s the enemy and I’m here. I’m at war with that side of life – with alcohol. I named alcohol as evil. I put the side I was on as good. Then I crossed out an O and got God. I put a D on evil and got ‘Devil’. I’m going to stay with God.”

CASE 1 had a military father and saw his fight against alcohol as a battle.

“I avoid alcohol in the jungle. I use common sense and instinct. For example I stay away from the bottle store or wherever traps may lie.”

Reading alcohol-related literature

CASE 25

“I read a lot of literature. That’s what I found useful. Once I understood the illness I could come out and share with others. I had to come to terms with it myself, first.”

Tuchfeld (1981) mentions that some individuals choose to be 'well-read' on alcohol issues. He noticed that as people increased their 'vocabulary of motives' they became more certain of their past problem. This increased understanding serves to increase and sustain commitment over time (Tuchfeld, 1981, p.637).

Structured routine

Thirty-two percent of participants seemed to find security in structure. Many researchers mention words 'stability' 'cohesion' 'organization' and stress the importance of a positive social and economic support system (Ludwig, 1985; Moos, 1994; Sobell et al, 1993; Tuchfeld, 1981; Tucker et al, 1994).

CASE 1 acknowledged his need for structure and the absence of stress.

"I will go home to-day – have tea and supper, watch TV and go to bed and read. Then I get up and go to work. On weekends I go to the beach. I have absolute peace of mind. I don't have a worry in the world. I don't have financial concerns or any debt. I go without if I don't have money."

CASE 12

"It's like every morning I'm bouncing along the freeway at between 120-180mph because I'm 'late' for work. Its 6.45am and I'm 'late' for work. I never leave before everyone is gone. It's hard to say I'm just gonna wake up

when I wake up. I have to do the same things over and over. I run and train every day. It's almost like an addiction."

Replacing alcohol

Twenty-eight percent of participants replaced alcohol with non-alcoholic substances such as milk or a flavoured soft drink. Eight percent chose less safe options such as cannabis and tranquilizers. Although these individuals stressed these were used on an occasional basis only.

Aversive thoughts

Twenty-eight percent of participants appeared to find motivation in

- remembering bad experiences,
- looking at people who were drunk, or
- thinking about the years of sobriety that would be lost if they returned to drinking.

CASE 3

"Since stopping drinking, a friend who retired a few months before I did, also a long-time drinker – died in September, last year. He used to have beer for breakfast. A hellova nice guy – he only drank beer – but he drank it all day. I now visit his wife who misses him. It made me realize it could have been me."

CASE 11

“If I go out tonight and someone says – ‘have a drink’, I might think ‘ I might be dead tomorrow, let me go for it. If I do, I’m dead.’ Other people’s experiences have shown me that. I’ve listened to that. For the first time in my life, I’ve listened. I usually don’t. I usually do the opposite.”

Assertive responses

Some participants come up with some unique responses when asked to drink.

CASE 15

“I say to people ‘I can’t drink – not ‘I don’t drink.’ There’s a big difference. I can’t drink alcohol, it’s not for me, I just cannot drink it. I find that when I say ‘I can’t’ that people back off. If you say ‘I don’t drink’ they say ‘have one.’”

The strategies, skills and processes generated and utilized by self-remitters bear a striking resemblance to those advocated for use in relapse-prevention programmes (Gorski, 1989; Langley, 1985). As the coping skills used in relapse prevention programmes are simple and plausible and based on cognitive-behavioural principles (Langley, 1985) it would appear that self-remitters were able to assimilate and access similar skills through a natural process of life-navigation and learning. Perhaps it could be hypothesized that

self-remitters possess better natural coping skills and resources than do non-self-remitters.

4.8.5 Difficulties Experienced in Recovery

TABLE 13: DIFFICULTIES EXPERIENCED IN RECOVERY

DIFFICULTIES EXPERIENCED	NUMBER OF PARTICIPANTS	PERCENTAGE
Socializing with people who drink	7	28
Craving	3	12
Stigma	3	12
Thoughts of alcohol	2	8
People forgetting to offer you a drink	2	8
Family problems	2	8
Loss of drinking friends	2	8
Alcohol in the work place	1	4
Loneliness and boredom	1	4
Friends teasing	1	4
Procrastination	1	4
Fear of future	1	4
Spouse's drinking	1	4

Participants were able to recall some recovery difficulties. Most were surprised at how easy recovery was and at how few difficulties were experienced. It would appear that those who are motivated for natural recovery, have sufficient internal and external resources to cope with the process (Moos, 1994). The nature of difficulties coincided with high risk situations as

identified in Relapse Prevention Treatment such as coping with social pressure, negative emotional thoughts and cravings (Gorski, 1989; Langley, 1985).

