Recovery in the Community: An Exploration of What Counselling Psychology Can Learn From Community Healthcare and 12 Step-Fellowships.

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Portfolio for the Professional Doctorate in Counselling Psychology

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Introduction to Portfolio:

Counselling Psychology,

Community Healthcare and Social

Justice

This portfolio is comprised of three papers that encompass my learning on the doctoral training for counselling psychology. The first paper is a constructivist grounded theory study into recovery processes underlying twelve-step fellowships from an insider's perspective. The second is a clinical case study of one of my clients from a doctoral training placement, whose early-terminated contract had a significant impact on my perspective as a reflective practitioner. The third is a publishable paper that reports the findings of my research in a reduced format.

These papers are related to each other in several ways. Firstly, they represent experiences of individuals who have had to seek therapeutic help outside of the National Health Service (NHS) to gain recovery. Secondly, these two papers demonstrate the stigma these types of client's face within society as they are often deemed to be 'untreatable'. However, despite this stigma, they have managed to empower themselves and take responsibility for their recovery. Thirdly, because they have dealt with concepts such as healing through connection and finding meaning, they have informed my work as an existential practitioner. These have also led me to reflect critically, both as a clinician and as a service user, about my therapeutic beliefs, role as a counselling psychologist trainee and views on social justice issues.

The first paper in the portfolio is an original piece of research that uses a constructivist grounded theory methodology, guided by my insider perspective to uncover the recovery processes that underlie twelve-step fellowships. The constructivist approach was particularly suited to researching social processes in this way because it recognises the importance of the researcher and participants as cooperative collaborators (Kathy Charmaz, 2006). It also enabled me to place my participant's experiences at the forefront of the analysis, in the understanding that they are the experts on this subject. Although not directly linked to counselling psychology therapeutic practice, I believe it adds to the body of counselling psychology knowledge. A greater understanding of the processes that recovering addicts find beneficial in their recovery helps counselling psychologists

to provide a more informed therapeutic approach. Learning from the specific mechanisms of change encountered in the fellowships, counselling psychology could then potentially develop improved initiatives to enhance the experiences of their clients who suffer from addiction.

The second paper I present is a clinical case study of a client I worked with in a community health setting, the MIND in Tower Hamlets Counselling Service. As a regular MIND service user, this client attended the counselling service for help during a period of depression in his life. I have presented the client's mental health background and an integrative treatment framework for our work together. I went on to describe how our work came to be pre-emptively concluded due to the complexity of his presentation and the further insights that occurred due to this.

The research and the case study share several similarities that relate to the larger debate about the constraints on NHS mental health provision. Both include individuals who have not been able to find recovery through traditional NHS routes and so had to seek help through community led services. Among my participant sample, there were several individuals who had tried utilise NHS services to gain recovery, but these had not been adequate, or the waiting lists were too long for them to wait in their time of crisis. Therefore they had had to seek help elsewhere for their addictions and had found this help in a community run, volunteer led recovery program. The case study client had complex mental health needs but could not gain access to therapy on the NHS because he had not received the formal diagnosis that he needed for specialised treatment and had been deemed to be ‘unsuitable’ by other NHS services. He thus found himself utilising MIND in Tower Hamlets day centre and counselling service for most of his well-being needs. It is important to note that MIND receives its funding from the NHS, as it recognises the crucial role such community-based services play in providing mental health services.

If both these community-based services had not existed, these clients would have had nowhere else to turn and would have had to cope with their mental health problems in isolation. Community resources are thus immensely useful for patients like these, who fall through the gaps in care provision. It could also be argued that the reason these services were able to help these individuals was that they were run (or partially run) by volunteers rather than professionals. Because they were not constrained by 'professionalism', they could provide healing sources of human connection and empathy. Because these volunteers had previously been service users, they could provide the care, time, acceptance and understanding that professionals simply cannot.

It is essential that individuals such as those presented can actively seek and gain help outside the traditional health care paradigm because people with chronic and complex mental health or addiction problems are often marginalised and stigmatised (Lewis, Lewis, Daniels, & D'Andrea, 2011). This stigmatisation can lead to isolation, stress and a sense of shame; because of this, they often do not receive the complex help they need on the NHS or care and empathy from the communities they live in (Dinos, Stevens, Serfaty, Weich, & King, 2004). The government's National Service Framework for Mental Health (Department of Health, 1999) encouraged mental health promotion as well as service provision reform in an attempt to tackle stigma and its effects. Despite not completely solving the problem, this attempt has had some success at bringing about changes (Boardman & Parsonage, 2009). As such, the "*judgmental attitudes of the past are giving way to respectful approaches that emphasise empowerment and self-direction"* (Lewis et al., 2011, p. 6).

One of the approaches that empowers service users is the increasing focus on the recovery model. The foremost principles of this method are: not just treating or managing symptoms, focusing on building resilience, helping that those who have mental illness to regain a meaningful life over which they have control and emphasising hope (Jacob, 2015). Because it increases self-efficacy, service user empowerment encourages

individuals suffering from mental health problems to make choices and take responsibility for their own lives. Thus, allowing them "*to weave the slender threads of a broken life into a firm pattern of meaning and responsibility*" (Frankl, 2004, p. 1). This assumption of responsibility is the first step in any therapeutic process because it is only "*once individuals recognise their role in creating their own life predicament, they also realise that they, have the power to change that situation"* (Yalom, 2010, p.144).

Counselling psychologists have constructed an identity as being reflective therapists and scientific practitioners (Woolfe, Strawbridge, Douglas, & Dryden, 2012). As such we combine evidence-based practice with humanistic values. Counselling psychologists also have a natural scepticism about a solely medical model approach to helping our clients. Instead, we try to focus on "*facilitating well-being as opposed to responding to sickness"* (Strawbridge & Woolfe, 2010, p.4). Therefore, as therapists, our goal is to help our clients improve their lives by becoming more 'resourceful in living' (Van Deurzen, 2015). As counselling psychologists, it is our duty not to try to help our clients 'escape' their difficulties but to 'face' them (Van Deurzen, 2015). In this way we do not teach people how to be self-directive, rather we help them see how they already are (Van Deurzen, 2012). By giving these individuals respect and care, they can find their own strength and are motivated to utilise resources in their recovery (Lewis et al., 2011). Therefore, I believe one of the imperative roles of a counselling psychologist is to encourage their clients to take an active responsibility for their own well-being beyond the therapy room.

While therapists are "*clearly not a substitute for human friendship*" (Van Deurzen, 2012, p. 38), through the therapeutic collaborative relationship, we provide an invaluable source of connection for our clients who have been stigmatised and isolated, and this can be incredibly healing. Counselling psychology believes that through healthy therapeutic relationships, that foster authentic connections, our clients are then able to alter their sense of self into a more positive perspective (James & Bellamy, 2010).

Because of this focus on the healing relationship, it is important that counselling psychologists have a clear sense of self because we do not just use learnt skills and evidence-based theories to achieve this relational depth, we also *"draw on personal qualities and maturity, gained through life experience."* (Van Deurzen, 2015, p. 143).

Because of this, it is critical that counselling psychologists be reflective about their own mental well-being. This does not mean, however, that individuals with a history of mental health concerns cannot be counselling psychologists. Jung (1983) believed 'wounded healers' made very effective therapists, providing a therapeutic experience that is beneficial to both client and counsellor (Wosket, 2016). Yalom (2010, p. 109) postulated that perhaps this is because they can *"empathise with the wounds of the patient"* or perhaps it is because they can engage *"more deeply and personally in the healing process".* Van Deurzen (2015, p. 157) believed that "*clients are more often helped by our failures and faults than by our merits and virtues, as long as we are prepared to face and learn from them. The people we accompany on this path need to know we are human".* Therefore, it is vital that we have taken care to reflect on our lives with critical awareness and learn from our experiences. Given the current diversification of modalities and the focus on evidenced-based scientific methods within counselling psychology, the use of the therapists' 'self' has the potential to bring the field back to the 'healing power' of the reflective therapist (Wosket, 2016).

Unfortunately, mental health clinicians often suffer from the very stigmatisation and discrimination that their clients face (Van Deurzen, 2015). As such, I have been greatly inspired by other psychologists, like Marsha Linehan and Rufus May, who been open about their mental health issues and have used their experiences to improve guide future psychologist. As such, I felt it was important that I included my perspective, as a previous service user and 'wounded healer', into this portfolio. As a service user, I have experienced first-hand frustration with an NHS that is struggling to meet the demands placed on its mental health services. This has compelled me to give voice to and

empower those individuals who are not getting adequate help. It is my most sincere belief that these individuals can return to being productive members of society with meaningful and contented lives. However, traditional methods of NHS healthcare provision might not be suitable for meeting their needs. Counselling psychology is uniquely placed to provide a personalised and integrated care because it operates on a reflective and empowering philosophy. This takes the needs of individuals into account and encourages the development of innovative, creative and empathic solutions to their problems.

Individual well-being and community contexts are inextricably linked, and as counselling psychologists, we cannot help but take note of how these (Lewis et al., 2011). As Goldstein (2010, p. 677) points out, counselling psychologists are not merely neutral bystanders, because we "*constantly point to the external events on internal experience*". We are thus, uniquely placed to develop an awareness of how the injustices of our society feed into the problems our clients face. Goldstein (2010) believes that the future of counselling psychology is to work with both our clients' individual and societal contexts because their personal experiences are embedded in that society. Counselling psychologists thus have a place, not just as clinicians who empower their clients, but as social justice activists and advocates. By getting to the root of systemic shortcomings, this will help our clients because it will *"not only lessen human suffering, but also prevent the maintenance and emergence of these problems*" (Fouad, Gerstein, & Toporek, 2006, p.2). Kagan, Tindall and Robinson, (2010) laid out six principles for counselling psychologists to actively increase social justice for their clients: ongoing self-examination, sharing power, giving voice, facilitating consciousness raising, building on strengths, leaving clients the tools to work towards social change. I hope that this portfolio has considered all these principles when laying out the findings of the research and case study.

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Part 1: Research

What is the Nature of the Recovery Processes Underlying Twelve Step Fellowships?

A Constructivist Grounded Theory Study

Abstract

Aims: This study aimed to explore the nature of recovery processes underlying twelve-step fellowships. The introduction gave an overview of addiction theory, fellowship principles and quantitative efficacy studies. I outlined my rationale for the necessity for research into the mechanisms of change that members experience during their journeys to recovery utilising the fellowships.

Methods: Constructivist theory laid out by Charmaz (2006) was deemed to be the most appropriate method for doing this given the research focus and my position as a researcher. Nine qualitative interviews, consisting of six sampling, two theoretical and one negative case, were conducted and analysed using Nvivo computer software.

Findings: Seven main categories were uncovered which crystallised around a core category of 'striving for and maintaining recovery'. Problems with the fellowships and alternative perspectives were also outlined. A model of the theory was presented, as well as models for each of the main categories and their sub-category interactions.

Discussion: This study has demonstrated that there are several implicit and explicit mechanisms of change involved in fellowship recovery: Working a Programme, Connecting With Other Addicts, Creating Change, Going to Any Lengths, Understanding Addiction and Coming to Believe. Problems with the fellowships include: coping with unhelpful members, the concept of 'God', old-fashioned concepts and lack of awareness of the fellowships. This theory brings together the elements of recovery into a cohesive whole. An evaluation and implications of the study are explored. My conclusions are supported by similar findings from other well-respected researchers and have shown that the fellowship programme is based on valid psychological principles.

KEY WORDS: TWELVE STEP FELLOWSHIPS, RECOVERY PROCESSES, MECHANISMS OF CHANGE, NVIVO, CONSTRUCTIVIST GROUNDED THEORY, INSIDER PERSPECTIVE.

Chapter 1: Introduction

1.1: Overview

This chapter outlines the reasoning behind conducting research on recovery processes underlying twelve-step fellowships. First it situates the historical and current thinking on theories of addiction and recovery. Then it moves onto introducing the fundamental structure of twelve-step fellowships and the recovery principles behind each element of the programme; followed by a look at criticisms levelled at the fellowship programme. A summary of the quantitative research conducted on fellowship efficacy is then given. This contextualises the rationale for this current research, which focuses on recovery processes using a qualitative grounded theory methodology. Finally, my relationship with the research topic is revealed and explored reflexively at the end of the chapter.

In keeping with the inductive nature of grounded theory research (Glaser & Strauss, 1967), the literature review was delayed until after the initial analytic exploration was completed. As such, the literature laid out in this chapter consists of what was necessary to the framing of the research question and is not a comprehensive review of current thinking around processes of change inherent in fellowship recovery. What became clear from this review of the literature, however, was that there is a lack of research in this area and this gave a persuasive reason for the focus of the study.

1.2: Background on the Concept of Addiction

While this thesis is not primarily concerned with conceptualising what addiction is and how it manifests, it is important that to outline current thinking and my personal stance on addiction. This outline will enable a better definition and discussion of the pathways to recovery, specifically the pathway offered by twelve step fellowships. Unfortunately

there is a ‘conceptual chaos' (Shaffer, 1996) around the concept of addiction. Many professionals have differing views on what exactly addiction is, what causes it and how to diagnose individuals as suffering from addiction in a clinically meaningful sense. The DSM-V and DSM-IV defined addiction as a “*maladaptive pattern leading to clinically significant impairment or distress for at least 12 months*”, with the presentation of two or more of the following criteria: compulsion, impaired control, withdrawal, tolerance and an inability to stop despite adverse consequences (American Psychiatric Association, 2006 p.16, 2013). Paris (2013) points out that these criteria provide a way of distinguishing between normality and a clinical relevant mental disorder. However, the DSM definition and criteria merely provide a way for clinicians to diagnose someone as an addict; they do not address the complex realities of individuals who struggle with addiction. Therefore, it is important to outline some common core features of addiction, giving more of a sense of how addiction affects them.

Often addictive behaviours begin as a coping strategy (Kardefelt-Winther et al., 2017). They thus serve a personal function such as mood modification (Orford, 2001), tension relief (Peele, 1979), or to mask or control underlying emotional and relational processes (Denzin, 1997; Larkin & Griffiths, 2002). Over time individuals experience a subjective loss of control (Marlatt et al., 1988) and the behaviour becomes compulsive (Leshner, 1997, 2001). Meaning the individual is unable to stop or moderate voluntarily without help, (Larkin, Wood, & Griffiths, 2006; Orford, 2001) and is often accompanied by obsessive thinking (Carlton K. Erickson, 2011; Carlton K Erickson & White, 2009). This continues despite the long term negative consequences of the self-destructive behaviour (Erickson, 2011; Larkin et al., 2006), which can affect an individuals health and social circumstances (Marlatt et al., 1988). Nonetheless, addictive behaviour patterns are repetitive and chronic (Larkin et al., 2006; Ohlms, 1995), with these behaviours being repeated for many years in some cases. Addiction is also characterised by high relapse

rates (Marlatt et al., 1988), with relapses caused not just by a physical craving but also because of poor coping strategies and other factors (Marlatt & Donovan, 2008).

Some clinicians believe that addiction is an imprecise term (Carlton K. Erickson, 2011; Leshner, 2001) and other adjectives describe the addictive experience better; alternative proposed terms included Orfords "*excessive appetite behaviour*" (2001, p.2), or impulsive or compulsive behaviours (Marlatt et al., 1988). Additionally, other clinicians believe that the term addiction has overly negative connotations and unfairly stigmatises people because it places all addicts at the edges of normal society regardless of their individual stories (Michael Larkin et al., 2006). Because addiction is at the extreme end of a continuum or spectrum of normal behaviours and experiences (Griffiths, 2005); Peele (1979) makes the argument that everyone can find addictive process at play in their lives. So this distinction between someone who is normal and who is an addict is inaccurate as there appears to be no discreet point at which "*normality ends and abnormality begins*" (Orford, 2001, p.29). However, although this is an important debate, for pragmatic purposes this thesis shall use the term addiction and leave the terminology debate for future consideration.

1.3 Theories of Addiction

Over the years there have many theories on the causes and mechanisms of addiction. Because of the dynamic nature of the advances in understanding, no one theory has entirely been able to cover all aspects of the topic. Rasmussen (2000) divided up these theories into three types of models: conventional models, such as the disease model and medical model; contemporary models, such as biological, psychological and sociocultural theories; and comprehensive models, such as the biopsychosocial model. Yet it is important to note that these three types of model overlap at many points. I shall give a brief overview of these in the following sections.

1.3.1: Medical (Or Physical Dependency) Model

For most of the early twentieth century concepts of addiction mostly focused on a physical dependence to either alcohol or drugs (Berridge, 1997) and some researchers believe that addiction research should only focus on those substances which can be described as producing physical dependence symptoms (Akers, 1991). The view that addiction is solely a physical dependence has traditionally continued to dominate professional psychiatric thinking in the field (Claridge & Davies, 2003). Leshner (2001), on the other hand, believes the distinction between physical and psychological dependencies to be archaic. Larkin and colleagues (2006) call the physical dependency model an 'oversimplification' that shows a lack of a full understanding of the complex processes at play within addicted individuals. It stands to reason that if a physical dependency is the only cause of addiction, then any one detoxified from their physical dependency would be 'cured' of their addiction (O'Brien & McLellan, 1996). One only has to look at relapse rates of such individuals to see that this is not the case; for example, Gossop et al., (1989) found that 71% of those treated for opiate dependency relapsed within six weeks. It also fails to take into account contextual factors that play a role in addiction, as displayed by heroin-addicted soldiers returning from the Vietnam war, who previously displayed no signs of addictive tendencies (Robins, Helzer, & Davis, 1975).

1.3.2: Disease Model

In light of the weaknesses inherent in the medical model, clinicians working with alcoholics have posited the idea that addiction was not a moral weakness but instead is a disease of the mind and body. It was most notably outlined by Dr Silkworth, in the chapter The Doctors Opinion, in the Alcoholics Anonymous Basic Text (Alcoholics Anonymous, 1939). It was then developed further by well-respected physicians, such as Mann (1950) and Jellinek (1960) and is now the commonly held opinion among addiction clinicians and biomedical researchers (Erickson & White, 2009; Gitlow, 1973; Leshner,

1997; Ohlms, 1995; Orford, 2001). However, this disease cannot be understood as a usual physical illness does, rather it is best understood as an emotional and relational disease (Denzin, 1997), that is expressed in the form of compulsive behaviours (Leshner, 2001).

This is not to say that the medicalised disease model is without its limitations, and there have been several vocal detractors (Davies, 2001; Fingarette, 1988; Peele, 1985) who disagree entirely with the concept. There is not space in this paper to give a full overview of the intricacies of the arguments for and against the disease model. Therefore, I will take a pragmatic view similar to Gitlow (1973), that until there is a more fitting alternative and since the World Health Organization considers addiction to be a disease, it befits me to as well.

1.3.3: Biological, Psychological and Socio-cultural Theories

These contemporary models of addiction can be divided into three 'types' of explanation; neurobiological, psychological and socio-cultural (Teesson, Hall, Proudfoot, & Degenhardt, 2012). Mitcheson and colleagues (2010) believed that as addiction researched is such a dynamic field, one must consider the value of the range of differing levels of theoretical explanations available, as these are 'intermingled' and not 'mutually exclusive' (Teesson et al., 2012) . As such, I shall give an overview of those that follow on from the disease model and feed into the biopsychosocial model.

1.3.3.1 Neuroscientific and Biological – Neurobiological

Neurobiological theories attempt to explain addiction in terms of the biological effects of substances on the brain. As we understand more about how the structure of the brain works, neurobiological studies have advanced addiction knowledge to a more contemporary understanding and shown evidence for the disease model. Brain

mechanisms and changes have been discovered in the brains of addicted persons when compared to non-addicted individuals (Leshner, 1997).

Erickson (2007) points out that the neuroscientific evidence linking alcohol and drug dependence to dysregulations in neurotransmitter functioning is extensive. The mesolimbic dopamine reward system (Blum et al., 2013; Fricchione, 2014), also known as the pleasure and reward pathway, is hypothesised to be 'highjacked' (Leshner, 2001), which leads to the inability to control addictive impulses (Erickson, 2011). There is also evidence of the endogenous opioid system is impacted not only by opiate based substances (Koob & Le Moal, 2006), causing tolerance and dependence, but also in the rewarding effects of other psychoactive substances (Teesson et al., 2012).

Drug dependence is also theorised to be based on neuro-adaptation (Koob & Le Moal, 2006), which postulates that changes occur over time until they "*reach a threshold at which the primary symptom of dependence occurs*" (Erickson & White, 2009, p. 339). This leads to long lasting changes in the brain function, which can affect cognition, memory and emotions that persist even after the addictive behaviour stops (Koob et al., 2004). Then once use of the substance is discontinued, the brain's 'homeostatis' is 'disrupted' (Koob & Le Moal, 1997), leading to symptoms of withdrawal. This appears to occur regardless of substance, pointing to common brain mechanisms underlying all addictions (Leshner, 1997). The problem with this theory is that there is little currently known about how these pathways can be reversed to achieve long-term recovery (Erickson & White, 2009). Therefore, more research needs to be conducted to understand the neural pathways to and recovery from this dysregulation of the mesolimbic dopamine system and endogenous opioid system. Koob and Le Moal (1997) also recommend integrating neuroscientific understanding with psychological understanding.

Genetic biology is also hypothesised to underlie addiction (Teesson et al., 2012), as people may inherit an increased vulnerability of developing a dependency problem. It has been found that substance and alcohol use disorder cluster in families (Kendler, Prescott, Myers, & Neale, 2003), however it is hard to gain a complete understanding of how much of this is related to genetic and how much to environmental factors. No single gene has been identified that relates directly to drug abuse (Teesson et al., 2012). Further, while there have been significant links found, it is not the case for every person dependent on substances also has a relative who is substance dependent. Similarly, just because you have a close relation who struggles with addiction it does not mean you are also destined to become an addict.

1.3.3.2 Psychological Theories – Cognitive and Behavioural, Rationale Choice, Personality, Psychodynamic Theories

Rasmussen (2000) pointed out that since addiction has come to be widely recognised to be a disease in itself rather than a symptom of another mental illness, there have been numerous psychological theories postulated and these have served to increase our understanding of addiction and its treatment options. These include Cognitive, behavioural, personality, rationale choice, and psychodynamic theories.

1.3.3.2.1 Cognitive and Behavioural theory

Cognitive and Behavioural constructs of addiction theories are numerous and have had several reiterations since Beck's (1976) cognitive model was adapted for substance misuse treatment (Beck, Wright, Newman, & Liese, 1993). In that model addictive behaviours were hypothesised to result from an interaction between levels of belief, such as substance-related beliefs that have developed from life experiences are 'activated' and this gives rise to automatic thoughts and triggers cravings (Mitcheson et al., 2010). Further to this Marlatt and Gordon (1985) postulated a social learning model of drug

relapse, and in this they expanded on Beck's theory but also discussed cognitive processes such as denial and rationalisation which can trigger a relapse is no coping strategies have been developed. However in the assessments of cognitive social learning theory little has been uncovered into the relationship between coping and craving (Niaura, 2000). Siegel (1983) put forward a theory of addiction which placed dependence in the context of the classical conditioning theory. Here addiction is a learned behaviour where reinforcement is the main factor in the development and maintenance of addiction. It has also believed that motivational factors play a large role in addiction and recovery. Prochaska and Di Clemente's (1986) trans-theoretical model of change introduced the concept of motivation into addiction understanding and has been enormously influential (Mitcheson et al., 2010).

The drawbacks of these cognitive and behavioural addiction constructs are that they do not addresses the biological factors inherent in substance dependence or allow for the unconscious processes that are at play (Niaura, 2000).

1.3.3.2.2 Rational Choice Theory

In trying to explain why addicts voluntarily engage in self-destructive behaviours, Elster and Skog (1999) developed a theory that views addiction as a form of rational choice. This theory is interesting as it explicitly formulates addiction as a social construct which serves a particular purpose for individuals (West & Brown, 2013). In this model, addictive behaviours are a form of self-medication utilised in an attempt to cope with "*subjectively perceived problems*" (Elster & Skog, 1999, p. 18). Addicts expect the addictive behaviour to give them the benefits they seek (i.e relief from troubling thoughts) and are willing to accept the negative consequences to gain their perceived benefit. When viewed in this light, the addict feels that their chosen addiction is preferable to the alternative, i.e. coping with life without drugs. West and Brown (2013) describe how this model starts with the individual making stable preferences, then moving onto unstable preferences

and finally into objectivity irrational choices. However, the rational choice theory fails to account for unconscious processes that occur in addicted individuals or the reality that many addicts choose to go to great lengths to try to recover but ultimately don't achieve this.

1.3.3.2.3 Personality theory

The concept of an 'addictive personality' (Teesson et al., 2012) has also been posited by some theorists. Eysenck suggested that addictive behaviour fits into a psychological resource model, where "*habits are acquired because they serve as useful function for the individual… related to the personality profile of the 'addict'*" (1997, p. S79). Therefore, these behaviours serve a purpose despite the negative consequences that inevitably occur. Francis (1996) did find some evidence to support the assertion that addiction could be related to personality types are those who are more moody or anxious, or impulsive or aggressive are also more likely to have substance use problems. However, since this evidence was based on correlational evidence no causal relationship inferences should be drawn, as it is likely it may be the substances causing the changes in personality.