4.8.6 Strengths, Abilities and Characteristics that facilitated Natural Recovery.

The question was asked of participants and families:

“What made you able to recover without treatment when so many others fail, even with treatment?”

**TABLE 14: STRENGTHS & ABILITIES THAT FACILITATED
NATURAL RECOVERY**

STRENGTHS AND ABILITIES	NUMBER OF PARTICIPANTS	PERCENTAGE
Self reliance	9	36
Spirituality	9	36
Self belief / pride	7	28
Strong-wills	7	28
Family pride	7	28
Common sense / instinct	3	12
Problem-solving / coping abilities	3	12
High achiever	3	12
Good self-esteem	2	8
Responsible	2	8
Humour	1	4
Communication skills	1	4
Strong values	1	4

In a similar study, Rudolf Moos (1994) queried why some people who are alcoholic can stop drinking and lead a normal life while others cannot stop drinking and seem to conform to the pathologising view that such individuals have some kind of defect which predisposes them to life-long crises and depression. Moos (1994) *inter alia* argued that many people are remarkably resilient, and use life crises as turning points, moments of opportunity, conversion and risk (Granfield & Cloud, 1999; Hirschberg & Barasch, 1995; Moos, 1994).

CASE 2

“I am self-reliant, responsible, have good coping skills. I am ‘sensible’. I had to cope at an early age and educated myself. I don’t have a lot of time for emotions. My parents divorced when I was four. I had to fend for myself. I don’t believe in ‘psycho-babble’ and looking for causes.

CASE 9 answers the question:

“The belief, determination that I am what I am and I can be better than what I am. The belief in myself. I believe it is in the genes. My father was a PHD and my brother and sisters all have a history of high achievement despite difficulties. I know where I belonged – an achieverI am supposed to be better than I am. I won’t stop reading and studying.”

CASE 10

"We were poor. We were eighteen kids. Dad managed. He didn't have other resources, he had to be helped spiritually. I never had special attention, I was the 14th child, but he had love for all of us. When I hear my father's voice, I jump. We had respect for him."

CASE 11

"I believe in the old fashioned ways and they work."

CASE 25

"I'm a much stronger person sober. I used to run away from my problems and use alcohol as a crutchI am quite a strong person, determined. I give 100% once my mind is made up. It depends on your self-esteemI wanted something better for myself."

CASE 1

"I was brought up by a man different from the average father. He was a Brigadier-General in the British Army, he reported directly to Churchill. He grew up under Victorian values of faith, trust and loyalty. He wouldn't lie, unless to protect something he valued. Something I'm awfully proud of. I love my fellow human beings. I use humour to resolve situations."

It could be argued that personal resources such as confidence and an easy-going disposition may be seen to be associated with the presence of social resources, such as supportive social and work contexts. These, in turn may be linked to more effective coping

responses and a better level of functioning and increased self-confidence. All of which may make natural recovery easier for such people (Moos, 1994).

What was notable was that 84% of participants were able to identify strengths and abilities which assisted them in recovery. It would be useful to compare this result with a similar group of treated alcoholics in a future study.

4.8.7 Rewards Associated with Recovery

Ninety-two percent of participants were able to itemize the rewards associated with a sober lifestyle and viewed their cessation of alcohol as beneficial.

TABLE 15: REWARDS ASSOCIATED WITH RECOVERY

REWARDS	NUMBER OF PARTICIPANTS	PERCENTAGE
Pride in self	9	36
Pride in stopping	7	28
Pride in stopping without treatment	4	16
Improved family relationship	8	32
Improved finances	5	20
Helping others	5	20
Improved work situation	3	12
Improved health	2	8
Improved living conditions	2	8
Improved spirituality	2	8
Loss of fears	1	4
Friends	1	4

Most participants experienced a sense of pride in themselves, in their sobriety and in the fact that they achieved sobriety without treatment. Previous researchers had found that entering treatment could lessen a person's sense of mastery or self-efficacy (Granfield & Cloud, 1999). That there was also an increased sense of self-efficacy associated with solving substance problems unaided by treatment (Granfield & Cloud, 1999). Participants listed experiencing improved family relationships, finances, work situations, health and community involvement.