1.3.3.2.4 Psychodynamic Theory

Developmental psychodynamic theory has also been used to formulate how addiction evolves in an individual. Flores (2001) describes how addiction can be understood as an attachment disorder where a person engages in addictive behaviours in order to 'self-repair' psychic ruptures. This theory combining elements of Bowlby's (1973) attachment theory, Kohut's (1976) self-psychology and affect regulation theory (Fonagy, Gergely, Jurist, & Target, 2004). Conversely to the desired effects, the addictive behaviours only serve to worsen the situation as physical dependence occurs and psychological deficits are exacerbated, leading to problems with emotional regulation and increased character

pathology (Flores, 2001). The addictive behaviour delivers a euphoric emotional experience that reinforces its continued use, while at the same time inhibiting healthy emotional experiences and regulation. As the individual has a pre-existing propensity towards unhealthy attachments, the addictive behaviour serves as a new attachment figure and substitute for interpersonal relationships.

Similar to the rational choice theory, Khantzian (2003) also postulates a modern psychodynamic theory of addiction as a form of self-medication. Here the addiction develops as an 'special adaptation' in an attempt to bear 'intolerable painful' experiences and emotions. While the individual does not address these underlying developmental emotional deficits, the individual is likely to be trapped in a cycle of relapse when they try to recover. Khantzian (2003) however, emphasises that psychodynamic addiction theory should complement with other theoretical perspectives, adding a dimension to the understanding of the biopsychosocial understanding of addiction.

1.3.4: The Biopsychosocial Approach

As we can see from the brief overview of the addiction theories above, no one model completely accounts for every element of the addictive picture. Teesson and colleagues (2012) point out that each type of theoretical explanation, neurobiological, psychological and social, is supported by empirical evidence. This makes the case for the pragmatism of combining these theories into an integrative comprehensive model.

As Griffiths (2005) points out, addiction does not occur in a vacuum; rather, addiction is a social construction (Truan, 1993). The processes by which an individual becomes an addict are complex (Griffiths & Larkin, 2004; Larkin & Griffiths, 2002), and have "*multiple interacting determinants*" (Orford, 2001, p. 319); such as the individuals' cultural, political and historical contextual background (Larkin et al., 2006; Orford, 2013). A biopsychosocial approach (Cloninger, 1987), which encompasses the study of the

genetic, neurobiological, psychological, sociocultural and behavioural factors (Flores, 2007) is the only pragmatic way to view the addiction and recovery paradigm (Leshner, 2001). As such, currently the biopsychosocial model is the most commonly agreed upon approach to understanding addiction.

1.4: Behavioural Addiction

This broader approach to the causes of addiction is leading to a change in the direction of addiction understanding and research, which no longer focuses solely on substance dependence. Orford (2001) theorised that behavioural and chemical addictions have a similar phenomenology and there is now a growing body of evidence for this understanding of behavioural addictions (Griffiths, 1996, 2017). Kardefelt-Winther and colleagues proposed a definition which could encompass either a chemical or behavioural addictions, as a "*harmful, repeated and persistent behaviour*" (2017, p. 2). When viewed in this light, problem behaviours with eating, gambling, exercise and sex (Gearhardt, Corbin, & Brownell, 2009; Griffiths, 1999; Orford, 2001) could also be said to be addictive.

In light of this, the DSM-V chapter on 'Substance-Related and Addictive Disorders (American Psychiatric Association, 2013), included behavioural addictions, or non-substance-related disorders, for the first time (Paris, 2013, Kardefelt-Winther et al., 2017). This signifies a fundamental shift towards a more progressive conceptualisation of addictive processes. However, Kardefelt-Winther et al., (2017) warned against broadening the scope of addiction diagnosis too much, for fear of pathologising common behaviours. The need for a formalisation of the criteria for addictions led to Griffiths (2005) outlining what he believed to be essential components for a diagnosis of addiction: Salience, Mood Modification, Tolerance, Withdrawal, Conflict and Relapse. If

these were present in an individual's presentation, then they could be understood as suffering from a clinically relevant addiction regardless of what the object of addiction is.

A more humanistic approach to this problem is to trust in an individual's self-diagnosis. It could be argued that if a person believes they have an addiction problem, then it is not appropriate for a clinician to argue against their subjective experience (Denzin, 1997). This is the philosophy of twelve-step fellowships; if a person feels they need to seek help for what they consider to be an addiction, the variety of fellowships ensure that there is a place for them to go, regardless of clinical opinion.

1.5: Recovery and Treatment

The NHS provides treatment for drug and alcohol addiction, which has proven to be not only effective (Gossop, 2006), but also cost-effective in the long term (Godfrey, Stewart, & Gossop, 2004). Unfortunately, while treatment funding is consistently reduced, this results in severe budget constraints, not all those who would benefit from treatment can access it. Public Health England (2014a) published findings identifying 1.6 million people as suffering from alcohol dependence in 2013-2014. However, only 114,920 adults received alcohol treatment through the NHS. The substance misuse statistics (Health and Social Care Information Centre, 2015) showed that only 39% individuals who were in contact with drug and alcohol services in 2014-15, started treatment within the year.

The options are significantly increased if addicted individuals pay to go to private treatment centres. However, these are often prohibitively expensive for the majority of addicts, especially given that suffering from addiction is significantly linked to economic deprivation (Public Health England, 2013). So alternative options must be sourced to help address this gap in help for those who need it. Additionally, O'Brien and McLellan (1996) argue, meaningful change is unlikely to occur from a single event treatment, so

any treatment for addiction should be effective in the long-term; with help being provided over a longer period than for a medical detoxification (Diaper, Law, & Melichar, 2013).

Psychologists thus have a unique role to play in researching addiction and recovery treatment alternatives, and in evaluating whether they are viable and effective. Already the greater understanding of the complexities of addiction and recovery has led to a greater understanding of more effective methods for treatment (Larkin & Griffiths, 2002; White, 2007). It remains to be determined what exactly constitutes 'recovery'? Laudet (2007) conducted a mixed methods study into the nature of recovery, finding that the concept is poorly understood, and this hinders the evaluation of treatment effectiveness. The majority defined recovery as total abstinence but also that recovery went beyond this. It was experienced as a "new life" incorporating an ongoing process of growth, self-change and reclamation of self. Whereas, White defined recovery as a multidimensional process that depends upon a person's capacity to "*actively manage their continued vulnerability*" as part of developing "*a healthy, productive, and meaningful life*" (2007, p.236).

There is now a growing humanistic recovery movement (Dossett, 2015; Laudet & Humphreys, 2013), which believes that those who suffer from addictions should be given a greater voice in the field of treatments for addiction. Neale and colleagues (2015) found that services users experience recovery as a process that involves learning to cope, rather than trying to cure. This means a shift in perspectives, from pathologising addiction to creating a greater focus on resilience and recovery (Laudet, 2007; White, 2005). There is a need for flexible resources which provide more agency and choice, to facilitate the changes needed for recovery (Larkin et al., 2006). However, Laudet and White (2010) point out that the current treatment model is to provide short-term treatments which are focused on symptoms, rather than long-term sustainability. In light of this, the current "*quality of recovery*" (Erickson & White, 2009, p. 340) that an individual can achieve will

depend largely upon their ability to incorporate personal and community resources into a long-term recovery plan.

One type of recovery resource already in widespread use is Twelve-Step Fellowships (TSFs). These community-based, volunteer-led support groups, which are available to anyone seeking help, provide an extensive and easily-accessible informal care structure to addicts (Moos & Timko, 2008). It was found that 77% of patients attending a drug and alcohol treatment facility had previously attended NA or AA meetings (Best et al., 2001) and over half of those had been referred by their GP, or other NHS treatment resource (Gossop, 2006). Although not as popular as in the US, where their influence is widespread (Kaskutas, Ye, Greenfield, Witbrodt, & Bond, 2008; Room & Greenfield, 1993), fellowships have taken root in the UK and have strong, stable membership numbers. The twelve step fellowships are based on the principles of twelve steps to recovery and twelve traditions for running the fellowship meetings. Underlying these principles are the primary concepts of addiction as a disease, meeting attendance, mutual aid, personal growth through completing the steps and increased spirituality. For an in-depth description of the fellowships please see Appendix A.

1.6: Criticisms of Twelve-Step Fellowships

There are some vocal critics of the fellowships, and some of the main concerns sceptics have are outlined below. First, there is some debate as to whether the fellowships have been proven to be effective in helping those with addictions. Dodes (2014) believes that research indicates only five to eight percent of individuals gain recovery longer than a year. However, Beresford (2016) questions Dodes' mathematical calculations, and Kaskutas (2009) points out that the research literature on efficacy is subject to interpretation depending on the viewpoint of who is reading it.

Second, the fellowships promote the view that ‘it works, if you work it’ (Laudet, 2003) but, as Glaser (2015) points out, this puts the blame on the member if they do not manage to achieve long-term abstinence. It may instead be the case that the programme just does not work for everyone, no matter how hard they try (Fuller, 1993). Dodes (2002) highlights that while he does believe that fellowships are effective for some people, it is not a ‘one size fits all' approach.

Third, Peele (2011) criticises the fellowships for overemphasising their success believing that other treatments, such as motivational interviewing and brief interventions, have shown better outcomes. He also admits that these treatments share many common characteristics with the fellowship programme. Peele (2011) then accuses the fellowships of ‘jealousy' and disinterest' in other forms of treatment. The fellowships, however, have not suggested that their way is the only way, just that they believe their way works (The Betty Ford Institute Consensus Panel, 2007).

Fourth, Glaser (2015) points out that many addicts also suffer from mental health problems, and the fellowships are not ‘equipped' to address these issues. It is true that having untrained members advising on mental health problems could have the potential to cause more harm than good, especially if members are discouraged from accessing professional help or taking medication. In reality, though, members are welcome to seek out other forms of help or leave altogether if they feel they need it (Nowinksi, 2015); "*a mental health professional can assist us in understanding our illness and explain our treatment options*" (Narcotics Anonymous, 2010. p.20-21).

The fifth criticism of the fellowships is that they are based on an outdated and unscientific understanding of addiction that has not been updated since its founding. There have been some findings that contradict some of its tenets, particularly around whether the concept of addiction being a progressive disease is factual (Vaillant, 2005). However

many members find that the majority of the fellowship's assertions around addiction and recovery remain as true today as when it began (Nowinski, 2015).

Sixth, there is some debate over whether moderation is possible (Ohlms, 1995; Peele, 1985). Peele (1995) condemns the fellowship approach for its advocacy of abstinence because he believes that a harm-reduction model is a more pragmatic approach which increases self-efficacy (Peele, 2011). However, may have overlooked that most of the people who seek recovery through the fellowships have already tried to moderate and failed. Leshner (2001) believes that once a person becomes truly addicted, they have crossed a ‘threshold', from which few can successfully moderate. While Gitlow (2007) points out that the majority of professionals are clear that moderation is unlikely to lead to a meaningful recovery in the long term.

The seventh criticism of fellowships is that they are similar to cults (Bufe, 1998). Despite the fellowship's continual assurance that it is a spiritual, not religious programme, sceptics like Bufe (1998) and Ragge (1991) remain unpersuaded by this. Laudet (2003) found that over half the substance users and clinicians in their study believed that the ‘religious aspect' of the programme was an obstacle, which shows that the confusion around whether to programme is truly spiritual or religious, is still a large concern for many.

The final criticism that many psychologists cite is the fellowship's emphasis powerlessness and surrender (Laudet, 2003), arguing that it reduces self-efficacy and self-actualisation. Truan (1993) believes that the programme takes away future chances for a normal life because it insists on dependence on the group. Members are taught to internalise a ‘self-fulfilling prophesy' (Nixon & Solowoniuk, 2008), where if they leave the fellowships they will eventually relapse. Thus, members might be afraid to leave in a fashion similar to cults (F. Alexander & Rollins, 1984). Yet, as Vaillant (2005) points out,

the original AA doctrine incorporated principles, such as the traditions, specifically to protect AA from becoming a cult.

Nowinksi (2015) points out that the fellowships' policy of silence, means that it does not respond to its critics and it does not correct the inaccurate information that is sometimes ascribed to the programme. Instead, it relies on members to spread the message of hope to still suffering addicts, relying on the positive changes they have made in their recovery to attest the advantages of the fellowships. An alternative way knowledge fellowships has been spread, is by psychologists who have investigated them and become convinced of their effectiveness as a programme of recovery. The evidence gathered on the efficacy of the fellowships is outlined below; including membership surveys, quantitative, and qualitative studies published by psychologists working in the field of addiction.

1.7: Membership Statistics

1.7.1: Alcoholics Anonymous Membership Statistics

Alcoholics Anonymous is the largest TSF and was founded in 1939. At the last membership survey there were 115,000 meetings worldwide and over 2 million members (AA World Services, 2014), with 4487 meetings in Great Britain and an estimated UK membership of up to 40,000 (Alcoholics Anonymous Great Britain, 2015). Below is Table 1, providing some of the data gathered from more recent membership surveys, from the UK, EU and Worldwide services (AA World Services, 2014, 2005; Alcoholics Anonymous Great Britain, 2005, 2010, 2015).

Membership Survey	UK 2015	UK 2010	UK 2005	UK 2002	World 2014	World 2001	World 2007	EU 2005
Ratio Male to Female	60:40	60:40	61:39	60:40	62:38	65:35	67:33	63:37
Under 1 Year Sobriety	27%	26%	27%	25%	27%	27%	31%	20%
Over 1 Year Sobriety	73%	74%	73%	75%	73%	73%	69%	80%
Over 10 Years Sobriety	32%	31%	28%	29%	36%	33%	36%	46%

Table 1: Membership survey findings from UK, EU and Worldwide AA services.

It is interesting to note that membership appears to be stable when it comes to sobriety lengths and gender ratio. An average of 27% report sobriety for a year, 73% over a year, and 34% have over ten years' of sobriety. There are more male to females, but the percentage of females makes up a significant portion of the membership.

1.7.2: Narcotics Anonymous Membership Statistics

Narcotics Anonymous (NA) is the second largest 12-step fellowship, founded in 1953 with 67,000 meetings in 139 countries (NA World Services, 2016b). Below is Table 2, providing some of the data gathered from recent membership surveys, from the EU and Worldwide services (NA World Services, 2016a, 2014, 2016b).

Membership Survey	World 2015	World 2013	EU 2015*
Ratio Male to Female	59:41	57:43	57:25:18
Under 1 Year Sobriety	8%	9%	8%
Over 1 Year Sobriety	92%	91%	92%
Over 10 Years Sobriety	47%	41%	33%

* N.B. The EU survey included the possibility for respondents to identify as other than male or female.

Table 2: Membership survey findings EU and Worldwide NA services.

There is far less membership data then for AA because NA has not conducted regular membership surveys. However what data is available gives us a similar picture. An average of 8.5% have a year abstinence, 92% have over a year, and 47% have over ten years. There is an approximate gender ratio average of 60% male to 40% female (or other).

1.7.3: Disengagement Rates

While the figures mentioned above seem impressive, it is important to note that these are the figures for members who are present in meetings at the time these surveys are being conducted. This picture does not include data on how many have disengaged from the fellowships. Because of the anonymous nature of the fellowships, meetings do not keep records of who attends them, how often and for how long. This means that it is difficult to gather information on the numerous people who come only occasionally, or attend fellowships for a short period and disengage, or disengage then return at a later date.

Combining and analysing membership surveys from 1977-1989 did yield some information about this, although this has not been updated since 1990. Alcoholics Anonymous (1990) reported that 50% drop out by three months, and by twelve months 90% have dropped out. So longer term attendance appears to happen only for a select few of those who go to AA meetings (Miller & McCrady, 1993b).

Another important factor to consider when reporting retention rates is that one cannot assume that a drop out is necessarily someone who has relapsed or have found the fellowships to be unhelpful. While it is undoubtedly the case that some people come to meetings and do not find it helpful in their search for abstinence and recovery; it could equally be the case that those who have found fellowships helpful, no longer attend because they believe they have gained a stable recovery and wish to return to their normal lives. It is also important to note that members who have a vested interest in the fellowships conduct these membership surveys and so it could be argued that they have the potential for not being a truly objective rendering of the results. However, with the fellowships focus on behaving honestly and ethically this perhaps increases the likelihood of statistical accuracy.

1.8: Research into Fellowships

In the following sub-sections below some of the quantitative research is presented, which lends strong weighting to the viewpoint that the TSF programme is effective in helping addicts achieve recovery. It is important to note that many of these quantitative studies are correlational in nature. Recent qualitative research findings have also been included where available and appropriate.

1.8.1: Statement of Clarity

In the interests of clarity, it is important to note that the majority of research conducted on TSF's has been conducted on AA (Humphreys, Moos, & Finney, 1995; Kaskutas et al., 2005; Moos & Moos, 2005). Recently though, fellowship research has diversified to include substance use fellowships such as NA and CA (DeLucia et al., 2016; Kelly & White, 2012; Witbrodt et al., 2014). As such, when I discuss efficacy outcomes I will use the word abstinence; this could mean from alcohol or drugs.

1.8.2: Project Match

In 1989, the NIAAA (National Institute on Alcohol Abuse and Alcoholism) conducted a matched sample randomised control trial (Project Match, 1993, 1997a, 1997b, 1998) to investigate comparisons between types of addiction treatment (Nowinksi, 2015). Project MATCH brought together respected alcohol treatment researchers of that time to conduct a national longitudinal inpatient and outpatient study (Nowinski, 2015).

Data was gathered over seven years, from 1,726 patients who had been diagnosed with an alcohol use disorder and followed up three years after treatment (Project Match, 1997a, 1998). Patients were randomly assigned to one of three alcohol dependency treatments, each of which ran for 12 weeks and were delivered by professionals (Project Match, 1997a). These being: cognitive behavioural therapy (CBT; Kadden et al., 1992; Monti et al., 1989), motivational enhancement therapy (MET; Miller, et al., 1992; Prochaska, Diclemente, & Norcross, 1992) and Twelve-Step Facilitation Therapy (TSF; Nowinski et al., 1992) which was adapted from the twelve-step programme laid out in AA (Alcoholics Anonymous, 1939, 2001).

This was the first time rigorous research had been conducted on the approach, and it was expected that the TSF treatment approach would not perform as well as the other

two (Nowinski, 2015). However, the study found that all three treatments helped patients attain significant and sustained improvements with their alcohol use (Project Match, 1997a). Indeed those without other pathologies gained significantly more abstinence in the TSF group than the CBT group (Project Match, 1997a). Also, those who had higher dependency showed more improvements after TSF and those with lower dependency did better in the CBT intervention (Project Match, 1997b). At the three-year follow-up, TSF showed a slight advantage over the other two treatments, showing that improvements could be maintained in the longer term (Project Match, 1998).

1.8:3 Meta-Analyses

Conducting meta-analyses are important because as Humphreys (2004) points out, when studies are combined in large meta-analysis, the problem of self-selection bias is mitigated. Emrick and Tonigan led a research team which conducted two comprehensive meta-analyses into the effectiveness of AA (Emrick et al., 1993; Tonigan, Toscova, & Miller, 1996). They reviewed over 200 studies to estimate the size of the effect AA involvement had on drinking outcomes. Although there is some debate as to the inferential effectiveness of these studies as they rely mostly on correlational analysis.

Both found that AA involvement was related to positive drinking outcomes. Emrick and colleagues (1993) found a modest positive correlation with psychological health and social functioning. They concluded that individuals, who invested more of themselves into the programme, experienced better drinking outcomes and improved quality of life. They also found that positive outcomes were linked to having and being a sponsor, working steps 6-12, carrying the message to other alcoholics, doing service and increased participation. Tonigan et al., (1996) found that despite the variety of meetings, overall AA experiences and outcomes are heterogeneous between AA members; which is important because it addresses fellowship quality control concerns.

1.8.4: Short-Term and Long-Term Recovery Outcomes

The evidence suggests that TSF attendance correlates positively with improved abstinence (Kelly, Stout, Magill, Tonigan, & Pagano, 2010); this positive relationship has also been foud to be causal in nature and cannot be attributed to other factors, like motivation or psychopathology (Magura, Cleland, & Tonigan, 2013; McKellar, Stewart, & Humphreys, 2003; Witbrodt et al., 2014). The fellowships have consistently been shown to have a positive effect on both short term outcomes (Cloud, Ziegler, & Blondell, 2004; Fiorentine, 1999; Timko & Debenedetti, 2007) and long term outcomes (Gossop et al., 2008; Kaskutas et al., 2005; Laudet et al., 2002; Moos & Moos, 2005, 2006; Pagano et al., 2013; Tonigan, 2001; Vaillant et al., 1983; Witbrodt et al., 2014). For example, Cloud, Ziegler and Blondell (2004) showed that AA affiliation predicted positive one-year drinking outcomes. Whereas Moos and Moos (2005, 2006) conducted a naturalistic longitudinal study which found that twelve-step attendees had better substance use outcomes than those who did not attend, at each follow up in years 1, 3, 8 & 16. Indeed the longer people remained active in AA, the more likely they were to stay abstinent (Moos & Moos, 2005).

These longer term findings are particularly relevant because as Hser et al., (1997) point out the recovery process is often cyclical, with periods of abstinence, relapse and treatments over the course of one's life. It appears from the longitudinal evidence that TSF's help to break this lifetime pattern. The most recent membership surveys of AA and NA show between 22-25% of members have over 20 years abstinence (AA World Services, 2014; NA World Services, 2016b). As we have mentioned there is the possibility that these membership surveys are biased, but there is corroboration from other research findings. For example, DeLucia et al. (2016) gathered data from NA members with up to 33 years abstinence. Shinebourne and Smith (2011) qualitatively explored the experiences and understandings of women who have engaged in AA and

are in long term recovery. They found that despite having, 15 or more, years of recovery, these women continued to engage in recovery practices, seeing them as an act of self-care. They noted that their involvement in AA activities and processes became habitually interwoven into their daily lives.

1.8.5: Attendance Patterns

Within those who attend TSFs, there are different patterns of engagement between the members and these have also been studied vis-a-vis their links to positive outcomes. Kaskutas et al. (2005) explored these patterns and found that the evidence was "*consistent with anecdotal data*" (p.1983); some never feel comfortable going to meetings, some do but disengage early on, some connect with the programme long term but it does not become part of their daily routine, while others go to meetings every day long term.

The most commonly researched engagement pattern is the frequency of meeting attendance and its links to recovery rates. Studies suggest that the more often individuals attend meetings the more likely they are to achieve abstinence in both the short term and the long term (Gossop et al., 2008; Humphreys, Blodgett, & Wagner, 2014; Moos & Timko, 2011; Pagano et al., 2013; Timko, Billow, & DeBenedetti, 2006; Witbrodt et al., 2014; Zemore, Subbaraman, & Tonigan, 2013). Kaskutas et al. (2005) conducted a longitudinal study over five years, whose results supported the hypothesis that continuous and more frequent meeting attendance, with steady active engagement, in the fellowships is linked to a better chance of recovery. Laudet & White (2007, cited in Laudet, 2008) also found that continuous attendance over a three-year period increases the likelihood of sustained abstinence.

1.8.6: Disengagement

The high disengagement rates found in the membership surveys have been discussed above but what do these disengagement rates mean for chances of recovery and are they markedly different from formal treatment? Disengagement rates in the first three months of substance misuse programmes have been estimated to be 50% or more (Palmer et al., 2009). Loveland & Driscoll (2014) conducted a meta-analysis and found that 80% of people who requested treatment dropped out between initially asking for help and completion of the treatment programme. Therefore, these attrition rates appear to be high for all forms of addiction treatment and not specifically for fellowships. What might be a more useful discussion than disengagement rates is why people disengage; is this due to factors specific to treatment modality, or due to individual factors such as readiness to change.

Moos and Moos (2005) found that those who disengaged from fellowships were less likely to gain recovery or maintain it if achieved. Kaskutas and colleagues (2005) not only found that the early disengagers had much lower recovery rates long term, but also that those who disengaged after a period of lengthy intense involvement had recovery rates which were not far off those of the other two stable attendance groups. Therefore, it appears that disengagement from meetings does not necessarily mean a significant reduction in recovery rates as long as initial involvement was high. Kaskutas et al. (2005) termed this ‘positive disengagement' because the reasons people reduce their meeting attendance could be for positive reasons, such as returning to productive lives outside of fellowships.

Kaskutas et al. (2005) also found that a third of those who had mostly stopped going to meetings, still identified as members of the fellowship. Some explanation for why their recovery rate was higher than expected could be that they had incorporated fellowship

philosophy into their life and still 'felt like' members. Cloud, Ziegler and Blondell (2004) also found that identifying as a member was one of their main predictors of recovery.

1.8.7: Engagement in Fellowship Activities and Acceptance of Beliefs

Kaskutas et al. (2005) felt that to understand better how recovery is operationalised in fellowships, studies should focus on which elements are linked to increased recovery rates. The most commonly cited fellowship activity that is linked to increased abstinence rates is having a sponsor (Cloud et al., 2004; DeLucia et al., 2016; Johnson et al., 2006; Pagano, Friend, Tonigan, & Stout, 2004; Timko et al., 2006; Zemore et al., 2013). Working the steps has also been found to lead to increased abstinence (Cloud et al., 2004; Greenfield & Tonigan, 2012; Timko et al., 2006); as has having a home group (DeLucia et al., 2016; Zemore et al., 2013); doing service (DeLucia et al., 2016; Zemore et al., 2013); reading fellowship literature (Johnson et al., 2006; Zemore et al., 2013); helping others (DeLucia et al., 2016; Pagano et al., 2004, 2013); and engagement in the social network (Kaskutas, Bond, & Humphreys, 2002). It has also been found that greater involvement in fellowship activities, outside of meeting attendance, is a strong predictor for abstinence (McKellar et al., 2003; Timko et al., 2006; Weiss et al., 2000).

Tonigan (2008) observed that the full benefit from fellowships is not attained without engagement in programme activities and practicing the principles that they advocate. Through qualitative analysis Cloud et al. (2007) found three related behaviours that improved fellowship affiliation and acculturation: internalising the norms, values and beliefs, engaging in sponsorship and peer mentoring, identifying at and enjoyment of meetings. They also found that if there was ambivalence related to any of these three factors this reduced the motivation to engage. Similarly, Timko, Billow and DeBenedetti (2006) found that the factors that most strongly predicted abstinence were not only involvement but also acceptance of fellowship beliefs. These beliefs included: committing to their abstinence, addiction as a disease, the unmanageability of their

previous lives and also the spiritual element of the programme. So, it appears that, as Nowinski (2015) points out, "*action combined with belief predicts recovery"* (p. 31).

1.8.8: Other Benefits to Fellowship Recovery

Although active involvement in fellowships helps with abstinence, there are other benefits besides freedom from active addiction. DeLucia et al. (2016) believe that the efficacy of fellowships can be measured not just by abstinence but also from other improvements in the lives of those who attend them. This is what Kaskutas et al. (2005) call the "*AA construct of recovery*" (p.1988), where recovery is defined as "*abstinence plus improved quality of life*" (Laudet, 2011, p. 44). Moos and Timko (2011) found that members who were actively involved had better quality of life outcomes than non-members. Improvements include: the reduction in negative consequences (McKellar et al., 2003; Tonigan, 2001), improved psychological well-being (DeLucia et al., 2016; Kelly & Greene, 2013; Laudet, 2011; Tonigan, 2001) and increased existential well-being and purpose in life (DeLucia et al., 2016; Tonigan, 2001).

Green et al. (2015) conducted a mixed methods longitudinal study of dual mental health and addiction recovery. They found that flexible peer support like that offered in NA and AA can be helpful for those with serious mental illness. Additionally, through achieving abstinence this can begin a mental health recovery process too. Kelly et al. (2010) found that greater attendance was associated with decreases in depression; and they postulated that this improvement in psychological well-being might also serve to reinforce further abstinence. But they also pointed out that these changes could be caused merely by the reduction in alcohol consumption. However, Delucia et al. (2016) found that duration of abstinence did not predict psychological well-being. Indicating that there are other factors, beyond abstinence, which add to an increase in psychological well-being. For example, DeLucia et al. (2016) also found that home group comfort was linked to lower levels of depression and was positively correlated with all their scales that

measured psychological well-being (self-acceptance, purpose in life, personal growth and positive relations with others).

1.8.9: Links to and Comparisons with Professional Treatments

Because clients who attend fellowships after treatment are more likely to be abstinent at follow up, fellowships appear to maintain recovery gains made in treatment (Gossop et al., 2008; Laudet, 2003; McKellar et al., 2003; Witbrodt et al., 2014). Because of this, fellowships have been utilised by most treatment centres as part of their recommended aftercare approach (Miller & McCrady, 1993b), with many inpatient treatment programmes highlighting the importance of ongoing twelve-step attendance (Humphreys & Moos, 2001). Estimates of those attending fellowships after treatment range from 56-75% (Humphreys et al., 1999; Tonigan, 2001). Laudet et al. (2007, cited in Laudet, 2008) showed that holding TSFs onsite in outpatient treatment increases the likelihood of abstinence one-year post-treatment by six times.

Dossett (2013) points out the Minnesota Model (Anderson, McGovern, & DuPont, 1999; McElrath, 1997), which is based upon twelve-step principles and techniques, has been the dominant theory in contemporary recovery for several decades. Many treatment centres, both in the US and the UK, utilise it as a treatment approach. Such programmes emphasize twelve-step concepts, have staff members who themselves are in recovery and have a spiritually orientated treatment environment (Humphreys & Moos, 2007). Humphreys & Moos (2001) found that patients treated in a twelve-step programme had significantly higher rates of abstinence than those who attended a CBT based programme; these results were also replicated by Humphreys & Moos, (2007) and Johnson et al. (2006).

This is not to say that twelve-step techniques and principles do not work well with other treatment modalities. Fellowship-specific concepts integrate well with more modern

psychological approaches, such as CBT, MET or Group Psychotherapy (Humphreys, 2004). Moreover, this appears to create a combined recovery effect since treatment participants who used both professional treatment and TSFs were more likely to achieve abstinence and remain so, than those who did either treatment or fellowships alone (Fiorentine & Hillhouse, 2000; Moos & Moos, 2005). Participants who had previously been to TSFs were also more likely to complete a 24-week professional treatment programme (Fiorentine & Hillhouse, 2000), and the effects work the other way too, with those who did both treatments being more likely to engage in the fellowships for longer (Moos & Moos, 2005).

1.9: Limitations of Research on the Fellowships

Because the nature of the fellowships is fluid, voluntary and anonymous, it is hard to find participants to gather data on, both in the short and long-term (Kaskutas et al., 2008). However, these difficulties are not 'insurmountable' (Institute of Medicine, 1989), but they require researchers to break free from 'traditionally valued' research designs (Miller & McCrady, 1993b). Most of the research has been conducted on samples that have been recruited through treatment centres in the United States, meaning that American inpatients have been somewhat over-represented (Humphreys, 2004). It could be argued this adds a confounding variable, as many studies do not measure recovery gained solely through fellowship attendance (Kaskutas et al., 2005). On the other hand, many studies that use samples recruited outside of treatment centres will suffer significantly from self-selection bias (Humphreys et al., 2014; Kaskutas et al., 2005).

Another problem with researching the fellowships is the homogeneity of the research object: the majority of research has been done on AA, NA or CA. This is probably because these are the most numerous fellowships and so the pool of participants is larger and easier to access (DeLucia, Bergman, Formoso, & Weinberg, 2015). However

behavioural or smaller substance-focused fellowships have mostly being overlooked, because of this fellowship research would benefit greatly from an increase in diversity.

Because of the traditions, the fellowships themselves do not facilitate research about their efficacy or mechanisms of change. However, this is not to say that the fellowships discourage research; rather they neither oppose nor endorse any research which is done (Kaskutas et al., 2008).

A significant limitation of the quantitative research conducted, and referenced in this introduction, is that many of these studies rely on making inferences from association based, correlational statistical methods. As many of the above fellowship researchers have pointed out (Kelly, 2016; Kelly, Stout, & Magill, 2011; Larkin, Wood, & Griffiths, 2006; Magura, Cleland, & Tonigan, 2013) one has to be careful about using correlational results to make generalised inferences about causality. Correlational analyses are used to "*determine the probability that the results for one variable are related to the results for another variable*" (Dane, 2017, p. 39-40). However, any inferences based on these analyses involve the researchers making assumptions, also known as a correlational fallacies, in how we interpret correlations (Haslam & McGarty, 2014). Significant correlations do not show causality, which is the evidence that one factor causes changes in another, instead of these changes being caused by a confounding variable or being unrelated altogether (Privitera, 2014). As Dane (2017) points out, unless there has been an element of random matching then the conditions needed to infer a causal relationship haven't been met. Other problematic factors which are inherent in making inferences from correlational data analysis are the effects of outliers and the restriction of range, both of which can be shown to skew the data in favour of one hypothesis (Privitera, 2014). For these reasons, it is important to point out that inferences made about fellowships being the cause of improved outcomes, should be viewed with caution.

Examples of studies that are referenced in the above sections yet utilise a correlational design are those conducted by Project Match (Emrick et al., 1993; Tonigan et al., 1996, as well as those conducted by Kelly and colleagues (Kelly, Stout, Magill, & Tonigan, 2011a, 2011b; Kelly et al., 2010; Kelly, Magill, & Stout, 2009). Therefore, it is important to frame the understanding of the effectiveness of twelve step fellowships with this in mind. While correlations between fellowship attendance and positive outcomes are useful information, this should be considered to be robust evidence only when viewed in conjunction with other studies that can measure a causal relationship and also with qualitative studies which give some insight into the lived experiences of these correlational relationships.

1.10: Rationale for This Study

1.10.1: The Problem of Addiction

Focusing on finding ways to help people suffering from addiction is imperative because the problem is widespread in the UK. For example, both alcohol and drug misuse are deemed to be a significant cause of premature deaths and a range of other health problems requiring treatment (Health and Social Care Information Centre, 2015; Public Health England, 2016a, 2016b, 2017a, 2017b). Deaths and hospital admissions due to these are increasing at an alarming rate since comparable records began in 1993 (Health and Social Care Information Centre, 2013), nearly doubling since 2005 (Public Health England, 2017b). Given that the estimated population growth for this period is 0.71% per year (Office for National Statistics, 2016) this indicates that there is a disproportionate growth of excessive alcohol or drug consumption.

It should be pointed out that these statistics focus solely on those who suffer from drink and drug addictions, but it is probable that there are also substantial numbers of

individuals who are suffering from other, less visible or understood addictions. Some progress has been made into investigating the scope of these addictive behaviours in the UK (Griffiths, 2017) and recognising the significant problems they cause to those suffering from them, as well as negative effects on our society. Accordingly the problem of addiction, both chemical and non-chemical, requires better research, treatment availability, and awareness.

1.10.2: The Place of Fellowships Within Counselling Psychology, Addiction Treatment and Research

As we noted above current fiscal constraints on healthcare providers are affecting the amount of funded professional treatments available to help tackle addiction (Laudet, 2003). Because of this, it is often hard for counselling psychologists to facilitate the help that their clients need. Fellowships are providing cost-efficient options to help relieve this strain. They run without needing resources from service providers and the costs to members, who can choose to donate at meetings, are minimal. Since they have the potential to fill an important role in addiction treatment, it is imperative that their efficacy in helping addicts to achieve meaningful long-term recovery be assured. As counselling psychologists, we must ensure that we not only evaluate which of the resources available can be of help, but also how they help. This is so that we can better advise our clients, who may need help outside of the services we can offer and make sure this advice is based on a comprehensive understanding of the subject, rather than conjecture. Research provides an unbiased and scientific way to investigate whether fellowships could be a successful part of a package of care for addicts.

The fellowships have been found to be effective as a complementary intervention (Gossop, 2006), which can in integrated well into a comprehensive care package (Fiorentine & Hillhouse, 2000). The current NICE clinical guidelines (Department of Health (England), 2007, 2011) recommend fellowship attendance as a psychosocial

intervention that can be used in the treatment of alcohol and drug use. These guidelines also state that clinicians should 'routinely' provide people with information about self-help groups based on 12-Step principles, such as AA and NA. Additionally many well respected addiction specialists have recommended that professionals working in addiction treatments should be fostering stable twelve-step attendance for their clients (Bogenschutz et al., 2014; DeLucia et al., 2016; Gossop et al., 2008; Humphreys & Moos, 2007; Laudet, 2003; Moos & Timko, 2008; Timko & Debenedetti, 2007; Weiss et al., 2000; Witbrodt et al., 2014; Zemore, Subbaraman, & Tonigan, 2013).

However, there is variability in the degree to which professionals and treatment centres advocate the use of fellowships. This may be because, as we have outlined elsewhere in this section, there are some concerns that psychological professionals have about the programme. Valliant (2005) argues that this skepticism appears to be unjustified, for it is based either on misunderstandings about the nature of the spiritual elements of the programme, or an inaccurate belief that they are not effective (Nowinski, 2015). Humphreys (2004) points out that just as research has a role to play in protecting the vulnerable against ineffectual and possibly harmful self-help organisations, it also has a duty to protect these organisations against professional guilds, which may wish to diminish and undermine the work that they do.

Despite the dispute about their suitability and efficacy in treating addiction, fellowships have shown an impressive pattern of persistence. To be still prospering after eight decades, relying solely on the dedication of volunteers is impressive (Miller & McCrady, 1993b). This suggests that something powerful and important underpins their success and this requires further exploration (Institute of Medicine, 1989). Research allows us to investigate the processes that underpin the fellowships and this knowledge could help counselling psychologists to develop better treatments to deliver to their clients.

1.10.3: Processes of Change

Since they began eight decades ago, the fellowships have been some of the most widely used resources for individuals seeking recovery, yet it also is one of the least robustly evaluated (Institute of Medicine, 1989). As is evidenced from the literature review, empirical research has so far mostly focused on quantitative outcome measures, but these studies do not uncover the deeper dimensions of the programme. Despite a wealth of anecdotal evidence, formalised investigations into the mechanisms for change are a relatively unexplored area. It is therefore still the case that little scientific evidence has unearthed how and why fellowships are helpful (Russell-Mayhew et al., 2010). Orford called for a shift in the focus of addiction treatment; he concluded "*treatment research has been asking the wrong questions in the wrong way"* (2008, p. 1) and proposed that future research should shift its focus to look at change processes within longer-term multi-disciplinary systems. Orford (2008) also pointed out that addiction treatment research should be updated to recognise that useful knowledge can be gained from a variety of sources, not just from positivistic research.

Therefore, qualitative research has the potential to enhance our understanding of the mediators of change, the "*links in the casual chain*" (Humphreys, 2004, p.119). For example, Delucia et al., (2015) recently concluded that investigating how each individual construct their programme of recovery benefits the overall understanding of recovery. This gap in knowledge about recovery processes provides not only the next stage in fellowship research but also in recovery research overall (Tonigan, 2008).

Some studies have applied qualitative designs to researching the fellowships, and these have provided clinically relevant and rigourous findings which give a greater understanding into the processes of change found in fellowship attendance (DeLucia, Bergman, Formoso, & Weinberg, 2015; Green, Yarborough, Polen, Janoff &

Yarborough, 2015; Kingston, Knight, Williams, & Gordon, 2015; Labbe, Slaymaker, & Kelly, 2014; Rodriguez-Morales, 2017; Rodriguez & Smith, 2014).

Rodriquez and Smith (2014) explored young men's experience of NA using an IPA analysis, focussing on processes of change and identity transformation. Results showed that in early recovery it was important for the men to address temporality concerns, overcome ambivalence and identify conflicts. For maintenance, participants described an increased sense of belonging, developing their social network and practising self-care. This identity transformation was facilitated through self-authenticity and accepting their identity as a recovering addict. Further to this, Rodriguez-Morales (2017) recently published a longitudinal IPA case study of a young adult participating in AA. Interpersonal changes were reported after just 2 months, including the development of self-care and increased emotional development. After 6 months there was in improvement in interpersonal issues in areas such as increased social network and relating to others. After 10 months the participant emphasised their enhanced sense of self-actualisation and spirituality. It was also found that increased authenticity, emotional expression and transformation of identity were woven throughout the experience of early recovery.

Two studies have qualitatively looked at the helpful and unhelpful elements of the fellowships on processes of change. Labbe et al. (2014) collected qualitative information during assessments for 302 young adults entering residential treatment, as well as follow ups at 3, 6 and 12 months. They found that the most helpful aspects of attending twelve step groups were cohesiveness, belonging and the instillation of hope. However, they did report finding it difficult to motivate themselves to attend meetings and some disliked the meeting structure. For those who never attended meetings, the most common reasons were not believing that they had a problem or needed treatment. Kingston et al. (2015) conducted a thematic analysis of 26 adults in AA and NA to explore the reported positives and negatives of the fellowships. Most reported favourable aspects such as positive and relatable role models, being able to reframe their substance use as

problematic, feeling less isolated, more cared about, opportunities for catharsis, practical advice, hope and emotional support. Those who viewed the program unfavourably did so because they rejected the concepts of a higher power, powerlessness or didn't view themselves as addicts. However, Kingston et al. (2015) concluded that those who did were often uninformed of some of the key philosophies behind the fellowships and that the misunderstandings could be overcome through explicit facilitation into the fellowships.

In a study bearing similarities to this present research topic, Delucia et al. (2015) conducted a grounded theory analysis from interviews gathered at focus groups with 19 long-term NA members. They set out to identify the key ingredients of recovery processes, as well as quality of life outcomes beyond abstinence. Three dimensions of characteristics were uncovered. Personal characteristics included willingness, hope, responsibility, perseverance and commitment to change. Program characteristics included meetings, sponsorship, step work, service. Fellowship was found to be an essential element of recovery and characteristics of this included interconnections, having fun in recovery and cultivating hope. 'Gifts of recovery' in intrapersonal, interpersonal and fellowship realms were also demonstrated; such as freedom, spiritual development, purpose in life, developed relational skills and acceptance.

1.10.4: The Rationale Behind My Research Design

This chapter has identified that fellowships have proven effective in helping individuals gain meaningful recovery. It has outlined the programme of recovery that the fellowships provide, yet there is limited evidence on the processes of change at play. The research aim of this study is to address this dearth in knowledge by qualitatively researching what key therapeutic factors the fellowships provide for those actively using them. I wish to understand better how, for those who have had success in gaining recovery using the fellowships, the programme has contributed to that success. It is believed that these

factors will provide some explanation for the fellowship's longevity and apparent success in helping improve the lives of addicts. It is hoped that this may also further the overall understanding of recovery processes, enabling counselling psychologists to enhance their approaches to treating addicts.

I will be utilising a qualitative design because I believe this is the best way to capture the processes of change people experience in the fellowships, for reasons that I shall outline in the next chapter. While doing so I also recognise that I must also uncover what members find unhelpful about the fellowships, as this could give some indication as to why some people do not find recovery using the fellowships and thus adds to the overall discussion of fellowship processes.

Because most of the research done so far on fellowships has occurred in the US, conducting this study in the UK fills the gap in knowledge about fellowships outside of its origins, enabling investigation of whether fellowship recovery processes are transferrable across the countries and culture. Because both addiction and recovery are social constructions, it is entirely possible that there could be variations in the factors that have the most impact depending on the culture the individual is immersed in.

Both Humphreys (2004) and Moos and Timko (2008) believe that observed outcomes from one fellowship are likely to reflect the impact of sister organisations because of the commonalities between them. The fellowships all operate on the same principles, philosophy, steps and traditions. They also employ the similar meeting structures and literature; as well as sharing the concepts of sponsorship and home groups. This generalisability reflects the growing understanding that different addictions have similar phenomenology, etiologies, processes and constructs (Orford, 2001). The studies that investigate multiple-fellowships are increasing in number (DeLucia et al., 2015; Johnson et al., 2006; Krentzman et al., 2011; Subbaraman, Kaskutas, & Zemore, 2011; White,

2010). These have not found discernable differences between recovery outcomes from different fellowships.

For this study, in the absence of evidence that shows otherwise, an assumption that fellowships have a similar efficacy will be made. Therefore, the recruitment of this study will seek participants from any fellowship. This acknowledges the experiential actuality; that since many addicts suffer from multiple addictive behaviours (Krentzman et al., 2011b), many members attend several fellowships at the same time. So, I intend not to limit myself to gathering data on one fellowship but instead focus on the experiences and processes that are common to the twelve-step recovery programme in all its incarnations.

1.11: The Development of the Research Question

I am conscious that while many members attend fellowships and gain meaningful recovery there are also many members who attend fellowships regularly but fail to gain stable recovery. There are those who have been to meetings and are deterred by certain elements of the programme so do not want to become regular members. Therefore, it is important to note that one of the major elements of this study is that I have interviewed individuals who go to meetings and find them helpful in their recovery, to varying degrees. I have not made assertions to the overall efficacy of twelve-step fellowships, as I have outlined above there are many studies which have looked at this, with varying outcomes. I want to answer these questions: for those who do find fellowships helpful in their recovery, what about them is helpful? What are the recovery processes that members experience in the course of engaging with the fellowship programme? In this way I aim to add to the evidence of what the fellowships could offer to the clients of counselling psychologists in the future.

Bearing this in mind, the research question of this study is:

What is the Nature of the Recovery Processes Underlying Twelve Step Fellowships?

With the adjunct questions of:

What was helpful about the fellowships? What was unhelpful?

1.12: Personal Reflexivity

This area the research was particularly important to me because I am not only a counselling psychology trainee and researcher; I am also an addict in long-term recovery and a current member of multiple fellowships. While I had been the recipient of excellent therapy from professional psychologists, I have found the fellowships to be instrumental in achieving meaningful long-term recovery. Although my experiences in the fellowships have not been perfect, I was intrigued with the philosophy behind their recovery programme, which allies well with my own beliefs. As a counselling psychologist trainee I developed the desire to look at this movement from the inside.

I myself was a sceptic before I was introduced to the fellowships because I had limited understanding of how they work. Since becoming a member, I have been frustrated by the misconceptions held and lack of awareness of the fellowships by my colleagues in the counselling psychology field and other professionals working in addiction. The experiences I have had of fellowships are vastly different from the perspectives my professional colleagues hold and I feel strongly about addressing this imbalance. Because of these misconceptions about the nature of the fellowships, professionals are not routinely referring clients with addiction issues to the fellowships despite guidelines from NICE to do so (Department of Health (England), 2007, 2011).

Because of my status as an insider (Dwyer & Buckle, 2009) in relation to the research topic, I have been aware from the beginning of the conception of my research ideas that

researcher bias could be a problem. Could I be able to study the topic without showing favouritism towards the fellowships? Could I look at the analysis and honestly put aside my own experiences and proto-theories about the topic? It became apparent to me through discussion with my research supervisor, that although this could be a concern for the reliability of the study, my insider status should not deter me. I could reflectively address any bias through a robust methodological design, and my own knowledge of the fellowships could be an asset rather than a hindrance. By applying a grounded theory qualitative method this enabled me to use my own understanding and experience in a way that is nuanced and thoughtful, to uncover perspectives that would not be possible for an outsider. While, at the same time ensured that I was constantly aware of the possibility of my own bias entering into the research and therefore made adjustments accordingly. I shall discuss more on how bracketed any assumptions produced by my insider status in the methodology section.

Being an insider also had one particular benefit that addressed relevant concerns about the current status of addiction research. I believed that this dual role enabled me to add to the body of knowledge in an original way that would be helpful to other members, future addicts seeking help, and for the professionals who work with them. Insider research aids in the reduction of stigma and increases the empowerment of service users. It is important to ensure that addicts have their experiences heard in a way that is humanising for them, especially because they have long been marginalised (Neale, Allen, & Coombes, 2005). Most research into addiction has been conducted by professionals who, although empathic, can only have a limited understanding of what is like to go through the experience of recovery. Therefore, I also chose to conduct my research on the fellowships as I agreed with Dossett (2015); it is vital for addiction research to give a greater voice to the views of addicts.

Chapter 2: Methodology

2.1: Overview

This research utilised a constructivist grounded theory method to study the research question, "What is the nature of the recovery processes underlying twelve step fellowships?" I subscribe to relativist ontology with a constructivist epistemology. I incorporated an insider/outsider perspective as a pre-existing member of a fellowship and a counselling psychology doctoral student. Nine participants were interviewed: six purposive samples, one negative case analysis and two theoretical samples. Interviews ranged from 45 to 75 minutes and were recorded and transcribed. A computer-assisted qualitative data analysis software program, NVIVO, was used to store, organise and analyse the data. Assumptions and biases were counteracted using inductive data analysis, memos and reflective diaries.

2.2: Personal Philosophical Position: My Values as a Researcher

All qualitative research is interpretative in nature, so the methodology I utilised was guided by the beliefs and values which I as a researcher hold about the world, how it can be understood and studied (Crotty, 1998; Denzin & Lincoln, 2005; Guba & Lincoln, 1994; Lincoln & Guba, 1995). Therefore, it was important that I identify my personal ontological and epistemological beliefs before choosing a research question and methodology (Crotty, 1998). These philosophical beliefs are all linked, as one flows from and guides the other (Denzin & Lincoln, 2005). I thus have a relativist ontological stance towards data and analysis, with a constructivist epistemological stance, which is guided by both a pragmatic and symbolic interactionist theoretical perspective.

2.2.1: Ontology: Relativism

Ontology is the study of being and is concerned with the question, "*What is the form and nature of reality?*" (Guba & Lincoln, 1994 p. 108). As Crotty (1998, p. 64) puts it, "*The way things are is really just the sense we make of them*": we can never really know if we see the world as it is, or just our interpretation of it (J. Smith, 2008). I recognise that what I consider to be reality is relative to me, constructed by my thinking, history, culture and language. As a result any understanding I have of a subject needs to be held "*much more lightly and tentatively and far less dogmatically"* (Crotty, 1998, p. 64).

I have a relativist position towards both my data and my analysis, acknowledging that my participants provide insight into how they personally understand their lives, while my analysis is guided by my personal understanding of their data (Willig, 2012a).

2.2.2: Epistemology: Constructivist

Epistemology relates to the question, "*What can be known about that reality?*" (Guba & Lincoln, 1994, p. 108). My constructivist stance assumes that knowledge is created or 'constructed' (Schwandt, 1994) through social processes (Gergen, 1991) and interactions between individuals (Creswell, 2013). I believe that my findings were co-created inductively as the research was conducted, since I was 'interactively linked' with the participants (Willig, 2012a). I have interpreted my participants' actions and meanings, as they, in turn, interpreted mine.

Constructionism assumes that there is no knowable external objective reality (Constantino, 2008). Instead, there are 'multiple realities' (Charmaz, 2006) that are guided by each person's own historical and cultural experiences (Landridge, 2004). Each participant's knowledge of the fellowships has been shaped by their experiences of the social world of the meetings they have attended and the other people with whom they

have come into contact. I have therefore had to develop a self-reflexive and creative interpretative understanding of fellowship recovery, placing myself as a 'bricoleur' (Denzin, 1994).