Granfield & Cloud (1999) noted that in order for self-change to be permanent, an individual had to perceive there to be benefits associated with the change. Acknowledgement of the rewards of abstinence is also an important part of the Alcoholics Anonymous 12-Step programme, where recovering alcoholics narrate stories of addiction as well as how dramatically their lives have improved (Granfield & Cloud, 1999; Mooney et al, 1992). This same programme offers a set of 'promises' which are made to entice the alcoholic into recovery (Mooney et al, 1992). Perhaps the participants describe this best.

CASE 11

"I have this wonderful life now. I paid cash for this flatmoney just starts to come in. My grandchildren love me, even the animals want to be with me. I feel like I'm getting paid back. There is a sense of achievement. Sometimes I get a bit smug."

CASE 25

"I feel good about myself. I attend church, no one knows about my problem there. I have a few good friends. All these things are important but most of all, I feel good about myself."

4.9 SUMMARY AND CONCLUSION

In Chapter One various working assumptions were outlined which guided this study. These assumptions were formulated as a result of reviewing previous studies of the phenomenon of natural recover and from practice wisdom. These assumptions were that:

1. Some alcoholics are able to recover without formal treatment.
2. There are variables or events that motivate initial behaviour change and which serve as incentive functions in the natural recovery process.

3. There are variables and events that maintain behaviour and that serve as reinforcing functions in the natural recovery process.
4. That certain intra-personal, genetic, psychological, social or environmental variables or factors may predispose individuals to natural recovery.

These results would seem to be congruent with these assumptions.

In summary, it would appear that certain individuals are apparently able to recover from a serious alcohol addiction without any formal assistance or treatment. Natural recovery seems to be precipitated by a process of cognitive pre-contemplation which culminates in a final decision to stop drinking. Individuals with serious physical dependencies appear able to resolve the crisis of physical withdrawal without medical assistance in most cases. Individuals seem able to generate a range of strategies and skills to initiate and maintain natural recovery. Some of these were documented previously and some were not. The support and assistance of families and significant others seems important throughout this process. The two factors which seemed to play the largest role in natural recovery were:

- the process of cognitive self-evaluation and

- the belief in a spiritual power greater than oneself.

Certain abilities, strengths and skills seem to pre-dispose certain individuals to natural recovery. Finally, the natural recovery process and the ability to solve one's own problems appeared to strengthen, empower and enhance one's feelings of self-esteem and pride, in seeming contrast to the disempowering and sometimes pathologizing process of submitting to formal treatment.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This study set out to document the participant's experience of natural recovery from alcoholism in order to gain a better understanding of the factors which precipitated their readiness to stop drinking and of the processes, strategies and skills harnessed by these individuals to achieve and maintain recovery.

What was envisaged was that a better understanding of the natural recovery process might inform practitioners about recovery from alcoholism and may have implications for treatment..

In this chapter, any conclusions drawn are done respectfully and tentatively, owing to the exploratory nature of this research. This study offers a gentle probe into the world of natural recovery and it is hoped that, at best, it would illuminate or highlight areas for further exploration and research.

The South African Context

Similar studies have been conducted in other parts of the world, but, to the researcher's knowledge, none have been conducted in South Africa. With this in mind, there was some doubt as to the existence of the phenomena in South Africa, or of the willingness of self-remitters to volunteer to participate in such a study.

The relative ease with which 25 participants were recruited seemed to indicate that natural recovery may be as prevalent in South Africa as it is in other countries. The researcher was heartened by the recruitment of a fairly representative sample given the limitations of the sampling technique. From this it may be inferred that natural recovery occurs in all races, genders, and economic groups in South Africa. Future studies might consider recruiting from a broader field including all provinces and language and education groups.

Findings generally indicate areas of commonality in the participant's experiences of natural recovery. Some differences were noted and explained by the broad scope and exploratory nature of this study, other differences would be explained by the

uniqueness of the South African context, other studies having been conducted in sophisticated first world countries.

5.2 NATURAL RECOVERY AS A PROCESS

Reviewing previous studies on natural recovery revealed that natural recovery was progressive in nature. That factors which initiated and motivated recovery were different from those factors which maintained recovery (Ludwig, 1985; Sobell et al, 1993). This study revealed similar findings. Individual's narratives seemed to differentiate the process into three distinct stages:

1. Pre-contemplation - thinking about the possibility or need to stop drinking.
2. Initiation of sobriety - deciding to stop drinking, including the method by which this is achieved.
3. The maintenance of the recovery process - keeping up the decision to stop drinking.