2.2.3: Theoretical Perspectives: Pragmatism and Symbolic Interactionism

Theoretical perspectives represent a set of assumptions we have about a certain "*way of understanding what is*" (Crotty, 1998, p. 7). Pragmatism (Mead, 1934) believes reality is made up of whatever is useful and practical, and 'works' (Creswell, 2013). As a pragmatist, I understand that I see my reality through my experiences and I am thus selective about what I have attended to in the world (Williams, 2008).

Symbolic interactionism (Blumer, 1969) assumes that society, reality and the self are constructed through symbolic interactions and experiential transactions (Annells, 1996). Denzin (1997) explained that the symbolic interactionist approach is suitable for studying the fellowships because members learn the attitudes of others, laid out in a 'pre-existing structure', then apply them to themselves.

2.3: Research Design

I agree with Charmaz (2000) that it is imperative for a researcher to continuously take reflexivity into account, and that research knowledge is constructed between the participants and the researchers. Therefore, I used the qualitative method of a Constructivist Grounded Theory (CGT) approach (Charmaz, 2006) for my methodology as this is in line with my philosophical beliefs and would provide the best means to inductively generate a theory of fellowship recovery.

2.3.1: Rationale for Choosing Qualitative Research

Rather than adhering to the 'quantitative detachment' (Gergen, 1991) of a positivistic research approach that would not allow for exploration of the individualised experiences found in the fellowships (Tonigan, 2008), I choose a qualitative approach. Charmaz (2009) deemed that by using rich, detailed data, obtained using a robust qualitative methodology, researchers could go deep into a phenomenon. Qualitative inquiry also has the advantage of being a person-centred approach to research (Kardefelt-Winther et al., 2017), which can explore participants' personal experiences in an intensive but also empathic manner. Thus, by employing a qualitative design, I was able to explore and interpret participant experiences, incorporating multiple subjective realities into a cohesive theory (Borkman, 2008). It also enabled me to capture quality descriptions that led to accurate conceptualisations of what these experiences meant to the participants (Willig, 2012).

Larkin and Griffiths (2002) believed that any understanding of the relationship between the fellowships and the individuals attending them needs to be formed through gathering subjective accounts of these experiences. Therefore fellowship recovery processes are best observed by studying actual individual 'lived experiences' of recovery (Denzin, 1997). Other studies have applied qualitative designs to researching the fellowships, and these have provided clinically relevant findings that meet the criteria for trustworthiness and rigour (DeLucia et al., 2015; Kingston, et al., 2015; Labbe, Slaymaker, & Kelly, 2014; Shinebourne & Smith, 2009, 2011).

2.3.2: Rationale for Choosing Grounded Theory

When choosing a methodology to study the phenomenon of fellowship recovery, it would have been appropriate to use either Grounded Theory (GT) or Interpretative Phenomenological Analysis (IPA). As Willig (2013) and Smith, Flowers & Larkin (2009)

point out there is substantial overlap between the two as they share many common features. Both of them share constructivist epistemological underpinnings (Mills & Birks, 2014), are inductivistic approaches (Smith, Flowers & Larkin, 2009), proceed systematically to identify themes in textual data, integrate individual cases into a complete picture and involve the categorisation of data to gain an understanding of the characteristics of a phenomena (Willig, 2013). However, IPA describes the lived experience of individuals who have all experienced the same phenomena while GT aims to generate a general theory of a process that is grounded in the views of the participants (Creswell, 2014). So IPA focuses on personal meaning making, while GT focuses on developing an explanatory account of a complex social process (Larkin, 2015). As such, as Smith, Flowers and Larkin (2009) point out IPA relies on a homogenous sample. Since the research question for this study was geared towards understanding what factors are helpful for recovery, and it wished to be generalisable to a broad a range of fellowship members as possible, this made grounded theory the more appropriate research methodology. However, this is not to say that interpretative phenomenological analysis, didn't also have the potential to produce relevant and interesting findings specific to counselling psychology.

Grounded Theory is focused on generating a theory that is 'grounded' in data, verifiable and relevant (Glaser, 1999). By "*joining epistemological critique with practical guidelines for action*" (Charmaz, 2006, p. 5), GT delivers credibility to a piece of qualitative research (Charmaz, 2009). I therefore, utilised a GT approach to ensure that I followed a reflective, rigorous and interactive method to study the recovery processes underlying fellowships (Birks & Mills, 2012; Strauss & Corbin, 1990). Adaptability and creativity were necessary to build a theory that suited both the phenomenon under study and the research situation (Strauss & Corbin, 1990). The GT approach also enabled me to generate a theory while simultaneously testing that theory out as it developed (Glaser & Strauss, 1967).

The GT analytic method utilised included elements such as simultaneous collection and analysis of data, inductive data-driven analytic codes, memo-writing of analytic notes, constant comparisons, theoretical sampling, categorisation and theoretical integration, and delaying the literature review until after independent analysis (Glaser & Strauss, 1967). By engaging in all these processes, I was able to increase the analytic power of the findings (Charmaz, 2006).

However, as Landridge (2004) pointed out, one of the concerns with GT is that simultaneous data collection and analysis could introduce bias. For example, I could believe that the data was leaning a certain way and then follow this direction in the next round of data collection, instead of remaining open to other theoretical possibilities. The second criticism of GT is that by reducing language to the merely descriptive, it has "*an overly simplistic understanding of the function of language in interaction*" (Landridge, 2004, p. 304). Fortunately, my role as an insider meant I was well versed in the linguistics adopted in fellowships, and this enabled me to capture rich, multi-faceted meanings.

Glaser and Strauss believed "*the researcher does not approach reality as tabula rasa (a blank slate). He must have a perspective that will help him see relevant data and abstract significant categories*" (1967, p. 3). GT theory allowed me to incorporate my own perspective into the analysis, using it as a strength rather than being hindered by its limitations.

2.3.3: Rationale for Choosing Constructivist Grounded Theory

Second-generation grounded theorists, such as Charmaz (1995, 2000, 2006, 2009, 2015a) seek not only to discover meaning but to cooperatively construct it through the interaction between researcher and participant. This updated method moves GT towards "*more modern methodological and epistemological assumptions*" (Charmaz, 2006, p. 9), which build upon the pragmatic symbolic interactionist perspective and assume a

relativist ontology (Charmaz, 2009), fitting more succinctly with my own ontological and epistemological beliefs.

In Constructivist Grounded Theory (CGT) the researcher is inherently part of the research, and it is understood that research is not a 'neutral act' (Charmaz, 2009). This is particularly suited to my research focus. Both the data gathered and the analysis is "*created from shared experiences and relationships with participants"* (Charmaz, 2006, p. 130). Accordingly, when I constructed my theory I reflected upon how my own experiences have unavoidably influenced my interpretive rendering (Mills, Bonner, & Francis, 2006).

Birks and Mills (2012) argued that CGT aids in a comprehensive explanation of the processes underlying the phenomenon of study because it includes variation rather than trying to enforce a 'one size fits all' analytical perspective. So in line with a constructivist belief about multiple perspectives and multiple realities (Charmaz, 2006, 2009; Creswell, 2013), I recognised that participants may hold differing views of recovery and twelve step fellowships. I thus made sure that I followed the leads in my data, trying to include everyone's vantage points. CGT aims to uncover the extent to which processes are "*embedded in larger and, often, hidden positions, networks, situations, and relationships*" (Charmaz, 2006, p. 130). Many of these influences may go unrecognised by the participants, so it was my role to make these explicit in my analysis, to give voice to the unvoiced: "*much remains tacit: much remains silent"* (Charmaz, 2009, p. 131).

Of course, as with any approach, CGT is not a perfect methodology. Dey (1999) believed that CGT is too prescriptive and so not purely inductive, as well as being affected by the same biases as were mentioned when the Glaserian method was outlined. Similarly, any theories constructed with this approach can only offer an interpretation of reality based on the context in which the research is conducted, not a fully accurate portrayal of the real world (Charmaz, 1995b, 2000; Guba & Lincoln, 1994).

2.4: Theoretical Sensitivity

Theoretical sensitivity is a "*personal quality of the researcher*" that indicates "*an awareness of the subtleties of meaning of data"* (Glaser, 1978, p. 1). It uses a researcher's level of insight as a methodological tool to gain deeper theoretical understanding. For this study, much of the personal sensitivity came from my 'insider' status (Asselin, 2003). While from a positivistic point of view this causes concerns about researcher objectivity, insider knowledge can be used to increase a conceptual rendering and thus theoretical understanding. As Lincoln & Guba (1985, p.208) say, "*tacit knowledge not only widens the investigator's ability to apprehend and adjust to phenomenon in context, it also enables the emergence of theory that could not otherwise have been articulated*".

2.4.1: Insider Research and Membership Roles

As an insider, I saw the world of my participants as equal and shared with them an identity and language (Asselin, 2003), as well as many common experiences and emotions. Dwyer & Buckle (2009) talk about the 'personhood' of the researcher being an ever-present aspect of the investigation, so it is important to acknowledge, "*there is no neutrality. There is only greater or less awareness of one's own biases*" (Rose, 1985, p. 77; cited in Dwyer & Buckle).

Adler & Adler (1987) recognised that in dealing with the same everyday problems and realities as members, insider researchers can naturalistically experience the world of the participants. Therefore I was able to understand the meanings and emotions behind member experiences as they themselves mean or feel them, rather than a secondary understanding that goes through an interpretive rendering (Adler & Adler, 1987).

However, being an insider research did mean that I sat in ‘the space between' (Dwyer & Buckle, 2009). I was an insider, but I was still a researcher and a therapist; thus I was also an outsider. I have had to look at a familiar setting from a different perspective and create a different ‘space and character' for myself, allowing my researcher self to emerge (Adler & Adler, 1987). This dual role brought with it stigma as well as benefits. I have had to ‘out' myself as a fellowship member to other outsiders, such as examiners or fellow professionals who might read my research, and this can bring with it negative associations. It also brought with it the possibility that this dual role cannot be dissolved, meaning that I can never go back to being ‘just' an insider, thus changing the experience and benefits that I gained from being a member in the first place.

Being an insider brought with it the added advantage of a better relationship with participants. With the recognition of being a fellow member, I found a more willing and fuller acceptance on the part of the participants, and this afforded me a level of trust and openness (Adler & Adler, 1987; Dwyer and Buckle, 2009). I hope that this helped me to provide profound and cathartic data gathering experiences that were positive for the participants. As Corbin and Strauss point out, the "*interplay between researcher and actors studied – if the research is intensive – is likely to result in some degree of reciprocal shaping*" (1994, p. 280).

2.4.2: Problems with Insider Research: Bias and Assumptions

Because the insider researcher is so close to the research topic, there are questions raised about “*objectivity, reflexivity and authenticity*” (Kahuna, 2000, p. 444) and these have the potential to seriously affect the trustworthiness of a study (Field, 1991). Glaser (1978; 1992) warned that a researcher might consciously or unconsciously apply their own concepts and ideas, thus introducing bias and assumptions into the analysis, so advised researchers to keep an open mind. Assumptions I might have made could have meant that I missed the opportunity to probe deeper in interviews, or created filters

through which I viewed the data or ignored data that seemed to me to be obvious or unimportant (Field, 1991; Mills et al., 2006; Strauss & Corbin, 1990).

Over-rapport is where insiders relate so much to participants that they fail to keep their critical analytical perspective (Adler & Alder, 1987). I therefore strove to ensure that I was not distracted when a participant recounted emotions or experiences that were similar to my own (Kahuna, 2000). Also, as Dwyer and Buckle (2009) point out, there was the danger in the analysis that I might have unconsciously put greater emphasis on experiences, meaning or feelings that matched my own experiences.

2.4.3: Researcher Reflexivity

Asselin (2003) felt that it is essential for insider researchers to design a study that incorporates researcher reflexivity in order to avoid these problems and called for researchers to bracket their assumptions in order to gather and analyse accurately. Researcher reflexivity can be defined as the "*process of reflecting critically on the self as a researcher*" (Lincoln & Guba, 1995, p. 183), making the unconscious conscious.

CGT is designed to use reflexivity to uncover and overcome insider researcher biases and assumptions (Charmaz, 2000, 2006, 2009) and I have been transparent from the beginning of my research (Birks & Mills, 2012). Memoing and keeping reflective diaries was an essential process that I used to reduce bias and increase the credibility of the findings (Lincoln & Guba, 1985). When any strong emotions were evoked, I acknowledged these using reflective diaries and memos (Asselin, 2003). This meant that I maintained an audit trail, which fostered openness about any influences on the data gathering, analysis and theoretical development (Mills et al., 2006).

Overall, it is a difficult but important task to try to maintain a balance between keeping an open mind, having a reflective mind and using theoretical sensitivity as an insider.

Dwyer & Buckle point out that in the end, the "*core ingredient is not insider or outsider status but an ability to be open, authentic, honest, deeply interested in the experience of one's research participants, and committed to accurately and adequately representing their experience"* (2009, p.59).

2.5: Quality

'Trustworthiness' is how a researcher can persuade those reading a study that its findings have scientific merit (Lincoln & Guba, 1985). Research can only increase understanding of a phenomenon under study if it is rigorous in quality (Costantino, 2008). Positivistic measures of quality have traditionally been described as internal and external validity, reliability and objectivity (Guba & Lincoln, 1994). However qualitative research now uses credibility, transferability, dependability and confirmability as more epistemologically appropriate paralleled criteria (Lincoln & Guba, 1985). To increase the probability of these trustworthiness criteria being met, qualitative researchers have developed many measures and tools they can use to ensure methodological rigour (Morse, 1999).

'Credibility' describes how methodologically and epistemological sound a study is. Charmaz (2006) believes that the credibility of research relies upon the suitability of the methodological paradigm employed, as well as its ability to provide deep analytic insights with wide-ranging implications. For this study, several methods were employed as credibility checks (Elliott, Fischer, & Rennie, 1999). As recommended by Lincoln and Guba (1985) an audit trail of memos and reflexive diaries examined both the process and product of the analysis. The audit trail also increased the quality of the other three trustworthiness criteria. Lincoln and Guba (1995) recommend using debriefing to increase both credibility and confirmability of a study, so I also used regular supervision. My supervisor aided me by asking "*the difficult questions that the inquirer might*

otherwise avoid" and provided "*a sympathetic listening point for personal catharsis*" (Lincoln & Guba, 1995, p. 283).

Credibility was further increased by the use of a negative case sample (Morrow, 2005), which ensured 'fairness' (Lincoln & Guba, 1986), challenged my own assumptions and allowed alternative viewpoints to have a voice. The action-orientated coding and constant comparative method suggested by Charmaz (2006) meant that the analysis stayed close to the data. Finally, 'thick descriptions' (Geertz, 1973) that incorporated cultural and contextual variations ensured a good fit of data.

'Transferability' is how much this study can be thought to be useful and add to the body of knowledge it seeks to investigate (Denscombe, 2010), whilst also containing generalisability (Morrow, 2005) and originality (Charmaz, 2006). To meet these criteria the research must have practical applications, so in my discussion below, I have attempted to demonstrate an integration of theory and practice also known as 'praxis' (Patton, 2002). As recommended by Morrow (2005), emphasis was placed on providing a rich description of the research context and the researcher self as an instrument. The processes and participants have been described to situate the sample (Elliott et al., 1999). I hope this will allow the reader to decide whether the study is transferable (Lincoln & Guba, 1985).

'Dependability' is how reliable the findings are thought to be. As recommended by Morrow (2005), research processes have been made 'explicit and repeatable' through thorough methodological explanation. Dependability has also been increased through triangulation (Lincoln & Guba, 1985), where findings from analysis of one participant's data have been checked against the others. This also created a 'co-construction' of meaning (Morrow, 2005) between the participants. Lincoln and Guba (1985) pointed out it is not possible to be dependable without being credible, so ensuring credibility also went some way to ensure dependability.

‘Confirmability’ is how much a study can be said to be ‘neutral'. Qualitative researchers can never be entirely objective in the positivistic sense, but they can strive to be reflexive (Morrow, 2005). Patton (2002) believes that a constructivist researcher should not only acknowledge their subjectivity, but they should also ‘embrace' it, as this adds ‘verstehen', a rich and deeper understanding. In order to maintain integrity in this study, the subjectivity of the researcher’s insider perspective was managed through a "*process of systematic, cyclical and critical reflection*" (Willig, 2012a, p. 17), followed by a thorough description of analytic processes and findings (Morrow, 2005).

2.6: Methods and Procedure

The study interviewed participants who identified as addicts, were in the first two years of recovery and who were actively engaging in one or more TSF. Participants were encouraged to talk about their experiences of recovery and what had been the most helpful, and unhelpful, aspects of the 12-step fellowships for them.

2.6.1: Ethical Considerations

Ethical considerations was at the core of the research design. All participants were treated with respect and dignity and the utmost care was taken to avoid any harm to them (Fontana & Frey, 1994).

This project received approval from City Universities Ethics board (details of which can be found in Appendix J, K and L), and it adhered to the ethical standards set out by the British Psychological Society (2010) and the Health and Care Professions Council’s guidance on conduct for students (HSPC, 2012).

The following procedures were followed to ensure ethical considerations were at the forefront of this study:

- Informed consent was sought.
- Participants were informed the study was voluntary and they could withdraw at any time.
- Interview recordings and transcriptions were anonymised.
- Interview questions respected cultural, religious, gender and other differences.
- Any hard copies of data were kept in a locked cabinet, and electronic copies were password protected.

For more information on procedures that were utilised to ensure ethics, please see section 2.6.5 below.

Since participants were sharing personal and sometimes sensitive information, there was the possibility that they might have become distressed when recounting their stories. Three factors protected against the occurrence of emotional distress. Firstly, as regular members of fellowships, the participants had become accustomed to sharing their experiences. Secondly, this study focused on the journey to recovery rather than asking about upsetting experiences. Thirdly, I am a counselling psychology trainee with experience of working with complex emotional needs, which enabled the early detection of possible heightened and distressed emotional reactions. It was thus hoped that the interviews were a therapeutic experience for the participants that encouraged them to reflect on the positives of their journey and served to strengthen their recovery.

2.6.2: Inclusion and Exclusion Criteria

The following were the inclusion criteria for taking part in this study:

- Any age (eighteen and above) or gender.
- Attending any TSF and could attend more than one fellowship concurrently, for example, AA and NA.

- Must have been attending twelve-step meetings for three months or more and be in the first two years of their recovery.
- Must report that they are three months abstinence from their addictive processes.
- Participants must have a sponsor, with whom they can seek support, guidance and discuss any issues bought up by the interview process.

The following were exclusion criteria:

- Persons under the age of eighteen.
- Participants who appear on screening to be in active and severe emotional distress.
- Participants with longer than two years stable recovery time.
- Anyone who has come into contact with the researcher, personally or professionally, before the recruitment stage.

2.6.3: Interview Schedule

Interviewing is the most common method for gathering data in qualitative research, as it is the best way to understand other people's experiences (Fontana & Frey, 1994). Charmaz (2006) believes that producing rich data is imperative in generating strong, grounded theories, so she advocates the use of intensive interviewing. This allows for an in-depth exploration of the topic being studied, helping the researcher enter the 'participants' world' (Charmaz, 2006).

I developed an interview schedule based on Charmaz's (2015a) interview recommendations, which included asking open questions, good pacing of topics, avoiding biased questions, and providing direction to the interview. The questions developed were thus open-ended, broad and general (Creswell, 2013), which

encouraged the participants to explore their own understanding of the topic and enabled me to listen carefully.

Having an interview guide allowed me to ensure that I kept to the themes I wanted to cover and did not get distracted (See Appendix E for initial interview guide). It covered topics such as meeting attendance, sponsorship, steps, traditions, relapse, struggles in recovery, support received, participants' thoughts on what recovery is, and what has been helpful and unhelpful to them in their recovery. I also posed ending questions that brought the interview to a close in a positive way (Charmaz, 2006).

I conducted a pilot interview to ensure that my interview guide covered all the topics I wanted to before using it with participants. I felt that the schedule did cover all the areas, but the interview lasted far too long and was rather repetitive if I stuck to all the questions on the original interview schedule, so I adjusted some of the question ordering after the pilot. For example, I asked about support networks earlier in the interview as this was something which naturally flowed on from talking about meetings. I also made sure to ask in more places for a balanced viewpoint of what was helpful and unhelpful about the fellowships. In the pilot I noticed in the participant naturally answered the questions I was going to ask and did not need much prompting. So I decided to ask even more open-ended, broad questions, sticking less rigidly to the schedule if questions had already been covered. This allowed the participants to lead the interviews in a way that was better suited to the inductive nature of CGT data gathering. (See Appendix F for final interview guide).

2.6.4: Purposive Sampling and Recruitment

In accordance with CGT, I used purposive sampling for the initial round of interviews. Participants were chosen who could be a relevant source of information "*in order to*

uncover the contextual social processes" (Cutcliffe, 2000, p. 1477) that I wished to study, whilst meeting the inclusion and exclusion criteria.

Sampling techniques that minimised the potential for bias were employed (Neale et al., 2005). Participants were recruited through fellowship meetings not affiliated with the researcher; posters (Appendix A) were pinned to notice boards at commonly used meeting venues. Any interested participants were invited to contact me using the contact information given. Interested potential participants were given an explanation of the research, and the inclusion and exclusion criteria were assessed by taking them through the criteria over the phone. At the same time, I screened their mental state by asking them about their current recovery and emotional well-being. Then, they were sent participant information sheets (Appendix B), by email. If after this they were still interested in taking part in the study they were invited to come for an interview.

Participants had to have been attending the fellowships for over three months to ensure they had an adequate amount of time to become fully immersed in the principles and philosophies of the fellowship movement. They also had to have achieved more than three months' abstinence because after this period members are deemed to be more stable in their recovery and are no longer considered newcomers. This is because there was the possibility that participants could discuss potentially upsetting experiences and I wanted to ensure that they had a greater chance of doing so without this negatively affecting their recovery. Participants with longer than two years' abstinence were not included as this study wanted to examine people in 'early' recovery. By two years, the experiences of early recovery will no longer be as fresh and salient in their minds. However, because of the cyclical nature of recovery, some participants had different lengths of abstinence time and time in the fellowships. All participants were encouraged to discuss the interview with their sponsors, to explore what taking part in the research might mean to their recovery.

My recruitment process sought participants regardless of which or how many fellowships they were members of. Since many fellowship members attend multiple fellowships, if I had limited the study to one fellowship only, many possible participants would have been excluded. The fellowships that participants came from are laid out in table 1. The main fellowships attended were Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Overeaters Anonymous (OA). Other participants attended fellowships such as Cocaine Anonymous (CA), Debtors Anonymous (DA), Sex and Love Addicts Anonymous (SLA), Marijuana Anonymous (MA) and Under-earners Anonymous (UA, a new fellowship that focuses on those who undervalue themselves at work).

The number of participants sampled was a balancing act between getting enough participants for a thorough exploration of the topic and the practical issues of time and finding suitable participants. Morse (2000) felt that a good qualitative study should have between twenty and thirty participants, but she also said the number of participants should be dependent on the nature of the topic. If the topic is evident and the information gathered of good quality, then this number can be reduced, and the study will still have good explanatory power. Glaser (1998) argues that researchers should keep sampling until theoretical saturation has been reached and that this logic overrides the idea that samples need to be a certain size to generate validity.

Bearing these considerations in mind, the initial sample size was six, and there were additional interviews for a negative case sample and theoretical sampling interviews to reach saturation. These participants provided a diverse sample, as they could be any age, gender and from any fellowship; this was to ensure data was obtained that covered a broad range of multiple realities and behaviours in varied situations (Lincoln & Guba, 1985).

To protect their anonymity, each participant was given an alias, and I provide demographics relevant to the study for each participant in table 3 below. Each participant

was a UK resident, and they came from varying backgrounds and social-economic statuses.

Participant Alias	Clean Time (Months)	Main Fellowship	Other Fellowships Attended	Other Treatments	Gender	Age
Claire	3	AA	None	NHS Drug & Alcohol Centre, Private Treatment Centre	F	61
Abdul	22	NA	AA	NHS Detox, NHS Drug & Alcohol Centre	M	50
Emma	6	NA	AA, CA	Therapy	F	38
Alice	18	AA	CA	NHS Drug & Alcohol Centre, Private Treatment Centre	F	27
Stephanie	10	OA	UA	None	F	41
Ed	17	NA	AA	Therapy	M	45
Kate	5	None	None	NHS Detox & Private Treatment Centre	F	65
Oliver	9	NA	AA	Private Treatment Centre	M	26
Irena	23	MA	AA, NA, SLA, DA, UA	None	F	36

Table 3: Participant Information

2.6.5: Procedure

Before recruitment, I identified and obtained local approvals (Creswell, 2013; Fontana and Frey, 1994). Fellowship service offices were contacted, and it was confirmed that the research did not break with any traditions.

Rooms were booked in City University buildings; participants were given instructions on how to get to City University Campus Reception and then were escorted from reception to the room.

Before collecting data, participants were given a verbal briefing, with the general purpose of the study outlined, and the procedure of the interview explained. The participants were given a chance to ask any questions they had about the interview procedure, but any further discussion was encouraged to be left for after the interview to reduce the chance of bias entering into the data gathering.