Pre-contemplation and Initiation of recovery

It appeared that for most self-remitters, the process of recovery began long before the actual cessation of alcohol use, in a process

of self-evaluation. The duration of this process varied from ten years to a few months. Bateson described this time of pre-contemplation as an awareness of social isolation and alienation, as an estrangement or disconnection from oneself and one's values and others (in Hirschberg & Barasch, 1995). The motivation that finally seemed to pre-empt problem resolution seemed to be fuelled by a desire to preserve social connectivity, to re-establish a collaborative relationship with the rest of the world and to feel more connected to oneself (Granfield & Cloud, 1999; Hirschberg & Barasch, 1995).

Of some concern was the length of time it took for problem resolution, as the amount of damage that could be caused physically, psychologically, socially, and spiritually by alcohol abuse could be excessive. It would be useful to conduct a comparative study with treated alcoholics and compare the length of time it took for problem resolution and to compare relapse rates of the two groups.

It appeared that relapse rates were low among those taking part in this study when compared to success rates among treated individuals leading one to conclude that it may be that self-resolution based on self-motivation and self-evaluation may lead to

a more permanent resolution of alcohol problems (Miller & Hester, 1986). This would seem to be hypotheses worth testing in a future study.

Various factors seemed to precipitate recovery. What became clear was that the actual events or factors were less important than the meaning ascribed to that event. The process of cognitive evaluation appeared to be integral to the motivation required to initiate recovery. This seemed often to be a lengthy process, which included pre-contemplation, often with a final event which seemed to act as a trigger which precipitated a final commitment. The proverbial “straw that broke the camel’s back.”

This process of cognitive evaluation appeared to be similar to the processes described in the Alcoholics Anonymous treatment programme as ‘hitting rock bottom’ (Mooney et al, 1992). The Alcoholics Anonymous programme and natural recovery share a similarity in that in both cases, the individual is left to a process of cognitive evaluation where the alcoholic evaluates his life negatively and attributes this to alcohol abuse, where the point of pain and understanding connect and the alcoholic decides that ‘enough is enough’ (Mooney et al, 1992; Moos, 1994). The danger appears to be that the alcoholic may never reach this point, or that

by the time he does, he may have no social, physical or psychological resources left to deal with the problem.

The role played by medical practitioners in motivating individuals was noteworthy. It would seem that this brief intervention had a powerful effect in motivating certain individuals to resolve their alcohol problem.

Alcohol withdrawal

An area explored by this study which did not seem to have been covered by previous studies, was how the self-remitter achieved abstinence. Knowledge about the physical consequences of alcoholism informs us that withdrawal from any drug of abuse can cause withdrawal symptoms (Mooney et al, 1992). How did this group of self-remitters manage without medical assistance? As most coped without assistance, it could be concluded that this aspect did not seem to be a hindrance to the recovery process. Most participants were able to access the personal, social and medical resources necessary to achieve sobriety.

This may have implications for treatment facilities with programmes based on the Disease Model where staff composition is heavily weighted with medical personnel and resources

Maintenance of recovery

The range of strategies used by this group of self-remitters seemed to be categorized into the following groups:

1. The behavioural or psychological avoidance of substances and related social cues which appear to stimulate the desire to use. Moos (1994) categorized this as avoidance coping.
2. Building of structure and non-alcohol related activities and alternatives. Moos (1994) categorized this as approach coping, actively problem solving and seeking support.
3. Establishing or reviving meaningful relationships with people whose lives are organized around non-alcohol related norms and activities This could be categorized as approach coping (Moos, 1994). The elimination of alcohol-related relationships, categorized as avoidance coping (Moos, 1994).

Researchers maintained that people who relied more on approach coping and less on avoidance coping were less likely to develop problems and more likely to recover if they did (Granfield & Cloud, 1999; Moos, 1994). This study revealed no evidence to support this assertion, but rather that a combination of both approach and avoidance coping was necessary to maintain recovery.

Avoidance strategies seemed necessary in the early stages of recovery. Later, participants seemed to use approach strategies to develop a new life style which consisted of new activities and new roles. This seemed to allow individuals to formulate a new identity. This new identity appeared to contribute towards a sense of pride and self-worth which seemed to be more congruent with individuals innate belief in themselves.

This appreciation of, and pride in oneself seemed to be the final stage in the transformation of identity and seemed to be the factor which contributed to lasting sobriety and a reduction in relapses.