Confidentiality was assured, and it was explained how this would be achieved in a practical sense. Because the interviews were being recorded and professionally transcribed, informed consent was sought for this and for permission to use the data (Fontana & Frey, 1994). The consent form (Appendix C) also explained that participants' data would be anonymised and the data kept in accordance with the Data Protection Act (1998). In line with the British Psychological Society's guidelines for ethical research practice, it was important that I assured the participants that their participation was voluntary and they could withdraw from the study at any time (British Psychological Society, 2010).

After the interview, there was a debriefing where further information about the aims of the research was given (see appendix D), and participants were encouraged to ask questions and to contact me if they had any further questions. The participants were all offered the chance to be sent a copy of the final research report and a copy of the transcribed interviews. Any hard copies of data were kept in a locked cabinet, and electronic copies were password protected.

2.7: Gathering Rich Data in the Interviews

I concur with Glaser (1978) who believed that theoretical sensitivity aids the researcher before analysis even begins, and I utilised it to form targeted interview questions and to listen empathically to interviews. My insider status helped build feelings of trust and rapport from which I gained more honest and rich interviews. I used the meta-language of the participants and the fellowships, rather than using professional jargon (Fontana & Frey, 1994). I also understood the interviews at a deeper level, because I have lived some of the experiences and emotions my participants talked about. The quality of our interactions shaped the emergent data, so I made efforts to learn participants' views respectfully and to understand the topic of study from their perspective. I followed Charmaz's (2006) advice that, if conducted sensitively, interviews can be beneficial for the participants as well as the researcher because they allow participants to tell their stories, reflect upon their journeys, be valued for their experiences, have an affirmative recovery experience and express emotions that may be 'disallowed' in other settings, and bring a cathartic aspect to the process.

Establishing rapport was essential to the success of the interviews (Fontana & Frey, 1994) because as Neale and colleagues (2005) pointed out, the interview may require the subject to disclose intimate information about illegal or upsetting activities. As the participants are all recovering addicts, they might have experienced stigma and discrimination in the past relating to these issues. I therefore endeavoured to validate their humanity and show respect to their experiences and perspectives. Charmaz (2015b) advises researchers to gauge when a participant is discussing a subject that is particularly emotionally salient to them, and I drew on my counselling skills to do this.

Developing a "*simultaneously attentive and analytic stance"* (Charmaz, 2015b, p. 1615) helped me to pose follow-up questions when I felt tacit meanings needed drawing out.

By doing this, the knowledge gathered in the interview was constructed between the participant and myself. I was careful, however, to ensure that follow-up questions were asked from a non-judgmental standpoint (Mills et al., 2006).

As previously mentioned, data collection was simultaneous with analysis (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1990). After each interview I coded the data before the next interview, building my theory from interview to interview and allowing it to shape my subsequent data collection.

Interviews were expected to last an hour, with actual interview lengths varying between 45 minutes to 75 minutes. Each interview was recorded and sent to a professional transcribing service, so as to ensure faithful replication of the data but also for pragmatic time reasons. This was explained in the information sheet, at the briefing and when the consent form was presented for signature.

2.8: Managing the Data Using NVIVO

The data collected from interviews was unstructured in nature, and as a researcher, it was my role to create order so that I could 'generate meaning' (Neale et al., 2005). Birks & Mills believed "*establishing structured mechanisms for managing your data are investments in your credibility"* (2012, p.39). Accordingly, to store, manage and analyse my data I utilised NVIVO, a computer-assisted qualitative data analysis software program (CAQDAS). Computers have already gained a 'substantial presence' (C. Silver & Fielding, 2008) in qualitative research, where current use includes storing interviews transcripts, creating spreadsheets for coding and keeping records of memos (Froggatt, 2001). CAQDAS programs enable the user to do all these things through one specifically designed programme; therefore, NVIVO was a 'container' (Lewins & Silver, 2007) for my analytical work. The CGT method can generate an immense amount of data, and NVIVO

stopped me being overwhelmed by the amount of information I gathered (Lewins & Silver, 2007).

NVIVO has tools which help with "*organising, exploring, integrating and interpreting data*" (Silver & Fielding, 2008, p. 339). Overall I believe NVIVO enabled me to stay close to and interact with the data (Lewins & Silver, 2007). For example, the coding and retrieving functions made the generations of codes fast and flexible, and I could refine these codes later if needed (Lewins & Silver, 2007). It was also easy to group these codes together to help with focused coding and retrieving the source information for each code. This also helped with the development and refining of theoretical coding as well as mapping out relationships within the data (Smyth, 2008)

Gibbs (2002) notes that NVIVO provides the ability to use and keep memos linked to, but separate from, primary data, as originally recommended by Glaser (1978). The system allowed me to sort and search memos, which aided in the development of inductive categories while keeping the independence and integrity of the data intact (Smyth, 2008). The date tracking for the memos meant I was able to keep a temporal record of my thinking and of the development of my theory and this enabled me to maintain an audit trail of my analytic thoughts (Silver & Fielding, 2008).

NVIVO's framework is specifically designed to fit closely with GT (Froggat, 2001). However, it is important to note that it is still the researcher who does the analysis, and the software merely assists the process. The authenticity of the research is dependent upon the user of such software having a good understanding of the methodology they are utilising (Silver & Rivers, 2016); thus it remained my responsibility to ensure that my methodology, ontology and epistemology were aligned with the use of this software (Smyth, 2008).

Concerns have been raised about "*short-changing the analytic process, generating superficial analyses, and forcing qualitative research into a single method*" (Coffey, Holbrook, & Atkinson, 1996; cited in Charmaz, 2006, p. 179), but Silvers and Rivers believed that this is a reflection of the "*lack of skill in using the software rather than the unsuitability for the analytic method*" (2016, p. 594). To ensure that I properly understood how to utilise the NVIVO software package I attended an intensive training course. This enabled me to use the programme to its full potential and to get the most out of my analytic process. For example, of the application of NVIVO please see appendix G, H and I.

2.9: Analytic Process

2.9.1: Initial Literature Review

Because 'everything is data', Glaser (1978) felt researchers should avoid doing an exhaustive literature review before beginning the analysis. If too much has been read, this could provide a partial framework for deductive conceptualising, rather than allowing for inductive exploration of the data. However, as Dey (1999) argued, this does not mean that a literature review should be discounted altogether as it is important to have enough information to guide data collection. To evaluate the relevance of the research and to guide the interview question focus, I conducted a brief initial literature review was conducted, but this was kept to a minimum (Charmaz, 2006, 2015a).

However, it is important to note that as a member of a fellowship I had already done extensive reading of fellowship literature in my recovery process. I tried, through reflective procedures such as memos, to use this to guide my theoretical sensitivity rather than to prepare codes or concepts that I wished to find in the data. Once I had nearly

completed my analysis, I began to do a more substantive literature review and was "*woven into the theory as more data for constant comparison"* (Glaser, 1998, pp.67-68).

2.9.2: Memoing

Throughout the process of data collection and analysis, memos were written to keep track of my analytic processes, to explore ideas about coding, to direct further data gathering and to ensure reflexivity. Because memo writing is thought to be the 'cornerstone of quality' (Birks & Mills, 2012), I began memo writing from the moment I decided to use the CGT methodology, as I wished to imbue my research with reflectivity from its inception. Memo writing is at its core a reflective process, providing me with a way to question my own feelings and biases that may have crept into the analysis (Charmaz, 2006). As theoretical sensitivity and reflectivity were so vital to the quality and credibility of this study, I kept thorough reflective diaries as well as theoretical and analytic memos.

Birks, Chapman and Francis (2008) explained that memoing provides four main functions: mapping research activities; extracting meaning from the data; maintaining momentum; and opening communication. I therefore created an audit trail of memos (Lincoln & Guba, 1985) that mapped research activities and kept track of how my thinking was being directed throughout the process. So that I could preserve the evidence of what generated my thinking process, I ensured that quotes from the data were included in my memos (Charmaz, 2006).

By exploring and thinking about my data, I was able to extract meaning from the data and develop my theory (Charmaz, 2006). Memos helped me to determine which codes were significant, think about my data conceptually, generate ideas and directions to follow and raise conceptual categories, but also to uncover any gaps in my data (Charmaz, 2015b).

Charmaz (2006) advocated writing memos throughout the research process, making them as spontaneous as possible to accelerate productivity. As a result, memos helped me to maintain my momentum because they kept me actively engaged with my data.

Birks & Mills pointed out through memos you able to "*converse with yourself both in real time and retrospectively*" (2012, p. 40), and writing memos kept me communicating with myself reflectively about the research and analysis process. Conversing with myself through memoing helped me to record my thoughts, ideas, insights and feelings about my research (Charmaz, 2006). This in turn enabled me to feel free to explore my ideas in a reflective yet grounded way once the analytic concepts became more complex. For an example of these memos, please see those provided in the results and discussion section, as well as in Appendix I.

2.9.3: Coding

Coding is a translation of raw data into a new form that can be analysed (Dey, 1999); it is about ‘making sense' of the data (Lincoln & Guba, 1985). Charmaz (2006) described coding as the ‘pivotal link' between data collection and emergent theory development, as it is when analytical conceptualising of the data occurs. The coding process formed the ‘bones' of my analysis that were then assembled to create a ‘working skeleton' (Charmaz, 2006).

The coding process in CGT is inductive, allowing the theory to emerge from the data, without preconceptions constraining it. This inductive approach also fits well with constructivist ontology because it lets multiple perspectives emerge and be identified (Lincoln & Guba, 1985). I had to examine each piece of data, give it equal consideration and then construct codes that were grounded in this data. Inductive coding ensures that one is open to seeing gaps early in the analysis and then locating sources of data to fill

them, through purposive and theoretical sampling. In this way, simultaneous analysis and data collection weave together to enable a deeper research process.

2.9.3.1: Reflectivity and Preconceptions

Concepts contained within codes can hold multiple meanings to each participant and the researcher, creating many "*conceptual vantage points*" (Charmaz, 2015b. p. 1615). This meant that, in order to interrogate the data empirically, it was imperative for me to remain reflective throughout the coding process. I had to be pragmatic and acknowledge the preconceptions I held. As Dey points out, "*there's a difference between an open mind and an empty head*" (1999, p. 251).

2.9.3.2: Initial Coding

The analysis of the data was built from the ground up through an in-depth line-by-line action coding of the interviews. My initial coding was not just naming fragments of data: it also involved interpreting, capturing and condensing the meaning behind each fragment (Charmaz, 2006). However, my initial codes were provisional, as I remained open to the possibility of refining them to construct codes that were the best fit for the data. For an example of line-by-line coding, please see Appendix G.

2.9.3.2.1: Action

Action codes identify specific processes (Charmaz & Bryant, 2008) and are short, precise analytic descriptions of 'gerunds', the verbs of actions (Glaser, 1978). I followed Charmaz's (2000, 2006, 2009, 2015a) method and coded each data fragment with words that describe actions while also sticking as closely as possible to the data. Keeping my codes "*short, simple, active and analytic"* (Charmaz, 2006 p. 50) avoided any inclination to conceptualise too early. Gerunds also helped me to recognise any implicit meanings and processes in the participants' experiences (Charmaz, 2015b).

2.9.3.2.2: Line-by-line

This study employed line-by-line coding as it means that each fragment of data is examined closely; with such a rich source of data as the interviews I collected, there was so much meaning even in one line that it was important not to miss anything. I was minded of Dey's (1999) assertion that any study that does not code each line of data cannot be said to reach theoretical saturation. By coding every line, even though it was labour intensive and time-consuming, I was able to reach deeper analytical conceptions with confidence that I had not missed anything. Charmaz (2006, p. 51) also believed this reduces the chances that a researcher "*superimposes their preconceived notions on the data*".

2.9.3.2.3: Language and 'In Vivo'

To protect the meanings behind their words, I tried to use the language of the participants, especially because meanings are sometimes implicit and subtle (Charmaz, 2009). I also used 'In Vivo' coding, capturing the exact phrase a participant used, creating 'symbolic markers' (Charmaz, 2006). Fellowship members tend to have a particular language they use, based on the literature and also in the form of slogans. To the outsider, phrases such as 'keep coming back' or 'easy does it' might seem simple, yet there are condensed but significant meanings behind the use of these terms. I had the ability to pinpoint when fellowship specific language and phrases were being used, in order to see the complex meanings behind them. Charmaz (2006) calls this 'insider shorthand'.

2.9.3.3: Focused and Theoretical Coding

While initial coding fractures the data into fragments, focused coding reconnects it (Birks & Mills, 2012). This step took place when I stopped merely describing the data and

started to synthesise it into hypothetical thematic categories (Charmaz, 2009). I identified the most common or conceptually important codes and used those to sort the initial codes into focused codes that encapsulated larger amounts of data (Charmaz, 2006). I undertook this process while constantly comparing data with data, and codes with codes, to ensure that codes were put into the correct category.

Theoretical coding was where I conceptualised "*how the substantative codes may relate to each other as hypotheses to be integrated into a theory*" (Glaser, 1978. p. 72). I integrated the focused codes into categories then considered how these categories could be related to each other. This formed the basis for theoretical codes. My codes were created based on abductive reasoning (Charmaz, 2009) but at this stage but I was also able to bring in some existing theoretical concepts if they fitted the analytic data. This added to the explanatory power of the theory by situating it "i*n relation to a theoretical body of knowledge*" (Birks & Mills, 2012). Because of the magnitude of processes being uncovered I created two types of theoretical codes to further sort these into a coherent structure: sub-categories and categories.

When I raised an initial code to a focused code or combined focused codes into a theoretical code, I made a memo to ensure that further codes I put into this category fitted conceptually. See Figure 1 for a sample of how transcript data was raised through initial coding and focused coding through to theoretical coding.

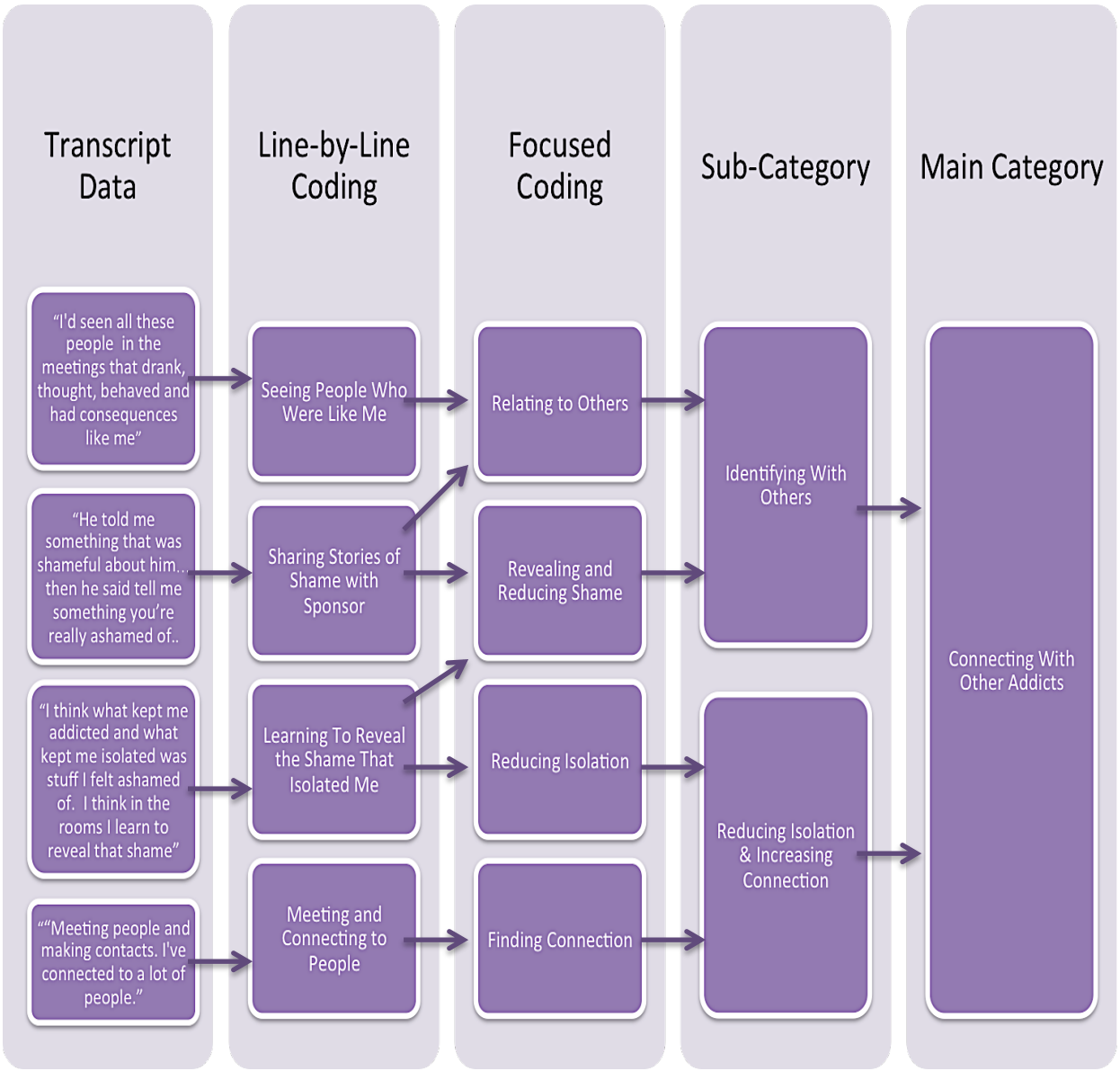

Figure 1: Sample of how theoretical categories were raised through coding

2.9.3.4: Constant Comparative Method

Constant comparative analysis occurred throughout the collection and analysis of data, and this aided the conceptual understanding of my theory development. It guided me when I formulated and reformulated my theory and helped ensure that there was sufficient representation of the processes at play (Charmaz, 2006). When comparing data, codes, memos and categories, I looked for similarities and differences within and between them, which enabled me to construct categories that were grounded in the data

(Landridge, 2004). This method of comparative analysis was entirely inductive (Birks & Mills, 2012), enabling me to draw out "*increasingly more abstract categories*" (Charmaz, 2015b, p. 1618). Memo writing was very useful in comparative analysis as it helped me to keep track of my theoretical abstractions.

2.9.3.5: Categorising Data

Categories explain ideas or processes in data (Charmaz, 2006) and the categorisation of data occurred from the moment I began coding. The very nature of coding consists of putting data fragments into prescribed categories. However, it is when focused and theoretical coding begins that categorisation begins to become conceptual, as I had to think about what each category consisted of and how it related to other categories.

Charmaz urged researchers to reflect on whether they had "*lumped properties under one category that might call for constructing separate, distinctive categories*" (Charmaz, 2006. p.61) that more accurately represented the data. Through my own comparative analysis, similarities and differences between categories did become clear, so I created sub-categories that captured the variety of interactions and processes at play.

2.10: Theoretical Integration and Development

A good theory aims to integrate all the processes at play (Charmaz, 2006). In order to do this I had to make sense of my data by using all the tools mentioned above. I also used a negative case analysis, theoretical sampling and diagramming to refine my theory. This ensured that my theory understood, not just explained, the phenomenon being studied (Creswell, 2013).

2.10.1: Negative Case Analysis

A negative case analysis is where a researcher seeks out instances that do not fit with the emerging theory. Lincoln & Guba (1985) believed that negative cases are a good measure of trustworthiness because variations and differences of opinion are not disregarded, "*giving voice to an otherwise ignored other*" (Seale, 2011, p. 74). I therefore felt it important to include one in my study, to help me remain unbiased and to give my analysis depth and diversity. In contrast with my original inclusion criteria, I sought someone who had not found fellowships to be helpful in their journey to recovery. This alternative perspective added a reflective scepticism towards my findings, which is vital for good research work (Seale, 2011).

2.10.2: Theoretical Sampling

Theoretical sampling is where a researcher seeks out participants to "*elaborate and refine the categories constituting your theory*" (Charmaz, 2006, p.96). This was conducted in order to develop the properties of the categories to their saturation point, not to achieve representative population distributions (Charmaz & Henwood, 2008). The analysis was well advanced by the time I sought out these participants (Glaser & Strauss, 1967), since conducting theoretical sampling too early could have meant imposing theoretical concepts on the data (Landridge, 2004). When deciding whom and how to theoretically sample I made a 'strategic decision' (Birks & Mills, 2012) to seek out participants who attended atheist meetings. My memos led me when making this decision, as they gave me an indication that my concepts surrounding non-religious spirituality would benefit theoretically from further exploration.

2.10.3: Diagramming

Strauss & Corbin (1998) in particular promoted the use of diagrams as a way to create a visual image of the emerging theory. I found diagrams an essential part of my theoretical integration, especially because I had so many categories and sub-categories. Diagrams helped to crystallise my understanding of the relationships between categories and how they fitted into the theory (Corbin & Strauss 2012).

2.11: Theoretical Saturation

Glaser & Strauss (1967, p. 61) defined saturation as when "*no additional data are being found*" that can help "*develop the properties of the category*". Therefore, I continued my data analysis until I reached theoretical saturation and I deemed the theory complete enough to have explored the phenomenon under investigation. I knew when I had reached theoretical saturation because all my subsequent data analysis fitted into existing categories without the need for new categories to be created (Birks & Mills, 2012).

Dey (1999) argues against the term 'saturation', believing that until a researcher collects all the data there is on the subject, they cannot say with full certainty that they have saturation. There could always be the possibility of new data revealing new concepts. Instead, Dey proposed aiming the term 'sufficiency' when "*categories seem to cope adequately with new data without requiring continual extensions and modifications*" (Dey, 1999, p. 257). Given the complex nature of the research area, I pragmatically acknowledged that since each individual had such a varied and unique experience, full saturation was a theoretical goal rather than a reality (Willig, 2008). However, I do believe that I reached theoretical sufficiency, as the coding from my final purposive and

theoretical samples was categorised sufficiently into existing categories without the need to create more.

One of the aims of my study was to generate a theory that uncovers the nature of the recovery processes underlying twelve step fellowships. I have outlined how I achieved this using a Constructivist Grounded Theory method, by utilising sampling, coding, memoing and theoretical integration. The quality of this analysis was assessed using research supervision. I have identified a core category, main categories and sub-categories and placed these into a model. The findings from this will be presented in the Findings chapter.

Chapter 3: Findings

3.1: Aims of this Chapter

I aimed to gain insight into the processes inherent in the 12-step fellowship programme, which participants found beneficial in their recovery, but also to uncover any elements of the programme that were not constructive. This study was not designed to measure recovery progress or outcomes; instead, it focused on exploring what the programme offered to participants during their journey to stable recovery.

The aim of this chapter is to present findings that arose through employing the constructivist grounded theory methodology. These findings are outlined in a manner which aligns with the philosophical beliefs of constructivist grounded theory, mainly that there can be multiple perspectives of reality between participants and that the phenomenon studied should be understood in relation to the historical and social contexts of the participants interviewed (Charmaz, 2006). Participants varied in the length of stable recovery they had and in how long they had regularly been engaging with the fellowships. Participants also varied in which specific fellowship programme they identified as members of, often engaging in more than one. This variability means that findings can be generalised across fellowships and can be said to represent the perspectives of those who are from three months to two years abstinent. However, as some participants had been engaging in the fellowships for longer, it is also possible that the processes identified here could be transferrable to those with longer periods of recovery.

Effort has been made to present these findings using accessible ‘jargon free' terminology (Neale, 2005), and wherever possible, in the same language as the participant accounts.

This is to ensure researcher bias is reduced and also to portray the experiences of the participants faithfully.

3.2: Overview of the Findings

Seven main categories that were considered to be key conceptual processes were identified during the analysis, with sub categories that explored the more specific elements of each process. The main categories and their subcategories are presented in Figure 2; each category will be explored in greater detail during the course of this chapter. Participants identified several processes that had contributed positively to their efforts, as well as some processes that mired the experience. Participant extracts also described experiences that suggested links between and within categories, and these links were integrated into the theoretical model.

Diagrams that demonstrate the interactions of the processes at play are included, as well as examples of memos and reflective diaries, which can aid in understanding the analytic progression. The negative case sample findings are discussed after the theoretical categories, along with the implications this has on the theory under development. A summary of the theoretical model and a diagram illustrating this is provided at the end of the chapter.

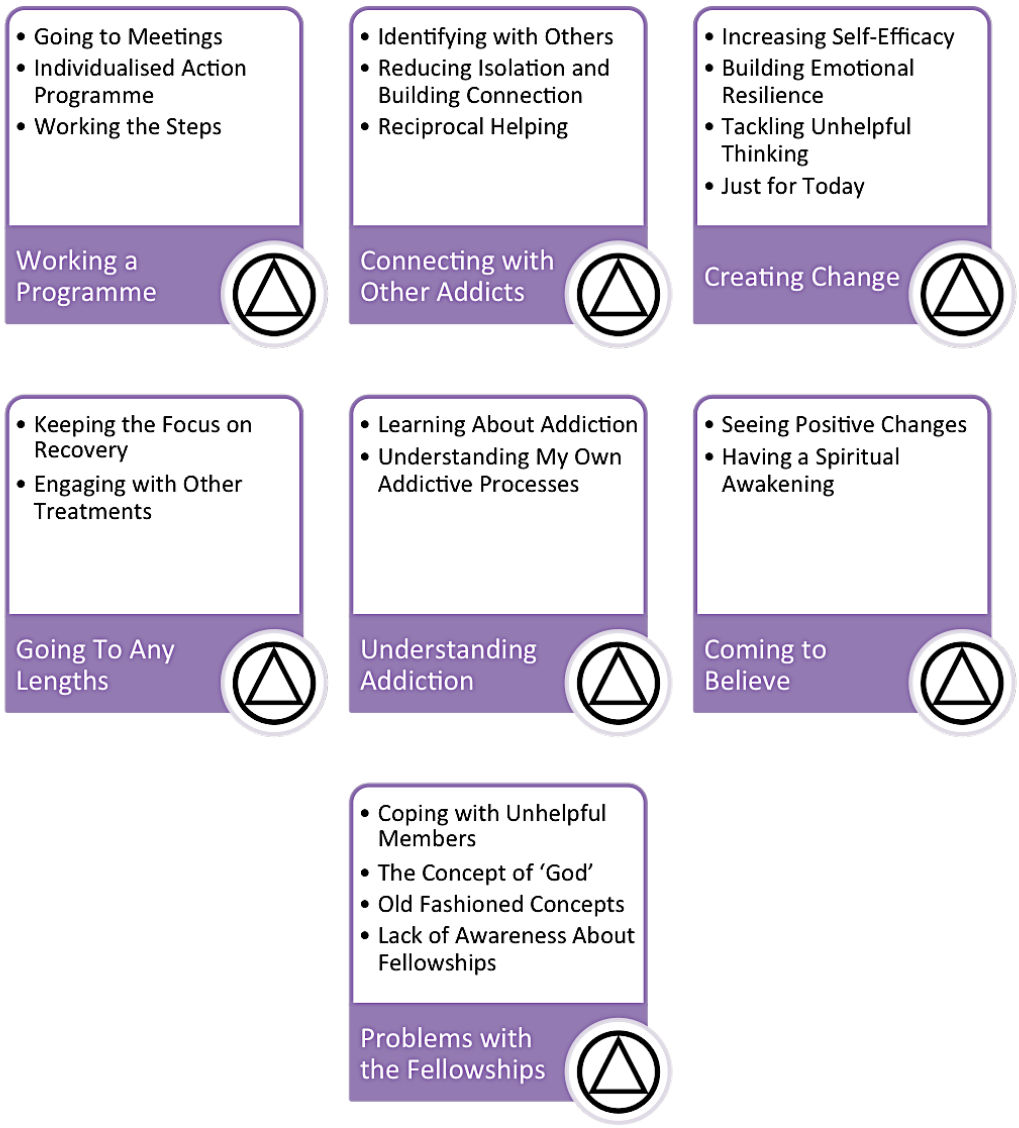

Figure 2: The Main Categories and their Sub-categories.

3.3: Working a Programme

Working a programme is a practical recovery process that consists of going to meetings, having an individualised programme of action and doing the steps. Figure 3 demonstrates the process and the relationships between the main category, and its sub-categories. Each sub-category has its own unique process, but they also interact with and enhance each other.

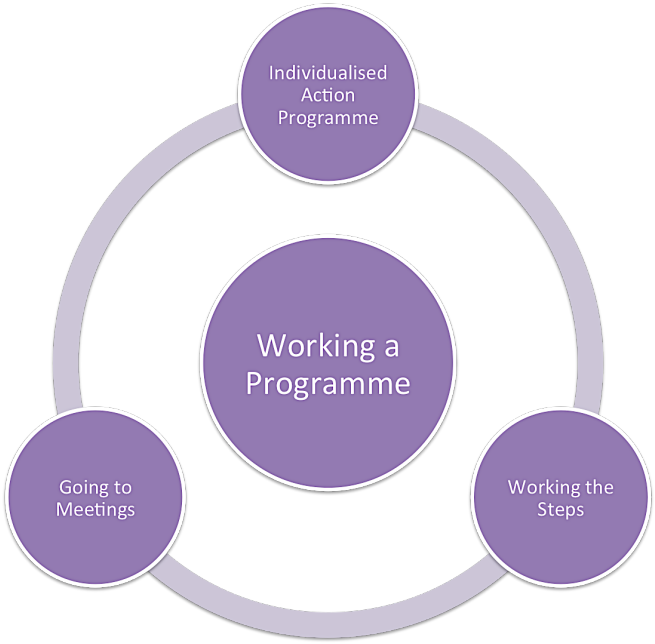

Figure 3: Relationship of the Main Category of 'Working a Programme' to its Sub-categories.

3.3.1: Going to Meetings

3.3.1.1: Benefits

All participants described going to meetings as a beneficial experience, allowing them to feel "*safe*" and "*connected*". Claire compares the experience of going to meetings as like "*coming home"* where she can be herself. This mirrors the emphasis Stephanie places on her home meeting, in which she gets comfort and acceptance. While Ed described that he felt comfortable in meetings because he was like everyone else.

"I feel safe and welcomed, it's like coming home. I feel a warm feeling going into these meeting, like almost a relief." CLAIRE [164-165]

"I walk into that room, and I feel like it's safe for me to be vulnerable. I'm never going to be judged… it's just such a safe place, really particularly my home meeting." STEPHANIE [108-109]

"You're surrounded by likeminded people… for the first time in our lives, you actually relax." ED [167-168]

In the context of explaining why the meetings were beneficial, all participants articulated the realisation that they were not "*alone".* Alice highlighted that meetings enabled her to hear others sharing the thoughts and feelings that she also had. Emma builds on this by highlighting that her feelings of isolation are counteracted by the meetings helping her to keep "*connected".* A further discussion of how meetings help by reducing isolation and increasing identification can be found the category 'Connecting With Other Addicts'.

"Meetings were massively helpful… to hear other people share what's going on in my head helps me to see I'm not alone." ALICE [142-143]"

"The meetings are a very important part of those changes, because otherwise I'd feel alone. I'd feel I was going mad. What goes along with that old life is substance abuse. The meetings keep me connected. They're not perfect, but they work." EMMA [182-183]

Alice described the meeting process as being helpful because they are restorative yet she also observed that she has to challenge her negative thinking, which tells her not to go.

"My head sometimes would say I don't want to go to a meeting, I'm too tired, I don't need it, and I'll get to it, and I'll feel so refreshed coming out of it. Meetings help me challenge my thinking." ALICE [142-146]

Stephanie also explained that meetings are a reminder of what could happen if she loses her recovery. These processes were linked to the category 'Keeping the Focus on Recovery', because they help challenge complacency.

"It reminds me of where I might end up… if I stop doing the things I need to do to keep myself abstinent." STEPHANIE [100-101]

3.3.1.2: Frequency

When discussing meetings and how they were utilised in early recovery most participants spoke of the recommendation to attend ninety meetings in ninety days to help achieve and solidify abstinence. Abdul explained that he was desperate so attended one hundred and fifty meetings in ninety days; he described this desperation as a "*gift"* [ABDUL, 41], that helped him to finally achieve stable recovery after years of trying.

"I did about 150 in 90 because I was desperate. My record was five in one day. I was living in the meetings." ABDUL [85-86]

Claire and Alice also describe trying to get to meetings daily in early recovery. Claire observes that regular meeting attendance gives her life structure and Alice, even in stable recovery, increases her meetings attendance if she is struggling emotionally.

"It gives me the daily structure that I need… I try and go every day. Sometimes life gets in the way. The longest I've been without is two days, and by that time I need to go to another one." CLAIRE [17-19]

"In the beginning, I went to a meeting pretty much every day… 20 months in, if I'm struggling I will increase my meetings, and if I'm alright, I'll do two or three a week." ALICE [124-126]

3.3.1.3: Service

Participants also described doing service at meetings as helpful to their recovery because it increased their commitment to recovery. Claire describes how service has helped her to overcome her shyness and become more involved in the community.

"Service helped me, being shy about sharing in the meetings. It helped me to connect with others... I find making the tea the best because people come and chat to you while you're making the tea. Or I find doing the literature helpful because you have to make an announcement. Anything where you can vocalise being part of the community in a practical way, not just turning up… because it gets you more connected." CLAIRE [430-438]

Alice observes that service commitments ensured she would go to meetings and Stephanie believes service provides her the opportunity to take "*responsibility"* in her life.

"Service was important for me in the beginning because my head would say I don't want to fucking go, but because I had a commitment, the other bit of my head will go what are they going to think about you if you don't turn up for your commitment? So, it would get me there." ALICE [872-875]

"I think all these service positions is about taking some responsibility, if you've got to do a certain job, then you've got to do it." STEPHANIE [717-718]

3.3.2: Individualised Action Programme

3.3.2.1: Action Programme

Several participants mentioned the programme is based upon "*action",* that it was something practical they could do to gain recovery.

"Going to a meeting that is an action, it is an action-based programme." ED [265]

"This is an action programme. The more action you put in, the more you get out..." ABDUL [143]

3.3.2.2: Tools

Most participants explained that through the process of engaging in the fellowships they had learnt *"tools"* that helped them with their recovery. Stephanie describes these tools as *"psychological techniques*" which help her control her compulsions. Emma explains that she worked out which tools were right for her and made sure to use them.

"Things I need to do to keep myself abstinent. It's a psychological programme, and you learn psychological techniques to help you manage the compulsion." STEPHANIE [869-870]

"Figuring out what your needs are and remembering to pick up the tools." EMMA [146]

Several participants identified the concept of the programme being multifaceted. For example, Ed believes the programme works because it covers all the "*angles*".

"I think the 12 Step programme is incredibly useful… because it hits the problem from every angle… Doing service, doing your gratitude lists, doing your prayer, doing the meetings, getting a sponsor. All these things are doing very different things… it's a cocktail of treatments." ED [242-247]

3.3.2.3: Choosing an Individualised Plan

Participants spoke of the importance of being able to choose for themselves which parts of the programme they wished to utilise in their recovery; suggesting that personalised choice was a helpful recovery process. Ed acknowledged that there are parts of the

programme that are most effective for different people. Alice describes being able to choose if she wants to try what has worked for others, applying the tools of the programme, to meet her current needs.

"Everyone I think has different elements of recovery which work most for them." ED [23]

"They're sharing what's worked for them… it's down to me if I want to apply them in the right way for me" ALICE [319]

3.3.3: Working the Steps

Stephanie believed that working the steps was in an integral part of engaging in her fellowship otherwise it is "*just another diet*". Alice has been through the steps several times and thinks this has increased her self-awareness.

"Doing OA and not doing the step work is just another diet" STEPHANIE [565-566]

"Each time I went through the steps I got a little bit more of an understanding. The third time it was really in-depth... you really look inwards" ALICE [432-434]

3.3.3.1: Change

The notion of change springing from the steps was posited by several of the participants. Abdul spoke at length about how completing the steps had helped him, and Alice explained that they are a process of change that enabled her to overcome her unhealthy behaviours.

"Do them and everything will change for you." ABDUL [144]

"The steps were about change. I'm ready to let go of all the behaviour and change… I can leave all that shit behind." ALICE [611-612]

Although each participant to some extent discussed each step, for pragmatic reasons, this results section will focus on those that were mentioned most frequently, steps one and four.

3.3.3.2: Step 1

Participants spoke about Step One in relation to understanding their powerlessness over their addiction and coming to see how unmanageable their lives had become. Participants described how this step helped them to recognise they were addicts and see the need to change their lives. Alice pointed out that what makes an addict is the inability to stop and the chaos that is found in their lifestyle. She also believes that because of our powerlessness, "*once we're drinking, it's too late…"* [ALICE, 481].

We all know people that drink a bit too much. But, they're not alcoholics. They can stop drinking and go back to work. They're not unmanageable and don't have the mental obsession I do." ALICE [457-458]

Emma spoke about Step One helping her to "*getting out of the denial"* [160-161] and how she already knew on some level that she was powerless.

"I think mentally I'd already done my step one before I even came in. The last weekend I used drugs, I didn't want to but I did… I realised my powerlessness." EMMA [491-492]

Abdul highlighted that he realised that his powerlessness was the crux of the problem and that having a thorough step one understanding gave him a "*strong foundation*" to his recovery.

"Step one was really the problem. I now know I was powerless. I didn't know that all these years. My dilemma was lack of power because my willpower is not enough… I admitted to myself that I was an addict… I really understood step one, making a strong foundation for me" ABDUL [108-113]

Alice associated her unmanageability with explicit consequences, such as losing her children, job or home. She later described how for her the unmanageability created a vicious circle from which she found it hard to break out of her addiction.

"I got to that point I was going to lose my kids. I would have lost my job and my home. My family wasn't talking to me." ALICE [355-356]

"It's just unmanageable for the whole of my life, before, during and after getting drunk. The more unmanageable you get the more you drink to make it go away." ALICE [469-471]

Abdul described an explicit unmanageability, in that he was in trouble with the police on a regular basis, but he also talked about the implicit unmanageability of self-hatred.

"The police and judges hated me; I'm a menace to society, they would say. I started to believe it, I self-hated. To look at myself in the mirror was hard." ABDUL [188-189]

Emma spoke about not being outwardly unmanageable, but instead having inner turmoil and distress.

"My life wasn't that chaotic from the outside. It was internally… I think my life was fairly functional. I didn't really act out. It was more acting in, cancelling, bailing, sabotaging and withdrawing. Just not showing up for my life. Making my life smaller and smaller until the only people that were really in my life were people that were drinking and

using drugs. It was that sort of unmanageability. I wasn't living in a bin. But still, it wasn't healthy. I was really depressed." EMMA [497-501]

3.3.3.3: Step 4

When discussing Step Four participants described listing and letting go of their resentments towards others and these accounts suggested that this an emotionally cathartic experience. Alice described finding step four to be beneficial as it is the opportunity to "*look at yourself and your fears and what drives you*" [441]; with this self-awareness, she could come to understand why she had behaved the way she had.

"We're blessed to get that understanding, because most people run through life, behaving and reacting and have no idea why they did it. To go through it really opened my eyes up to my behaviours." ALICE [577-579]

"It's where you get to free yourself. It was amazing. It was tiring. I felt emotionally exhausted. I felt empty. Just because it was all gone. All that hate" ALICE [593-594]

Stephanie described how the process freed her from negative thinking and this enabled her focus on her future.

"I had two and a half note-books and I can hardly remember any of it now. It was ridiculous just carrying that stuff round. It made me understand my relationship with food, cleared out a lot of crap so that I could just concentrate on the important things, like the future." STEPHANIE [575-578]

3.4: Connecting With Other Addicts

All participants described the connection with other addicts as being helpful in their recovery. Figure 4 clarifies these processes through illustrating the sub-categories, their

relationship to each other, and the main category. The sub-categories are interactive and interweave to create a sense of identity, community and connection with the others they meet in recovery. This category is linked to the sub-category of 'Going to Meetings'; for it is at meetings that participants heard other people share their stories and began to see they were not alone.

Figure 4: Relationship of Sub-categories to Each Other Within the Main Category of 'Connecting With Other Addicts'.

3.4.1: Identifying with Others

All participants described finding the connective process of identifying with others in the fellowships helpful in their recovery. This process subsumed the processes of relating to others, sharing with others and reducing shame.

3.4.1.1: Relating to Others

All participants described relating to people at the meetings with similar stories to their own. For example, Stephanie recalled at her first meetings that she realised she was not alone and Ed also articulated finding identification with people who had similar thoughts to him.

"it's helpful to know that you're not on your own. When you go into your first meeting, you hear other people saying the same things that you've been thinking all your life."

STEPHANIE [505-506]

"I heard people who thought like me… I hadn't really heard that before… I'd spent my whole life wondering what the fuck is wrong with me? Then coming in there, hearing that, getting the identification and realising this was what's wrong." ED [63-67]

Claire expressed a similar experience and highlighted that despite being from different socioeconomic and cultural backgrounds, she was still able to find the same amount of identification with them. Claire also described herself as "*one of them*", which suggested that she had developed a strong sense of belonging in the fellowships.

"Hearing other people's stories I realised I was one of them. Some of their experiences mirrored mine… We are all absolutely the same on some level… Even though they might have come from a different walk of life to me. I've identified with a lot of other people" CLAIRE [112 – 115]

Abdul and Alice linked the experience of seeing people who used to be like them and have recovered, saying that it gave them "*hope*".

"What he was sharing was what I've gone through. I started to understand that these people are just like me and there's a way out. I was given hope there." ABDUL [62-63]

"I'd seen all these people that drank, thought, behaved and had consequences like me and they don't do it anymore." ALICE [23-24]

3.4.1.2: Sharing with Others

The process of identifying with others was facilitated through the act of sharing with others and participants suggested that gave them a sense of catharsis and hope. Emma recalled how as a newcomer she found it moving when she experienced people sharing their feelings and receiving compassion from others as a result.

"I was really moved by people sharing their pain, their shame, their deepest, darkest human stuff and in return receiving love and empathy." EMMA [52-53]

Abdul described being put at "*ease"* by his sponsor sharing something personal as it meant he felt more comfortable him some of his own story.

"He shared something bad about himself, that he had come to terms with…. it made me feel at ease." ABDUL [241-242]

Alice emphasised that she feels comfortable sharing her own story if it will help others, as she has come to terms with her behaviour in the past.

"I will tell my story to anyone because it'll help. I'm not ashamed of it. It's who I was." ALICE [794-795]

3.4.1.3: Reducing Shame

A topic that came up in the majority of interviews was shame and how this isolated them. Either shame about behaviours while using or from the stigma of being an addict, but more often that they used addictive behaviours to self-medicate because they felt shame about who they were. Participants described how the fellowships helped reduce this

shame. Abdul articulates experiencing shame for his antisocial behaviours and how these behaviours made him dislike himself. He also shared "*shameful*" experiences with his sponsor and in doing so, he realised that he was not at fault for the abuse he had experienced in foster care.

"I used to sit there in tears with the remorse and shame about myself… I didn't like myself for the way I was behaving." ABDUL [180-181]

"He told me something that was shameful about him…then he said tell me something you're really ashamed of... I told him a very shameful thing that happened to me. I realised I was carrying someone else's shame." ABDUL [229-230]

Emma realised what led her to isolate and use drugs were those feelings of "t*oxic*" shame that she developed from experiences with her father; she then described how sharing her shame with others helped to reduce it. Irena echoed this, describing shame as a "*core*" feeling, which keeps us *"hidden*", but that the fellowships heal by encouraging members to share it with others.

"I think what kept me addicted and isolated was stuff I felt ashamed of. In the rooms I learn to reveal that shame and get empathy. It dilutes it. I think toxic shame and addiction, go hand in hand… Feeling that you are bad, it's very easy to throw a load of substances down your neck…." EMMA [119-123]

"Shame is a big core one. Shame for depression, shame around past stuff… Hearing other people talk about the stuff that we feel great shame over, and realising that we shouldn't feel so shameful about it. Sharing our shame because shame keeps us hidden." IRENA [468-470]

3.4.2: Reducing Isolation and Building Connection

All participants spoke about how fellowships helped them achieve recovery by reducing isolation and building the connection in their lives. We have already touched on this in the sections on ‘Going to Meetings' and also in ‘Identifying with Others'. But isolation and connection also encompass other elements of the recovery picture, which will be outlined below.

3.4.2.1: Isolating

Participants explained how in their active addiction they were isolated in some way, either physically or emotionally, but also of how addiction made them feel that they wanted to be alone, even when they were lonely. In the following extract, Alice describes her physical isolation and links it to her negative thinking. Earlier in the interview, she had explained how when she drank, she got very paranoid and found it difficult to leave the house, which in turn meant she had no one to talk to about how she was feeling, so she drank more to cope. Irena described a similar desire to isolate because she did not feel "*safe*".

“My drinking was always indoors so I was very isolated. Very alone. My head will always tell me I’m the only one with a problem” ALICE [138]

“I totally isolated myself from the world because I didn't feel safe.” IRENA [266]

Ed described a desire to overcome his addiction on his own and linked his isolation to being egotistical; similarly, Abdul discussed how he isolated because he believed he should overcome his addiction on his own.

“I want to be my own - I want to be egotistical.” ED [153]

"I was isolating, trying to work this one out my way. It never worked." ABDUL [188]

Emma believes that addicts suffer from feeling that they do not belong and this is what leads them to isolate.

"We all have this sense of somehow not belonging, of isolating ourselves and feeling like it's only us. We're alone." EMMA [304-305]

3.4.2.2: Connecting

All the participants described finding a connection in the rooms and indicated that this helped them with their recovery. Emma spoke of her recovery being abstinence and connection; that the strength of the fellowships was in "*human connection*".

"What does my recovery mean to me? Well I suppose first of all it's not using drugs. It's connection." EMMA [770]

"I think that is the power of the rooms. It's that human connection." EMMA [548-549]

Claire described how the meetings had helped her meet people whereas Emma admitted that since she lives alone and no longer sees her "*old using friends*" the meetings are a way for her to make new connections with new healthier friends.

"Meeting people and making contacts. I've connected to a lot of people" CLAIRE [92]

"I live on my own. I don't see any of my old using friends, if I didn't have meetings, I wouldn't be able to connect with other human beings... It's helping me to form closer relationships with people." EMMA [172-174]

After years of isolation, Irena explained that what drew her to the fellowships was that she could connect to people and feel that she "*belonged*".

"People were very warm and welcoming. They were interested in me, they wanted to know how I was. I just knew I was at home, that's where I belonged… That was probably the first attraction for me, I connected to people." IRENA [30-33]

3.4.3: Reciprocal Helping

All participants described the mutual aid element of the fellowships, in the context of recovery friendships, sponsorship and the focus on helping newcomers.

3.4.3.1: Being Helped

In early recovery, participants described the reciprocal helping paradigm as receiving help from others when they were at their most vulnerable. Emma likened the help from other fellowship members to metaphorical "r*opes*" that she used to help herself climb out of a hole.

"As soon as I said I can't do this on my own, help, went to NA meetings, the ropes came down. Then I started to climb out." EMMA [144-145]

Claire explained how she could be completely honest with her fellowship peers as they can understand her experience in a way that others, who have not suffered from addiction, cannot.

"I've made great friends I can call at any time and say anything to… Because they can understand things in a way that other people that haven't been through that experience can't." CLAIRE[166-167]

3.4.3.2: Sponsorship

All participants had sponsors and several of the participants were also sponsors themselves. Both Ed and Emma mention being able to "*trust*" their sponsor; Ed states

that he gets guidance from his sponsor and Emma mentions that her sponsor understands her.

"We talk, he guides me. It's one addict helping another… I get advice about recovery. It's a big trust thing" ED [581-582]

"I trust her and she's great. I feel she gets me." EMMA [180]

Claire feels that non-directive way her sponsor works with her is beneficial, because instead of telling her what to do, she focuses on helping Claire understand the concepts in the Big Book, as well as suggesting ways to cope with her emotions.

"She will gently encourage and if I don't do it that's fine, she doesn't chastise." CLAIRE [475-476]

"She was going through the Big Book with me, helping me reach a deeper level of understanding and suggesting emotional tools to help my journey." CLAIRE [494-496]

Emma recalls how her sponsor was generous with her time, working hard to help her, without expecting anything in return.

"I'm kind of in awe of the whole process of sponsorship. When I finish a step, I go to her house. We go through it meticulously, unravelling it. It's really intense work. I'm sometimes there for 2-3 hours. It's such a beautiful process." EMMA [435-437]

Not every participant, unfortunately, had an entirely positive experience with their sponsors. After having two sponsors, one of whom relapsed and one of whom was too inexperienced to cope with her relapses; Alice eventually found a sponsor who could support her with her specific needs. She describes how this helped her finally find a meaningful and stable recovery.

"My sponsor understood the mother's point of view, which is what I really needed support with. For me, the turning point was getting the sponsor that really suited me." ALICE [97-98]

3.4.3.3: Helping Others

Emma explained that when she helps someone, she feels a benefit from this experience, describing the chance to help others as a "*gift".* She describes the process of reciprocal helping as being a "*virtuous spiral*" in which old timers support newcomers, who in time will support other newcomers.

"It's one addict helping another. If I phone somebody up and I have a problem, I can share my pain with them. They will benefit from that interaction as well. Before, I didn't want to speak to someone because I'd be burdening them, whereas now I'm starting to think of it more as a gift. I like it when people phone me when they have a problem and I can help them, because it helps me. It's this mutual exchange." EMMA [104-109]

"I suppose I kind of see meetings and recovery as being a virtuous spiral of people. You start off at the bottom of the spiral. As you're moving in, everyone's reaching down and trying to pull up the newcomer." EMMA [691-693]

Alice described helping others as an important part of maintaining her recovery describing how it gives her a sense of purpose and meaning. She also emphasised that it helped remind her how far she had come on her journey to recovery.

"It gives me such a great sense of achievement… when I was drinking, I felt useless, no good to anybody. Now, helping others just lifts me up." ALICE [204-206]

"It feeds my soul. It gives me ease and comfort to help someone else. It also reminds me of where I've come from and how far I've grown." ALICE [131-132]

3.5: Creating Change

Participants described processes through which they were able to facilitate change in their lives and thus maintain their recovery. These processes interacted with each other and with other processes in the other main categories, such as 'Working the Steps' and 'Understanding My Own Addictive Processes'. Figure 5 illustrates the interactive nature of these processes and how the sub-categories feed into each other, around the central main category of Creating Change.