The participants seemed to regard their ability to resolve their problem without professional help as important and this seemed to reduce the stigmatization associated with alcoholism. It appeared

that once the drinking problem was resolved, it became permissible to acknowledge talk about it, in fact, some seemed to consider this achievement a point of pride.

Some participants seemed to engage commitment mechanisms such as community service and/or joining a church, which seemed to assist in the formation of a new healthy identity and which seemed to enable them to make sense of previous destructive behaviours (Tuchfeld, 1981).

Social context

It would appear that a link exists between a cohesive, functional social context and natural recovery. Further study seems necessary to establish whether self-remitters do better because they enjoy more cohesive family and social units or whether those factors and resources which enable them to recover naturally also contribute to their enjoying a more cohesive social network. In other words, their natural skills and abilities predispose them to forming closer associations and relationships.

Most self-remitters in this study enjoyed family support and belief in their ability to recover. This appears to contradict some

treatment approaches which encourage tough love and active interventions (Perkinson, 1997).

The approach which appeared most successful was that of continued, stoic support, leaving the alcoholic to deal with the problem. Alanon, the support system which exists alongside Alcoholics Anonymous to assist families of alcoholics, has a philosophy of detachment with love that appears to be most synergistic with this approach (Mooney et al, 1992).

Spirituality

There seemed to be a strong relationship between spirituality and recovery, in the motivation and initiation of abstinence and in the maintenance of sobriety. There was strong anecdotal evidence among most self-remitters interviewed which seemed to induce participants to believe they had experienced either physical healing and / or sufficient help and support to enable them to stop drinking and to maintain abstinence.

The difficulties with scientific study of spirituality are noted and it is difficult to know how this phenomenon can be further explored. Perhaps researchers have to acknowledge its presence and its

unknowableness, and accept that it remains, for now, at the edge of scientific knowledge.

The varieties of spiritual expression and experience were noted and although it would seem integral to the recovery experience, it seems that great freedom and latitude needs to be given and prescription needs to be avoided. The Alcoholics Anonymous programme acknowledges this relationship and that the concept of a “higher power” is central to the recovery process.

Resources which Facilitate Natural Recovery

The experience of participants in this study, seem to suggest that having structural and individual resources can be a critical element in a person’s ability to overcome dependency problems without treatment. Those who possess an assortment of resources, seem better able to overcome dependency without treatment than those with limited resources. Granfield & Cloud (1999) referred to resources such as education, occupational skills, financial stability, supportive family and friends, problem-solving and social skills.

Conversely, people from disadvantaged and impoverished backgrounds may not be the best candidates for natural recovery

(Granfield & Cloud, 1999). However, in this study, some participants who had limited resources but access to education and strong family values, were able to self-remit. Undoubtedly there may also be many people who have such resources who are unable to successfully resolve their dependency problems.

One could then conclude that people who possess recovery resources appear to be better equipped for natural recovery, but that there are individual exceptions. Most of the individuals in this study were able to identify various strengths, including family pride and self-belief. Most possessed a good sense of self-worth and self-esteem despite, in some cases, fairly disadvantaged social contexts.

5.3 THE ADVANTAGES OF NATURAL RECOVERY & IMPLICATIONS FOR INTERVENTION, TREATMENT & PREVENTION.

This study would seem to support that natural recovery is possible and exists in South Africa. While it would seem to be a viable option for some, it may not be a feasible option for everyone suffering from addiction. It is not the purpose of this study to

advocate in any way in favour of natural recovery over formal treatment.

Having said this, there would seem to be some advantages to natural recovery for the individual and society. These advantages seemed to be:-

- A diminished financial burden to individuals and families as cost of treatment and of time lost from work is avoided.
- Attending treatment and group meetings can be disruptive to individuals, families and employers. Conversely self-remitters suffer little disruption.
- The self-remitter avoids the stigma of being labeled alcoholic. Often entering a treatment programme has lifelong implications in the way the alcoholic is viewed by others. This can often have practical implications, for example insurance cover may be refused or prospective employers may be prejudiced.
- Self-remitters appear to enjoy an increased sense of self-efficacy and self-empowerment as a result of their ability to

resolve their own problems with alcohol. This probably results in increased confidence and ability to solve other problems in the future.

Implications for Intervention

The concept of self-empowerment as embodied in the strengths perspective has gained considerable acceptance among helping professionals in recent years (De Jong & Miller, 1995; Granfield & Cloud, 1999; Saleebey, 1992).