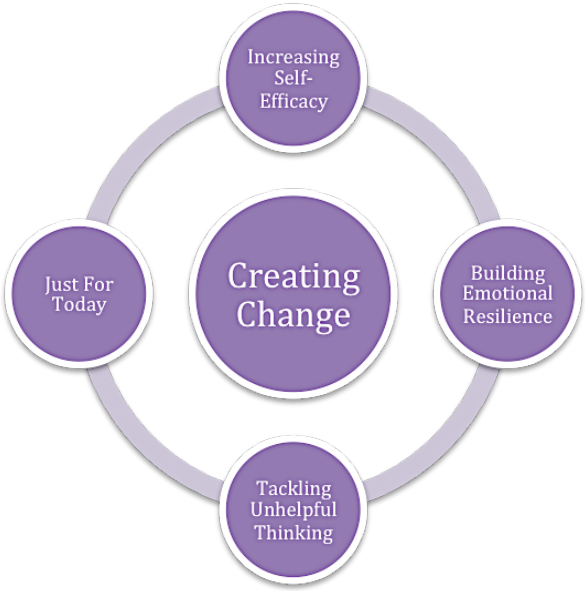

Figure 5: Interaction of the Sub-Categories of 'Creating Change'

3.5.1: Increasing Self-Efficacy

Participants described a process where they realise that change has to come from within themselves and not from an external source. Alice explained that she reached a point when she knew she could not carry on relapsing and this helped her to choose to make changes in her life. Abdul also knew it was him who needed to change if he wanted things to be different. Ed believes that it is unlikely one can recover without making changes to the rest of their life.

"I think when you're in a place when you know that you're completely battered by it and you can't continue to drink, that's the point where you will change your life… I had a choice, either carry on drinking or change and I wanted to change." ALICE [402-403]

"If I wasn't to change, nothing would change, I would just be the same person from before." ABDUL [247-248]

"Whether it's credible to go through the process of recovering and not make massive changes to the rest of your life seems unlikely to me." ED [388-389]

Both Claire and Stephanie articulated their understanding that they cannot change others, so the only change they can affect is within themselves.

"Courage to change the things I can, like your addiction, thought patterns, behaviour, that's within your power. I can't change other people; I can just change my reaction to them." CLAIRE [381-383]

"There is no point wasting your energy trying to change things that you're never going to change. You've got to change the things you can, which is you." STEPHANIE [737-739]

3.5.2: Building Emotional Resilience

Accounts suggested that participants were able to facilitate change through building emotional resilience. Alice described how she came to realise that what kept leading her to relapse were the struggles she had with her emotions. Claire built upon this to explain that she was maintaining her recovery by learning to cope with her emotions better.

"What that really helped open my eyes up, was that it was about that emotional stuff, that was my trigger." ALICE [334-335]

"The thing I'm working on is being able to just sit with my emotions. Since I've been sober the problems I had before are still around, but I'm better able to deal with them."

CLAIRE [126-127]

Stephanie observed that she had learnt that it was okay to allow herself to feel emotions, suggesting she got relief from the healthy outlet of her feelings.

"I know that showing emotion is not going to send you crazy… Whether it's anger or tears or happiness, I know it feels good. Emotion is a sign that this is important."

STEPHANIE [163-165]

3.5.3: Tackling Negative Thinking

Resentments, anger, pride, anxiety and depression were a part of every participants' experience, and they all described how the programme had helped them to overcome such negative thinking. Abdul described how he tried to address the resentments he held towards those in his life because there were unhealthy for him. Alice recalls that when she first came into recovery she struggled with her feelings of anger, which would cause her to relapse.

"My father, whom I hated all my life. My family, most of my friends, anyone I had resentment with… it's poison for me to keep that stuff in me." ABDUL [173-174]

"Resentment is the number one offender, and I was so angry when I came in… these things just pile up on me and I get to a point where I go 'oh, I know what will make that go away. Let's have a drink.' You can let go of that hate." ALICE [599-603]

3.5.4: Just For Today

The concept of Just for Today was mentioned by participants as a process which enabled change, in several ways. For example, Emma and Alice both described how scary the thought of "*never*" using drink or drugs again was to them; Just for Today enabled them to focus on staying 'clean' in the here and now. Ed highlighted how the 'Just for Today' philosophy could be used to help get through times when one is close to relapsing.

"It's keeping it in the day… because if I thought well I can never use drugs again, I'd just say oh fuck. Whereas if I think I'm not going to use drugs today, I can deal with that. It's breaking it down into manageable pieces." EMMA [725-728]

"My head was like I'm never going to be able to drink again. What the fuck am I going to do with no drink? That was so important for me in the beginning. I just need to do what I need to do today to get through it sober. ALICE [851-853]

"Just for Today when the urge comes upon you… When it's bad, you always know you can get through the day." ED [481-482]

Claire found that the ability to live in the moment freed her from worrying about the future.

"It's so comforting that you just have to get through your day without picking up. Not projecting to tomorrow, just keeping it in the day." CLAIRE [321-322]

3.6: Going to Any Lengths

Going to any lengths is an implicit extension of 'Working the Programme' but appears to be a separate process in its own right. Figure 6 illustrates how the willingness to go to any lengths in recovery can lead to the sub-categories of 'Keeping the Focus on Recovery' and 'Engaging in Other Treatments'.

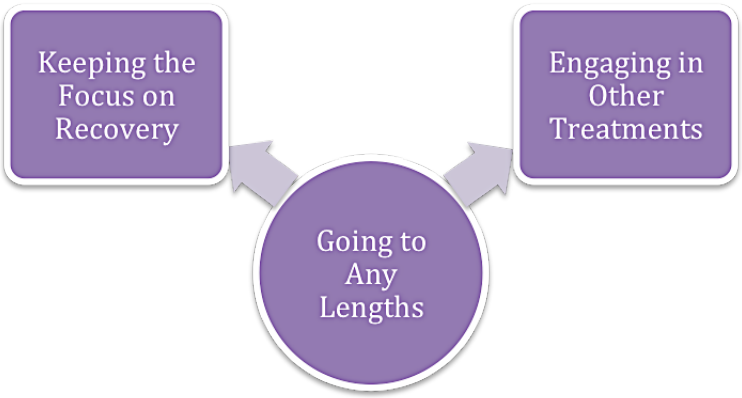

Figure 6: The main category of 'Going to Any Lengths' leading to it's sub-categories

3.6.1: Keeping the Focus on Recovery

3.6.1.1: Ensuring Recovery Comes First

Participants described ensuring that recovery needs are put before all other needs. Claire, the participant with the least sobriety, recognises that she needs to prioritise her recovery. Abdul clarified that he must put recovery first because if he lost his abstinence anything else he values will also be lost.

"My sobriety comes above everything in my life including my children… The most important thing at the moment is keeping sober day-to-day." CLAIRE [417-418]

"Anything I put in front of recovery, it could be the second thing I lose, because the first thing I'm going to lose is recovery" ABDUL [455].

Ed explained how he made sure he prioritised meetings by comparing it to his using behaviours, believing that if addicts put as much effort into their recovery as into their addictions, then they will recover.

"I always used to manage to squeeze in a bit of time to use drugs. That was my rule for missing a meeting. If I could honestly say, the reason for missing [the meeting] was so pressing I would have not gone on a night out and used drugs. I could then miss the meeting." ED [218-219]

"I think if most addicts would put in a quarter of the effort we put in for recovery as we did into our using we'd be okay." ED [228-229]

When Alice left treatment she had to cope with her ex-partner, with whom she had a fractured relationship, and parents who were still in active addiction. She had to work hard to make sure it did not affect her recovery.

"It's really hard when you're trying to change your life… but everything else is the same." ALICE [260-261]

3.6.1.2: Challenging Complacency

Oliver hypothesised that if he were to relapse, then it would be a result of stopping working the programme, as he would get complacent.

"If I stopped going to meetings and stopped calling my sponsor, just totally dropped it. I imagine I'd convince myself quite quickly that it would be fine to do some drugs." OLIVER [558-559]

Alice pointed out that it is easy to forget what active addiction was like, pointing out that it only takes one slip to return to that state.

"The further on you get, you forget that desperation you had when you first came in. You get complacent… We're all one drink or one drug away from being a newcomer again." ALICE [134-135]

3.6.2: Engaging with Other Treatments

3.6.2.1: Treatment Centres – Private and NHS

Four participants described how they had combined professional treatments with their fellowship attendance to gain stable recovery. Abdul went to an NHS inpatient treatment centre, which was explicitly based on twelve-step principles and Oliver went to a private treatment centre that adapted the twelve-step programme for its own use.

"They were doing a twelve-step based programme." ABDUL [68]

"I went to inpatient rehab for a month. They have their own version of the steps, which is pretty similar." OLIVER [17-18]

Both Claire and Alice described trying to get help using NHS resources, but then when they could not access that help or it did not work, they both had to go to a private treatment centre, which encouraged using the fellowships as aftercare.

"I did two forms of treatment. The first place was through my GP. They got me to do a drink diary to cut down and that didn't work. So I went to a private treatment centre." CLAIRE [34-36]

"I went to the GP; I had to stop drinking for them to help me. Couldn't stop drinking so had to pay to go to a 12-step fellowship treatment centre and that's where I got introduced to meetings." ALICE [11-13]

3.6.2.2: Therapy

Emma believes that therapy and the fellowships work well together and elsewhere in the interview she described that her therapist helped her see the need to stop using drugs.

"I have a therapist… It's helpful in a different way. I think they work together. It's another tool for self-awareness." EMMA [148-150]

Ed explains that his therapist is helpful but she seems ambivalent about the fellowships.

"I have a wonderful Freudian woman… She understands a limited amount about the fellowships… She has an ambivalence towards the higher power issue because she has a strong belief in self-actualisation." ED [332-337]

3.7: Understanding Addiction

This section presents the findings that explore the process of being educated about addiction through the programme and how this helps fellowship members in their pursuit of stable and lasting recovery. Figure 7 shows how one process feeds directly into the other, where participants described how understanding addiction theory, in general, enabled them to apply it to their own experiences.

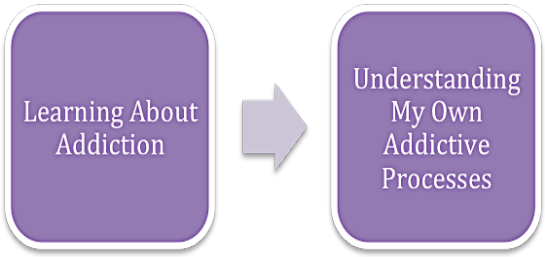

Figure 7: Interaction of Sub-categories Within the Main Category of 'Understanding Addiction'.

3.7.1: Learning About Addiction

Participants appeared to find the educational side of the programme helpful and this process is intrinsically linked with 'Understanding My Own Addictive Processes'.

3.7.1.1: Reading Literature

Most participants discussed reading literature to some degree in their interviews, mostly in relation to the Big Book, but also their own fellowship specific texts and other supporting literature. Claire explains that reading literature is a large element in her own recovery programme. Abdul explains how he could relate the literature on a personal level.

"I find the Big Book very positive. I read a personal story at the back every night. I also read Understanding the Twelve Steps, the Thought for the Day and Just for Today. Reading literature is a big part of my recovery" CLAIRE [54-56]

"I was highlighting certain bits out of the book which I could relate to myself, I could see myself in here." ABDUL [134-135]

3.7.1.2: Understanding the Disease Model

The concept of addiction as a disease is explained in detail in the Big Book and participants recalled how it changed their perspective on themselves.

"It answered questions that I didn't even know that I'd had. It means that I wasn't this terrible weak willed person. It changed my concept of myself." CLAIRE [422-423]

"I learned that it was not me being a failure or lazy or greedy or weak. It was something that was beyond my control; it's not my fault." STEPHANIE [296-297]

Although all participants describe finding the concept of the disease model to be helpful, some also acknowledged their own scepticism around the accuracy of the theory and so moderated the disease model to fit their own views. Emma changed the concept to mean a "dis-ease" with herself while Ed felt the disease model was not an exact fit but it was a pragmatic description.

"What I do is separate dis and ease. I'm not at ease with myself. I want to change how I feel. It's a dis-ease… because 'disease' makes me feel like I can't do anything about it." EMMA [732-733]

"We know it doesn't work like that but we don't know how it works. Addiction is not a disease but it's very much like a disease… it's a good metaphor." ED [364-367]

3.7.2: Understanding My Own Addictive Processes

Another aspect of the process of 'Understanding Addiction' is coming to understand how they have come to be addicts, how their addiction manifests itself and what underlies their addiction.

3.7.2.1: Understanding Why I Used

Participants described developing an understanding of why they used. Emma suggested that part of her defence against relapse is having a greater compassionate awareness of this process. Abdul attributed the reason behind why he used, as wanting to "*numb*" his feelings. Ed explained that the reason used drugs was because of his inability to accept himself.

"I think part of the way to stop yourself going back down that hole, is to go 'how did I get here?' Otherwise we're just going to start using again. I think 12-step recovery helps us to unravel that. If you stop using drugs, then you'll find out why you used them… To understand my story not with shame but with self-compassion, empathy and kindness." EMMA [248-253]

"I couldn't manage my emotions and my feelings, I always acted on them. I needed to use and drink to keep me numb, because I couldn't cope with life." ABDUL [124-125]

"Understanding you are compelled to do drugs because you feel unable to accept yourself and your feelings, the pain, the incredible anxiety." ED [135-136]

Irena grew up with an "*alcoholic father and a co-dependent mother*" [102] and she spoke of her addictive processes being outlets for the pain she felt in childhood. Claire also explained that she came to see that the traumatic experiences she had gone through were also part of the picture.

"I started to realise that all of these things connected to traumas in my childhood. They all spring from the same place, they're just different manifestations of that pain." IRENA [76-77]

"I just thought my body was getting addicted to it, I didn't think it was my mind ever… until it was clearly pointed out, I didn't know. I had been through a lot of things and drank because of it." CLAIRE [411-412]

3.7.2.2: Learning from Relapse

Claire, Alice, Stephanie and Ed all identified relapses in their recovery; but they described using these as a learning experience. For example, Alice realised that she had let her stress levels rise, while Stephanie described that letting "*resentments build up*" had caused her relapse.

"I was getting 35-40 days sober and then the pressure of work and kids. I was like a cooker exploding, I'd blitz out for a week and then try again." ALICE [49-50]

"I had been letting some resentments build up. I hadn't been doing the work I needed to get rid of those." STEPHANIE [611]

3.7.2.3: Recognising Cross Addiction

Most participants identified in interviews that they believed themselves to be prone to multiple addictive behaviours to varying degrees. Abdul, Alice and Irena all described serious cross addiction issues, in addition to their primary addiction.

"I put down the weed but then I picked up the drink and realised I have a problem with that too. I am a member of many fellowships: MA, NA and SLAA, AA, DA, UA. So I identify as an addict of many things." IRENA [68-70]

3.8: Coming to Believe

This category combines the processes of coming to believe in the programme, through 'Seeing Positive Changes' and coming to believe in a higher power, through 'Working a Spiritual Programme'. Both of which come together to create a belief in our ability to achieve recovery and of living a better life. Figure 8 illustrates these processes.

Figure 8: Intersection of Sub-categories to Create the Main Category 'Coming to Believe'.

Abdul describes how he gradually developed a belief that the programme could work for him. Emma explained how going through recovery is a process that "*requires faith*".

"At the time I didn't believe it but I came to believe… I knew that I could do what they did." ABDUL [127-128]

"It's a coming to believe… Becoming a more functional, happier person, that's a process… That requires a kind of faith." EMMA [560-562]

3.8.1: Seeing Positive Changes

Participants highlighted that part of the process of 'Coming to Believe' is seeing the positive changes it brings. Stephanie described how the programme has helped her reach her full potential. Alice earlier in the interview had described a fear that quitting drinking meant she would "*never have fun again"* [136] but she describes how her life has improved with recovery.

"I feel like I've become the person that I was always supposed to be… Being a kinder, nicer, positive person." STEPHANIE [278-279]

"Life goes on after you put the drink and drugs down. It gets better... Recovery, gives me ease, comfort and peace. It gives me a new way to live by." ALICE [923-924]

Claire and Alice described improvements in their relationships with family and loved ones.

"Being in the fellowships has brought about changes in the relationships with others in my life. My relationship with my children has been amazing." CLAIRE [190-191]

"It's given my kids their mum, my mum her daughter back. I didn't have a relationship with my mum apart from an aggressive one, since I've come into recovery… It's given us a new relationship." ALICE [937-939]

Stephanie described that as a sponsor, she has been able to see the positive changes the programme has bought to her sponsee's life.

"I'm taking a girl through it at the moment and she's changing unbelievably... it reminds me of how great this is and how it works" STEPHANIE [819-822]

3.8.2: Having a Spiritual Awakening

This is the area where theoretical sampling was focused because further exploration was needed before saturation could be reached. On the whole, being spiritual was seen as being helpful, but most participants were ambivalent about the concept of a higher power. What has been included in this category are those mentions of spirituality or a higher power being useful; a presentation of extracts where the focus on spirituality was viewed negatively is presented in section 3.9.1.2

3.8.2.1: Increasing Spirituality

Irena used an apt metaphor to describe her view that you cannot completely define spirituality, but you can feel it. She later described spirituality as "*connection*" and "*transformation*".

"I can explain it with a metaphor. If I'm standing on top of a mountain with a blind person and I'm looking at a beautiful sunset, I can try to explain what beauty I see in front of me. This woman would never understand, but if I try to explain how it makes me feel, we can connect on that level.." IRENA [176-182]

"Spirituality is about connection and transformation." IRENA [230]

Oliver was particularly ambivalent towards the higher power issue, nevertheless had gone through a process of reflection of what his views on sprituality were. He echoed the

thoughts of many participants that "*doing good*" was a major component of spirituality. Alice believed spirituality was learning to appreciate what she had in life.

"I define spirituality as doing good, and an awareness of self." OLIVER [188]

"Spiritual growth is about feeding my soul and seeing the magic in the world every day. It's having an appreciation for normal stuff" ALICE [201-204]

3.8.2.2: Coming to Understand a Higher Power

All of the participants explained during their interviews that they weren't religious in the traditional sense, but that they had explored the concept of a higher power and had incorporated this into their recovery.

Stephanie echoed the majority consensus among participants when she stated that she is an "*atheist"* but that she has a higher power.

"I'll say I'm an atheist but I have a higher power. It sounds like a contradiction, but it works" STEPHANIE [862-863]

Abdul explained he was not religious but believed "*something"* protected him, as he had come close to death several times in his active addiction.

"I have come to believe and understand a power greater than myself. I believe in the universe, it's my concept of a higher power. I'm not really a religious person but I believe… there was something looking after me, because many times I shouldn't have made it. I've had overdoses." ABDUL [192-197]

Oliver described some advice he was given when he sought guidance; that a *"power greater than yourself"* can be anything other than you, so he defines the group as his higher power.

“He said, do you think there's anything which is more important than you? I said, yeah. He said, well, that in itself is a power greater than yourself.” OLIVER [306-308]

“The group helps me stay sober. I believe in the power of the group. It doesn't matter who's in that group. It could be 20 new people I've never met before, but as long as they're in recovery, it has the same power.” OLIVER [324-328]

Both Emma and Ed mentioned connection when discussing their personal higher power concept.

“Higher power is anything that is more powerful than me… it connects me to the world. It takes me away from that feeling of isolation and separateness. “ EMMA [535-536]

“It allows us to feel loved. The higher power connection is a very strong connection.” ED [354-355]

Box 3 presents a memo I made concerning how each individual’s higher power concept appears to be a construction.

Memo 20/7/2016 - Higher Power as a Construct?

"My higher power, well it started off being OA, so basically the existence of this other thing with other people who can help, and then it became a little puppy that I happened to come across in a café. Now, it's this imaginary best friend called Phil. He might change. At the moment, he's my best friend; I can go to him with anything. He will always give me nice, clear advice if I listen to him." STEPHANIE [354-360]

This statement struck me, because although she was avowedly atheist, Stephanie also described finding having a higher power a powerful source for good in her recovery. When she described how she came to construct a concept of a higher power herself, I began think about how we all construct our idea of a higher power to some extent from influences throughout our lives. Our HP construct is unique to each of us.

Of course there is also the element of choice, as we choose what to put into our image of a Higher Power. We can choose to disregard long held ideas, in favour of something that fits more succinctly with our beliefs and embodies the characteristics we need for our recovery.

This journey to choosing a construct of a Higher Power has opened participants up to a spirituality they hadn't perhaps explored before. It makes them think about how they see the world, how they want the world to be, how they want to fit into that world. So far in my analysis I have struggled to understand where to put higher power, god and spirituality. As such I believe that exploring, coming to understand and having a belief in a higher power are all part of the same process. We don't have to have a fully defined concept of a higher power to benefit from it; even the journey itself is part of the process.

Box 1: Reflective Memo About Exploring the Concept of a Higher Power.

3.9: Alternative Perspectives on the Fellowships

This section of the chapter encompasses a different side to the story told so far. Part of creating an unbiased study is the importance of allowing space for an alternative perspective. 'Problems with the Fellowship' incorporates those aspects of the fellowships

have been unhelpful to the participant's recovery. The negative case sample is also discussed, giving voice to a participant who has not wanted to utilise the fellowships in her recovery.

3.9.1: Problems with the Fellowships

This section outlines the category that incorporates the problematic elements of the fellowships as reported by the participants interviewed. Figure 9 demonstrates how processes feed into problems within the fellowship structure, and how they may be linked to each other.

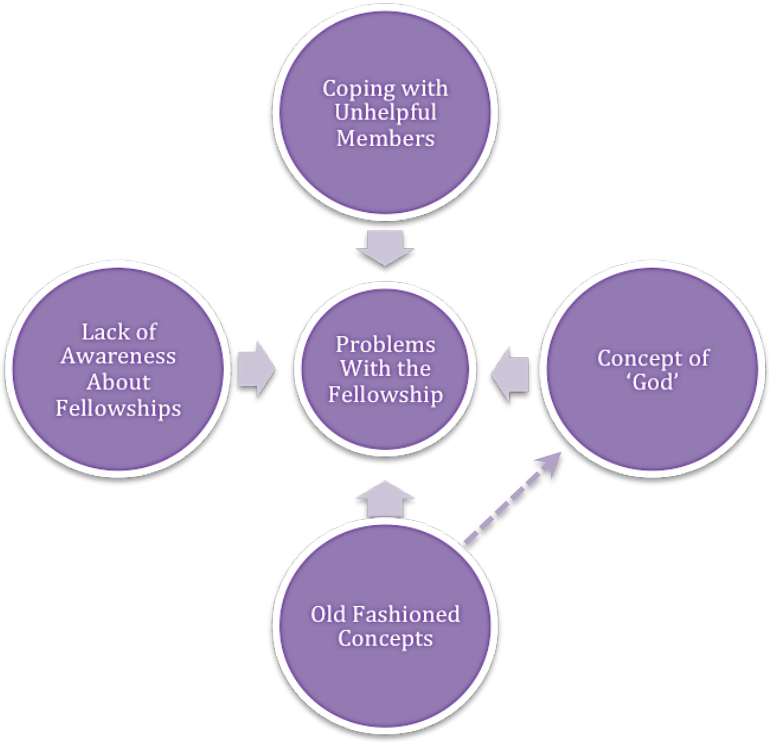

Figure 9: The Problems with the Fellowships

3.9.1.1: Coping with Unhelpful Members

One of the most frequent problem participants discussed was that they had occasionally had to cope with other members who were unhelpful to their recovery. Participants

described experiences with people who were acting out, who tried to enforce their opinions onto others and even those who behaved in a sexually inappropriate manner. Irena and Oliver described meeting some members who "*preached*" about their way of doing the programme.

"People like to preach at other people about recovery. They tell you how you should be doing it." IRENA[531-532]

"There are some who believe if you're not doing it their way, then you're not committed enough to the programme and you're going to relapse" OLIVER [434-435]

Alice observes that there are a few people who go to meetings and lie about their recovery, or who act out in other ways which could be harmful to other members. Ed described an incident when someone was sexually inappropriate towards him in early recovery.

"There are people that go to meetings, who are telling other people they're recovered and how to get recovery, but act out in other ways, and that's a dangerous thing," ALICE [290-291]

"Some people are arseholes. I met one in early recovery. There was a guy who was extremely sexually aggressive with me in front of other people… You cannot sexually police people in the room. On the other hand vulnerable people could get hurt." ED [401-406]

Irena points out that such people are also in recovery and so might be unwell. Emma believes that the reality of the being in a fellowship means that there will be some challenging people.

"We're all addicts, we're all trying to do our best obviously and everybody's in a different place. We do get triggered" IRENA [527-528]

"I have come across difficult people. I think that is the nature of recovery. The meetings are a melting pot of how to be more socially resilient" EMMA [224-225]

3.9.1.2: Concept of 'God'

The overreliance on the word 'God', but also on what are perceived to be religious concepts, was mentioned by eight out of nine participants. Emma describes how she initially was put off the programme by the use of the words 'God' and "*him*", as it had too many religious connotations. Although she later came back to the programme and finds it helpful, this is still a problem for her. Stephanie believes that if the programme used the word 'Higher Power' in it's readings instead of 'God' then more newcomers might come back.