There appears to be a strong link between individual resources and strengths and natural recovery. Common strengths, abilities and processes appear to be involved in the natural resolution of all problem conditions and may be generalized to other psychiatric disorders and crises such as depression, divorce and bereavement and post-traumatic stress disorders. It would appear that harnessing the individual strengths and abilities that result in an increased capacity to solve immediate and future problems may have important implications for future social policy.

Implications for Treatment

There appear to be similarities and differences in the processes leading to natural problem resolution and treatment. The similarities are that:-

- There are psychological processes which precede alteration of a drinking pattern.
- There are psychological and social processes and factors which accompany the maintenance of sobriety.

There are many common strategies, skills, and processes which were used naturally by self-remitters and which can be found in treatment programmes. These include *inter-alia*:

- Complete abstinence from alcohol.
- Avoidance of alcohol and alcohol-related cues.
- Developing of alternative non-alcohol related activities.
- Engaging in the process of cognitive self-evaluation.
- Using cognitive strategies to motivate oneself.
- Reading alcohol related information and literature.

The main differences between natural recovery and formal treatment seem to be:

- A primary treatment goal, implicit or explicit, appears to be acceptance of the 'alcoholic' label. Natural recovery does not necessarily require the internalization of, what may be perceived as a stigmatic label. This may have implications for the individuals self-concept and identity.
- Treatments are logically concerned with institutional controls, such as antabuse medication, urine tests, meeting attendance. Natural recovery is dependent more on internal controls and motivation. There may be a link between this and the low relapse rate experienced by this group of self-remitters. This may be an area which could be considered for future research.

The process of self-evaluation, or cognitive appraisal appeared to be central to the motivation for natural recovery and may have important implications for treatment programmes. More research needs to be carried out on understanding this psychological process and / or incorporating it into treatment programmes. Individuals seem to need to be encouraged to engage in a process of weighing

up the advantages and disadvantages of continuing to drink as opposed to the advantages and disadvantages of abstinence. It would appear that it is this natural self-evaluation that provides the impetus for problem-resolution.

Negative Perceptions of Formal Treatment

Treatment programmes appear to continue to be viewed negatively and to be associated with the stigma that often accompanies addiction. For individuals capable of natural recovery, this option was available, but treatment providers should be concerned that negative perceptions could keep people who really need treatment away. It seems that real effort is needed to destigmatize alcohol-related problems and the treatment thereof so that implications of going for treatment need not be so far-reaching and disruptive.

Related to this is the perception of the loss of control and disempowerment experienced by submitting to treatment. This seems to be in sharp contrast to the feelings of self-efficacy, pride and empowerment of self-remitters. Treatment providers need perhaps to favour programmes which empower and reinforce people's natural recovery processes, strengths and abilities in

favour of programmes which stress powerlessness and dependency.

It seems that recovery may not necessarily be dependent on the acceptance of an alcoholic identity, and that such acceptance may do more harm than good. That treatment approaches which teach people how to improve coping resources and life contexts and empower them to be self-reliant may be more appropriate.

Implications for Prevention

Over the years there has been much debate over the efficacy of prevention measures in relation to substance abuse. It is worth noting that more of the participants in this study appeared to have benefited from any external information about the disadvantages of using alcohol. Their motivation seemed to come from personalized experiences of the harmful effects of alcohol. However, 16% of the participants in this study did make use of literature about alcoholism after they had made a decision to abstain. There could be implications for prevention in this finding.

5.4 RECOMMENDATIONS FOR FUTURE RESEARCH

As envisaged, this study highlighted the possibilities for future research in a number of areas. One of the limitations of this study was the restriction experienced in recruiting a sample. There seems enough evidence that an enlarged nationwide study is needed, drawing a truly representative sample of all population and language groups and genders.

This study focussed on natural recovery from alcohol. It would be useful to know whether these findings could be generalized to recovery from other substances.

Comparing natural remitters with a treated group could also yield answers to questions such as:-

- Is there a difference in the time it takes from the onset of a problem resolution, in natural remitters and treated individuals?
- Is there a difference in the personal and social resources of the natural remitters and the treated individuals?

- Is there a difference in relapse rates in natural recovery and treated recovery?

More detailed and quantifiable data are needed in the process of cognitive evaluation or appraisal as it seems that 'recovery-readiness' is a key factor in any recovery programme. The apparent effectiveness of a one-off intervention by a medical practitioner needs further investigation with a view to developing and training in brief-interventions.

5.5 CLOSING COMMENTS

This study leads the observer to feel optimistic about people's ability to overcome alcohol problems. It would seem to challenge the pessimistic view of addictions that seems so prevalent among practitioners and treatment providers. It may be that the power that individuals have over alcohol is often greater than the power alcohol has over individuals. The researcher found that in interviewing 25 individuals, one uncovered 25 different unique and creative narratives of courage and resourcefulness. It seems clear that people with substance problems can not be pigeonholed into one convenient theory or model. Studies on natural recovery seem

to caution helping professionals against underestimating human strengths, abilities and most of all, the power of the human spirit.

Resolution of problems, disorders or life-crises are not experiences shared by a special few. All people struggle each day to understand and cope with difficult situations. This process seems to have common elements that help people eventually successfully reach their goals and in this process become stronger, more actualized and mature human beings.

“The belief, determination that I am what I am and I can be better than what I am. The belief in myself. I believe it is in the genes, My father.... brother and sisters all have a history of high achievement despite difficulties. I know where I belong.... as an achiever. I am supposed to be better than I am” (CASE 9).

“I admit this may not be the ‘right’ journey, but it is my journey” (CASE 13).

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APPENDIX 1

**Letter to the Editors of Newspapers and
Magazines requesting their assistance in
publishing a letter or article to recruit
participants in the study**

APPENDIX 1

The Editor
Various magazines/newspapers
Durban

Dear Sirs

RESEARCH: CHEMICAL DEPENDENCY

I am a social worker in private practice, specializing in the treatment of alcoholics and their families.

I am conducting research into the recovery process of Alcoholics who have never been involved in treatment programmes. Overseas research tells us that 20% of alcoholics do recover without any formal treatment. I believe that these people may have an interesting story to tell and that we, as professionals can learn much from them which will help other alcoholics.

I would be very grateful if you could assist me in finding such people, by printing the attached letter in your magazine/newspaper. I would be happy to reciprocate by providing you with an article or an interview when this research is completed.

I am conducting this research as part of a Masters Thesis under the auspices of the University of Natal, Durban.

I look forward to your reply

Yours faithfully

LINDA DILLON

APPENDIX 2

Letter to the public requesting their participation in the study

APPENDIX 2

The Editor
Various Magazines
DURBAN

Dear Sir,

DID YOU BEAT ALCOHOLISM ON YOUR OWN? CAN YOU HELP?

I am a social worker in Private Practice specializing in the treatment of alcoholics and their families. I am conducting research for a Master's Degree under the auspices of the University of Natal, Durban Campus.

I am wanting to interview people who believe that they had an alcohol problem and who have successfully overcome their problem without formal treatment. I am interested in speaking to people who have been sober for more than two years and who have not attended Alcoholics Anonymous (AA) or any other treatment programme.

I believe that these people may have an interesting and useful story to tell and that they can play an important role in helping other alcoholics and drug addicts.

This research in no way attempts to minimize the role played by AA, SANCA and other treatment programmes, but wishes to explore other dimensions of recovery.

If you wish to be part of this research, please contact Linda Dillon on 031-2023978. Interviews will be conducted in person, and will be treated in absolute confidence. For practical reasons, I would like to hear from people living in Kwa-Zulu Natal.

Looking forward to hearing from you and hearing your story,
Yours faithfully

LINDA DILLON

APPENDIX 3

**Published letter to the editor recruiting
participants for the study in the Independent on
Saturday, September 19, 1998.**

THE INDEPENDENT ON SATURDAY
SEPTEMBER 19 1991

Help needed on alcoholism

From LINDA DILLON
Durban

I AM requesting your assistance in locating members of the public to take part in a research project I am undertaking.

I am conducting research into "natural recovery" from alcoholism. Research findings in other countries show us that at least 20% of alcoholics who recover do so without access to formal treatment.

I would like to interview people who have achieved two or more years of sobriety without attending Alcoholics Anonymous, any formal treatment programme, or counselling.

Recent studies have shown us that

these stories of recovery contain information which is invaluable to other alcoholics and professionals working with alcoholics.

People who are interested in taking part in this study should contact me on 031-223 978. All information will be treated in the strictest confidence and anonymity will be protected.

I am a fully qualified, experienced social worker specialising in addictions and currently conducting this research under the auspices of the Social Work Department of the University of Natal. I am currently in private practice and was previously Senior Social Worker for many years at Lulama Treatment Centre.



E & O

APPENDIX 4

**Published article about the study in the Daily
News, November 12, 1998.**

Lifestyle

DAILY NEWS, THURSDAY, NOVEMBER 12,

Giving up drinking without help

LIFESTYLE REPORTER

OVERSEAS research shows that of all alcoholics who recover from their addiction, an impressive 20% stop drinking on their own without professional intervention.

Linda Dillon, a social worker in private practice who specialises in addiction, would like to do similar research in South Africa.

"I would like to interview people who have achieved two or more years of sobriety without attending Alcoholics Anonymous, any formal treatment programme or counselling.

"Recent studies have shown us that these stories of recovery contain information which is invaluable to other alcoholics and professionals working with alcoholics."

Ms Dillon would like to interview about 20 people as well as a relative from one case. All information will be treated in confidence and anonymity will be protected.

She is a qualified, experienced social worker conducting this research under the auspices of the social work department of the University of Natal. She was previously a senior social worker at Lulama treatment centre in Durban.

She may be contacted on 22 3978 after Monday.



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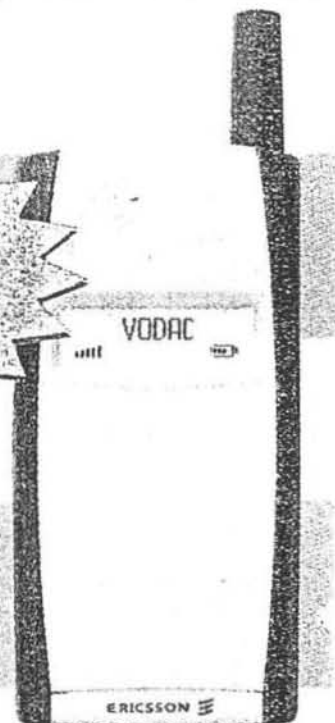
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APPENDIX 5

Semi-structured interview guide

APPENDIX 5

SEMI-STRUCTURED INTERVIEW GUIDE**PARTICIPANT INTERVIEW****Identifying Details**

First Name

Gender

Age

Race

Area of Residence

Occupation

Religion

Marital Status & Brief History

Children

Family of Origin

Siblings

Alcohol or Addiction History of Family

Length of Sobriety

Present Drinking Status

Treatment History

Exploratory Questions

Drinking History (age started, when problem started)

What was your drinking pattern like before you decided to stop?

How did alcohol affect your :

- working life
- social and family life
- physical well-being
- emotional and mental well-being
- other...

What made you decide to stop and when?

How did you achieve this?

Why did you choose not to go to treatment?

What strategies, skills and abilities did you use to stay sober?

What difficulties did you experience in recovery?

What rewards, if any, have you experienced in recovery?

What unique strengths, abilities or characteristics enabled you to succeed where so many have failed?

FAMILY INTERVIEW

What is your experience of the participant's drinking history?

When did the problem start?

When did the/she decide to stop drinking and why?

How long have they been sober?

What is their present drinking status?

Have they ever received any kind of treatment?

How did they stop drinking?

What strategies, skills or abilities did they use to stay sober?

What difficulties did they experience in recovery?

What role, if any, did you play in their recovery?

What unique strength, abilities or characteristics do you think they possess that enabled them to succeed where many have failed?

Do you use alcohol at all? (Optional question)

APPENDIX 6

The Twelve Steps of Alcoholics Anonymous

APPENDIX 6**THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS**

STEP ONE: We admitted we were powerless over alcohol and that our lives had become unmanageable.

STEP TWO: We came to believe that a Power greater than ourselves could restore us to sanity.

STEP THREE: We made a decision to turn our will and lives over to God as we understood Him.

STEP FOUR: We made a searching and fearless moral inventory of ourselves.

STEP FIVE: We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

STEP SIX: We're entirely ready to have God remove all these defects of character.

STEP SEVEN: We humbly asked Him to remove our shortcomings.

STEP EIGHT: We made a list of all persons we had harmed, and became willing to make amends to them all.

STEP NINE: We made direct amends to such people wherever possible, except when to do so would injure them or others.

STEP TEN: We continued to take a personal inventory and when we were wrong promptly admitted it.

STEP ELEVEN: We sought through prayer and meditation to improve our conscious contact through God, as we understand Him, praying only for knowledge of His will for us and the power to carry that out.

STEP TWELVE: 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.