"I read the 12 steps and dismissed it after the second step, because I'm not a religious person... I don't like that it says Him as a God. That bugs me. I zone the word God out." EMMA [216-217]

"When I first started, I was like, what is this? I don't want to say a prayer. If I hadn't had been quite so desperate, I probably would have gone after the first meeting. Everything is a God with a capital G and him with a capital H. Instead of the word God I say higher power. I think if we always used 'higher power' and not 'God', that would be much more attractive to people. The god thing, it scares people away" STEPHANIE [354-359]

Irena highlighted the contradiction in the emphasis on being completely honest in her recovery but at the same time having to regularly use a word that feels so dishonest to her beliefs.

"I can't say the word God. How can I be honest in my programme if I'm just going along with the concept of God, even if I don't believe it? I can't do both… It's an honest programme. Why am I lying to myself?" IRENA [203-206]

To further explore the concept of a higher power, the theoretical samples were asked whether it had been helpful or unhelpful to their recovery. Oliver believed that he would have had the same quality of recovery if it had not been part of the programme and he also felt it was a "*hindrance*" to him at first. Irena also felt she would have just as strong a recovery without having the higher power element, yet she believed that the focus on a higher power was different from spirituality.

***"Facilitator:** If they took all the mentions of higher power and spiritual principles out of 12 step recovery, would that have made any difference to your recovery? **Interviewee**: I would say no. It wouldn't have made any difference to my recovery. **Facilitator:** Is it an obstacle that people have to overcome or is it a positive thing? **Interviewee:** It was a hindrance for me at first." OLIVER [374-378]*

*"**Facilitator:** So, if there was no mention of God or higher power, in the programme, do you feel you'd have had just as good a recovery? **Interviewee:** Yes, I do believe that strongly. **Facilitator:** So, you can work the programme without having to have any kind of spirituality?*
***Interviewee:** Spirituality, now that's another word, isn't it?" IRENA [215-220]*

3.9.1.3: Old Fashioned Concepts

Some participants pointed out that some elements of the programme are "*old-fashioned*" and less scientific than modern treatments. Stephanie believes that the literature should be updated, so they are more relatable to newcomers. Oliver felt that the concepts used in his treatment centre were more scientific than AA.

"It's quite old-fashioned… if somebody had just given me a Big Book to read when I first started, it wouldn't have made any difference to me. They could change the wording of it and make it more modern." STEPHANIE [748-750]

"My view on it is that the way the rehab does it is probably the modern scientific way, because it's much more self-driven. It's like here's your defects, here's how you can deal with them. AA is based on a cruder understanding of the science behind recovery." OLIVER [76-78]

3.9.1.4: Lack of Awareness About Fellowships

The lack of awareness about fellowships among 'outsiders' was a problem for many participants. Emma describes how she did not have a clear concept of what fellowships were like before she went and Stephanie recalls that even though she knew about AA and NA, she did not know that there was a fellowship that focuses on compulsive eating behaviours.

"I didn't really know what they were; I just had a very vague idea" EMMA [5]

"I'd never heard of anything. I knew that AA and NA existed but I had no idea there was an OA" STEPHANIE [9]

Alice ended her interview by highlighting that she thinks professionals should know more about the meetings as if she had been told about them by the professionals, she believes she would not have been without support, which led to her relapse.

"I think more people need knowledge of them, GPs especially. The GP didn't tell me about it, neither did the alcohol worker or counsellor they referred me to. Instead I tried doing the journey on my own and ended up [going] back out there." ALICE [950-952]

3.9.2: Negative Case Sample

As part of the rigour of the grounded theory methodology a negative sample, Kate was sought. This participant was someone who had been to a few meetings and decided that the fellowships would not be helpful for her and had then managed to obtain recovery without the aid of the fellowships. Kate described how the turning point for her recovery was when she came to admit to herself she was an alcoholic and that she did not have control over her drinking.

"I came to realise that I couldn't control the alcohol. I couldn't just have one glass."

KATE [14]

Kate's current period of five months of sobriety had come after a stay in a private treatment centre, and she had been in an NHS treatment centre three times previously. Kate said treatment had been helpful because it helped her identify her "*triggers*" and develop strategies for *"coping*". She also attended a weekly support group, provided by her treatment centre, which has helped her see that she was not alone.

"It made me realise what my trigger points were and find different ways of coping with them." KATE [228-229]

"I'm going to the aftercare meetings once a week. It's interesting listening to other people's problems and seeing the similarities between their problems and mine. I'd always thought that it was just me who had all these problems." KATE [181-183]

Kate described the coping strategies that she had been utilising to help her in her recovery. First, she said that she tried to remember how bad her addiction had been. Second, she took it one day at a time and third, she employed relaxation techniques she when got stressed.

"My coping strategy is (1) remember the consequences… What you were like, how awful it felt and how frightened you were." KATE [231-232]

"Just one day at a time and realising that to drink again would probably be fatal." KATE [273-274]

"I still get exasperated. I cope with it differently. I sit down, listen to some music or go for a walk." KATE [505-506]

Kate mentioned her "*network"* of friends as one of the most helpful components to her recovery, both old, and new friends whom she met in recovery.

"I've got a lovely network of friends. Two very close old friends that I've known for a very long time... And I've become good mates with a girl at the aftercare group. We hold each other up…" KATE [311-313]

Although she does not utilise fellowships in her recovery, Kate recalls that she has been to around four AA meetings, a year and a half ago, but she decided that they would not be helpful for her. Although she was surprised that she came in contact with people similar to her, she still felt she did not "*fit in".* She did not like the synthetic atmosphere there, stating that she felt a pressure to share.

"I was surprised because there were so many people who are like me, middle aged women." KATE [353-354]

"They felt very cliquey. I didn't feel like I fitted in. I thought, no, I'll handle this on my own." KATE [450-451]

"I felt that it was artificial… that some of the people who were telling their stories were over-exaggerating." KATE [397-398]

Kate pointed out that the use of 'God' was off-putting and felt the 12 steps, focused on negative concepts, saying that she did not want to "*discuss*" her defects "*with someone else"*.

"I thought there was too much emphasis on God; it put me off." KATE [468]

"I looked at the 12 steps, and the only one that interested me was the first one… I think it's too negative. We know what our defects in character are and it's up to us to sort them out. I don't particularly want to sit and discuss it with somebody else." KATE [416-418]

Another interesting point Kate raised in her interview was that member of fellowships "*defined"* themselves as being an alcoholic and she did not want that for herself.

"It was as if their whole lives were defined by the fact that they are alcoholics. I don't want to define my life as being an alcoholic." KATE [523-524]

3.10: Explicit Versus Implicit Recovery Processes

The emphasis participants placed on how valuable each process had been differed between participants; some participants found more explicit recovery processes helpful and others indicating that underlying implicit processes enhanced their recovery more. Figure 10 illustrates which categories involve either explicit or implicit processes, demonstrating how these interact with each other. A more detailed explanation of what is meant by explicit and implicit processes in this context can be found in the sample memo described in Box 4.

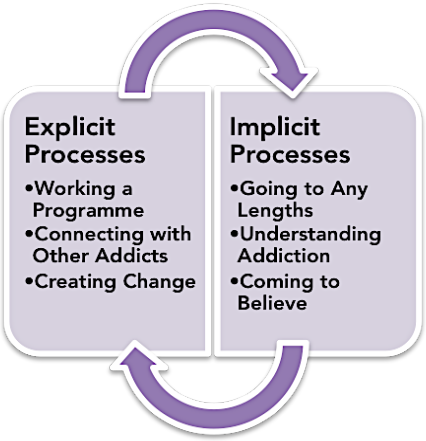

Figure 10: The main categories interacting as implicit and explicit processes

3.10.1: Explicit Processes

Explicit processes are deliberate and conceptual in nature; they are concepts that are clearly communicated by the participants, leaving no room for implication or uncertainty. Three main categories were deemed to contain more explicit processes than the others: 'Working a Programme', 'Connecting with Other Addicts' and 'Creating Change'. Working a programme was a category where participants described practical behaviours such as: going to meetings, following a plan and working the steps. In 'Connecting with Other Addicts' participants explained that the programme increases connection, identification, and abstinence-based support networks. When 'Creating Change', participants explained how the they have learnt to change their thinking and behaviours through the practical and emotional resources offered by the programme.

3.10.2: Implicit Processes

Implicit processes are evocative and experiential; they are inherent in the nature of the experiences of the participants. This can also include processes that are implied by participants but not directly stated. Three main categories that were defined as using

implicit processes were: 'Going to Any Lengths' and 'Understanding Addiction' and 'Coming to Believe'. 'Going to Any Lengths' highlights a process where participants put in extra effort to make sure they stayed sober. Understanding Addiction' appeared to empower participants through psycho-education that enabled them to recognise addictive processes. 'Coming to Believe' meant that participants started to believe the programme would help them, as well as going through a process of spiritual growth.

Memo 18/11/16 - Explicit or Implicit?

When raising focused codes to categories, I followed Charmaz's (2006) advice to distinguish between explicit and implicit to more clearly understand the processes. However, this is not to say that the delineation between them was clear at all times. In order to decide how to classify them, I used the constant comparative method. Going back to the data and writing a memo discussing each category helped me to decide how to incorporate them into my theory.

The processes in the category 'Going to Any Lengths' involved the implication that by putting in extra effort, a participant's recovery was strengthened, for example Stephanie talked about choosing to *"do it properly"* [739]. Yet, because extracts often explicitly outlined putting extra effort into recovery, they could be argued to be an explicit process, *"I will do anything I am told and go to any lengths to maintain my sobriety"* [CLAIRE, 81]. 'Coming to believe' could also be said to include some highly explicit recovery processes, since mentions of 'God' and 'Higher Power' run throughout the interviews. The process of 'Seeing Positive Changes' is an implicit process where participants developed the hope and faith that they too could get better. Others describe a process of implicit exploration and reflection *"I'm so grateful I'm on this journey now and I'm not that person anymore"* [ALICE, 201-204]. So I have categorised it as an implicit process despite some participants explicitly stated they felt the guidance of a higher power. *"If something happens that's prevented me picking up, well that must be some sort of higher power."* [CLAIRE, 333-335].

Box 2: A Memo on How Explicit or Implicit Processes Were Categorised.

3.11: Core Category: Striving For and Maintaining Recovery

The core category that incorporates all main categories into a central concept was identified as ‘Striving For and Maintaining Recovery'. This core category was understood in the context of the participants' specific experience of engagement in the 12-step fellowship programme. Although each participants’ experience was unique in nature, the participants were members of the programme primarily because they were striving for long-term recovery. The main categories were moderators for this process, each providing a different route by which participants were able to reach stable recovery. Each category also interrelated with each other and worked together to create a progression towards meaningful recovery. This is demonstrated in Figure 11, while the relationships between the core category and the main categories are outlined in Table 4.

Figure 11: The Core Category and the Seven Main Categories

Main Category	Category Overview	Link to Striving For and Maintaining Recovery
Working a Programme	Examining practical elements the 12-step programme offer and the ways in which they are used	Tools which are used in striving for and maintaining recovery
Going the Extra Mile	Enhancing recovery by committing to working the programme comprehensively	Ensuring recovery is achieved and maintained
Understanding Addiction	Understanding what addiction is and how it applies to each individual	Psycho-educational processes informing recovery
Connecting with Other Addicts	Exploring the benefits of being in a fellowship with other addicts	Linking with others who are also striving for recovery
Creating Change	Identifying ways in which participants have changed and how they achieved this	Enabling achievement and maintenance of recovery through change
Coming to Believe	Exploring spiritual growth and a belief in their own recovery	Adding a spiritual dimension to the recovery journey
Problems With the Fellowships	Outlining the problems which members encounter in the fellowships	Factors which could impede recovery

Table 4: The Relationships between the core category and the main categories

3.12: Summary and Theory Explanation

The findings outlined in this chapter identify what recovery processes underlie the twelve-step fellowships that enable participants to strive for and maintain recovery. This chapter has also outlined any negative elements of the fellowships that participants discussed. The analysis establishes both explicit and implicit processes, which combine and interact to facilitate participants in their journey towards a stable recovery. Overall the process of attaining recovery appears to be built from the bottom up, where the processes interact together to create a compounding effect, strengthening the recovery of the individual seeking it.

Figure 12 illustrates a proposed model of how 12-step fellowships help addicts who engage with them when striving for stable recovery. It demonstrates how fellowships integrate both implicit and explicit processes in this journey, as well as how these can feed into each other. The extent of interrelation between categories is too numerous to succinctly incorporate into a diagram, so for pragmatic reasons I have included the two most pertinent links. 'Going to Meetings' is strongly linked with helping to improve connection because it enabled participants to meet a support network. 'Doing the Steps', whilst not the only route to 'Creating Change', certainly facilitated the process by which lasting beneficial changes could be implemented into both the behaviours and thinking patterns of addicts. I have also included the category of 'Problems with the Fellowship' to illustrate how in utilising fellowships in their journey for recovery, members may encounter some issues that are intrinsic to the programme.

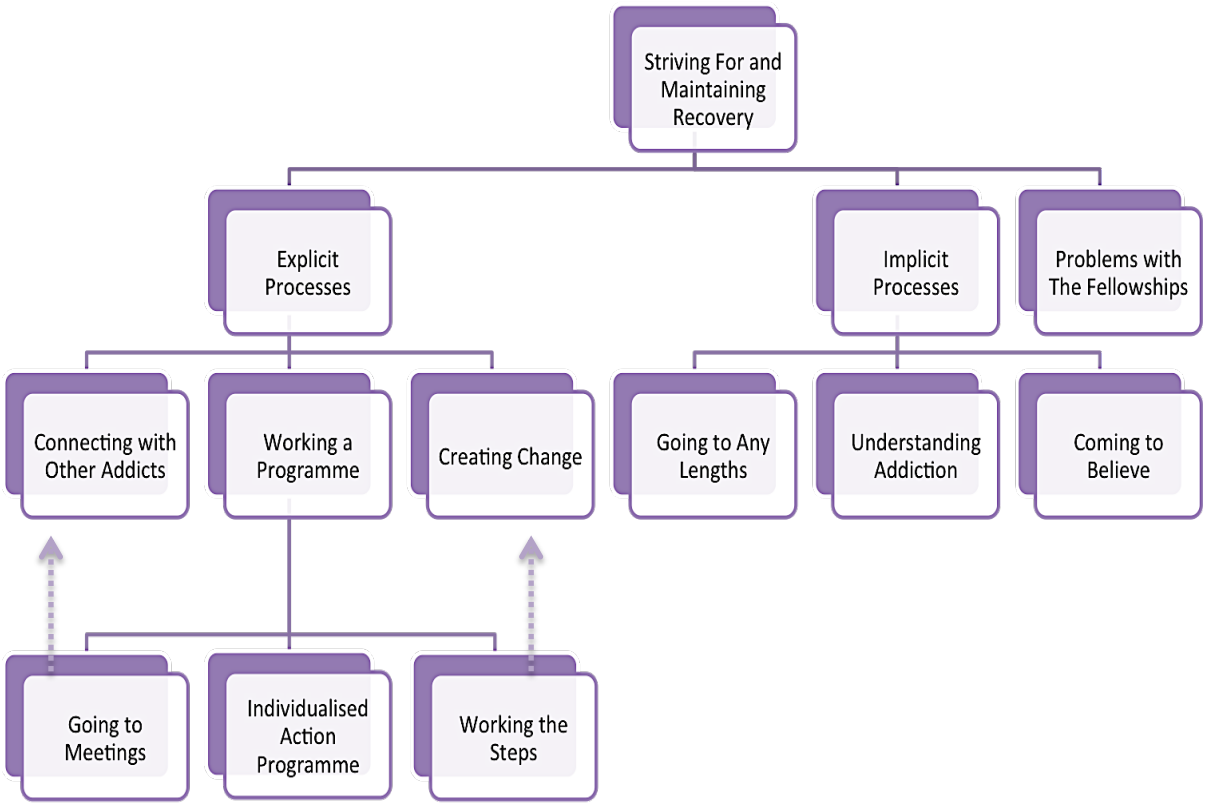

Figure 12. A Proposed Model for the Main Processes Underlying Twelve-Step Fellowship Recovery

In the next chapter, these findings will be discussed further, with links to relevant literature and research. How this theory could have real-world applications will be highlighted, methodological concerns will be addressed, and suggestions for further research will be outlined.

Chapter 4: Discussion

4.1: Overview

In this chapter I discuss the findings laid out in the results section, presenting the model as a whole and discussing its interrelations within categories. I situate these findings in a greater contextual understanding and link them to existing theories and research findings. An evaluation of the quality of the study is then presented, and the implications of the findings discussed. I explore my personal reflections on the study, highlighting areas where I have had to challenge my own bias and some of the rewards I have gained from conducting this research.

4.2: Discussion and Interpretations of Research Data

This research has found that fellowships offer a myriad of therapeutic mechanisms to those who attend them. These interconnected processes serve multiple functions in aiding recovery and are either primarily explicit or implicit in nature. As such these processes combine to create a comprehensive programme covering most areas in participants' lives.

To give a greater understanding of their nature, these categories were separated into mainly explicit and implicit recovery processes. There were three explicit recovery processes: 'Working a Programme', 'Connecting with Others' and 'Creating Change'. There were three implicit recovery processes inherent in the programme: 'Going to Any Lengths', 'Learning about Addiction' and 'Coming to Believe'. However, it is important to note that these categories all had both implicit and explicit elements to them to some extent, because they interacted with participants' recoveries in varying and nuanced

ways. This suggests that there are surface-level recovery mechanisms operating while other more intrinsic processes work under the surface to bolster recovery gains.

The findings of this study are supported by similar findings conducted by well-respected researchers and experienced clinicians from America. For example, Moos (2008), Kelly (2009) and Kaskutas (2009) all hypothesised that the processes appearing to mediate recovery can be placed into inter-related categories. Broadly speaking these were psychological (affective and cognitive) mechanisms, existential/spiritual mediators, social support and learning, and behavioural mechanisms. These inter-related categories fit together with those proposed in this study. Psychological mechanisms were apparent in the processes of creating change and going to any lengths; as well as the emotional benefits gained from going to meetings and working the steps. Spiritual processes were encompassed by the category of coming to believe, as well as finding meaning through helping others. Social support and learning mechanisms were involved in the processes of going to meetings, understanding addiction and connecting with other addicts, while active behavioural mechanisms were apparent in working the programme and creating change, and in the focus on actively helping others.

Importantly, every participant, apart from the negative case sample, described utilising each element of the programme to varying degrees. It was thus clear that participants had benefited from a multidimensional and personalised approach to their recovery. Participants combined the beneficial aspects of fellowship recovery in a way that best suited them. Similarly, Vaillant (2005) observed that while one of these recovery mediators alone might not be enough prevent relapse, usually two or more of these combined are effective in aiding recovery, with the more factors present, the better. I agree with Kelly (2016, p. 4) who explained that having access to multiple helpful recovery processes at the same time provides a diversity of ‘pathways' to recovery, helping "*different people in different ways*".

There was a core category of ‘Striving for and Maintaining Recovery' that encompassed all the processes uncovered. The participants' accounts all focused on their journey towards maintaining a stable meaningful recovery in the long-term and the fellowships provided the vehicle for the recovery processes outlined in this chapter. This could mean that the main recovery process of the fellowship programme is its persistent focus on recovery, with every element being directed towards the achievement of that goal. What is noticeable about these recovery processes is that through encouraging lasting behavioural and emotional changes they are not simply focused on gaining abstinence but on long-term relapse prevention and an enhanced quality of life.

In the course of researching the positive elements of the programme, attention was also given to investigating any negatives of the programme. It was found that drawbacks included: ‘Coping with Unhelpful Members', the ‘Concept of God' running through the programme, being based on ‘Old-Fashioned Concepts' and there being a ‘Lack of Awareness about Fellowships' in outsiders. The negative case sample described how she had found recovery without utilising the fellowships and explained why she did not want to use them. In light of these factors, it is necessary to underline that the fellowships are not a perfect system and they do not work for or suit everyone. However, it appears from the participants' accounts that there are many processes in the fellowship programme that are helpful to many recovering addicts and thus can provide tangible benefits to those who attend them.

4.2.1: Working a Programme

‘Working a Programme' is the active process of engaging in a 12-step fellowship programme that takes recovery out of the theoretical and into the practical. The theory presented proposes that this explicit, active process forms the foundation of the participant's recovery. If this base is strong, then members can build on this to achieve abstinence and create a longer-term meaningful recovery. This process involves

incorporating elements such as going to meetings, having an individualised programme and working the steps, which combine to augment each other. For example, the first point of entry into the fellowship programme is going to meetings. Through going to meetings, newcomers are introduced to the other elements of the recovery programme such as service, sponsorship, using recovery tools and the steps. They can choose which of these tools they wish to use if they want to work the steps and if they want to continue going to meetings. Through the process of working the steps, members then begin to see the need to change their lives, and this bolsters their motivation to continue to go to meetings and continue with their recovery gains. Meetings are also linked to working the steps because there are some meetings that are step specific, where the discussion topic is based on the concepts contained within particular steps.

4.2.1.1: Going to Meetings

The theory laid out suggests that meetings are the ‘cornerstone' (Nowinksi, 2015) of fellowship recovery. Through this integral process of going to meetings on a regular basis, these group experiences have long been believed to be a potent mediator of change (Kassel & Wagner, 1993). Several factors were contained within this subcategory, illustrating the different aspects of meeting attendance: ensuring the continuation of regular meeting attendance throughout recovery, having home groups and doing service at meetings.

It became apparent from participant accounts that meetings were particularly helpful in early recovery when as newcomers they were striving to achieve initial abstinence. Meetings provide the opportunity for catharsis (I.D. Yalom, 1985) through sharing with others, but also to obtain support and hope from listening to and identifying with others’ stories. However, it seems that the benefits of meeting attendance continue after the newcomer phase. Continuing to go to regular meetings well into abstinence seems to provide members with the psychological tools to guard against relapse and maintain a

healthy mindset. These processes could explain why meeting attendance has been found to be linked to long term abstinence (Witbrodt et al., 2014).

Home group meetings and service commitments appeared to provide a strong source of connection and belonging, which in turn seemed to strengthen commitment to continuing to attend meetings and thus, recovery. This finding is supported by DeLucia and colleagues' assertions that home groups provide a "*context for important interpersonal connections*" (2016, p.827). Additionally, having a service commitment means that members have to take responsibility for making sure they follow through with this commitment. This responsibility seemed to increase the sense of 'authorship' (Yalom, 1980) and purpose (V. E. Frankl, 1969) the participants felt in their recovery. For a more in-depth discussion on how meetings increase connection, social support and identification with fellowship members see section 4.2.2 'Connecting With Other Addicts'.

4.2.1.2: Individualised Action Programme

The theory postulated suggests that a major strength of the programme is the ability for members to develop their own individualised action programme. This introduces the element of choice into members' recovery and appears to empower recovering addicts by giving them the chance to have greater agency over their recovered lives. Which, Borkman (2008) points out, is in contrast to other professional treatments that make the ultimate decisions for clients. After the powerlessness of addiction, which strips the choice away from an addict, this new freedom to choose to do what suits their needs could be a therapeutic process in its own right.

Because members can choose from a variety of practical tools, their recovery plan can be multifaceted, flexible and realistic; this means it is highly pragmatic. This also means that as DeLucia and colleagues (2015, p.18) observed, members can create a "*unique recovery experience that evolves to meet their changing needs".* Tools that members

can choose from include, but are not limited to: gratitude lists, daily inventories, meditation, praying, talking to sponsor and friends, reading literature. These different components interact and combine practically to help build recovery, but it also appears that these tools act as emotional exercises that help manage negative emotions and control compulsions.

Fellowship recovery appears to be a very active process. Rather than passively waiting for change, through the programme members can take control of their recovery by 'doing things' that they know will help them. This is succinctly summarised by the following phrase from the basic text: "*we put our willingness into action*" (Narcotics Anonymous, 2008, p. 35). Actions that members take include: attending meetings, working the steps, reading twelve-step literature, contacting other fellowship members and doing service.

The participants' accounts suggest that the focus on action helps give structure to lives of members, especially in early recovery. This gives newcomers a sense of purpose and also reduces the daily boredom that can result from having long periods of inaction that previously would have been taken up with the addictive behaviour. The need to take regular action to remain abstinent thus became the norm for the participants, which helps to secure their recovery in the long-term. Similarly, Shinebourne and Smith (2011) found that these fellowship activities become a new part of the member's daily existence, interweaving with their existing lives to become 'habitual'.

4.2.1.3: Working the Steps

Working the steps is one of the active processes that were mentioned above, and this appeared to be an important part of the participants' recovery journey. The theory suggests that although working the steps is not mandatory, there are benefits to be had from incorporating them into a member's recovery programme. This is because the steps seemed to be intrinsically linked to change, either the desire to change or how change

was stimulated in a participant's life. This change then facilitated the participant's recovery by allowing them to move past the issues that had kept them stuck in active addiction. For a more in-depth discussion on how working the steps facilitates change please see section 4.2.3 'Creating Change'. Interestingly, because the steps are an incremental process, each step worked seemed to have a compounding effect on the strength of the participant's recovery. With each step taken, participants described experiencing a greater awareness of themselves and their addictions. However, while the concepts contained within each of the twelve steps has a specific recovery benefit, the steps that were mentioned most often and seemed to be most pertinent to recovery were Step One and Step Four.

Step One is where members admit powerlessness over their addiction and recognise that their lives had become unmanageable. Rather than serving to make a member feel powerless over their lives, it seems that this step works to increase motivation for change, an important psychological factor that mediates successful recovery (Laudet, 2003). For example, the process of admitting powerlessness, not just to themselves but to another, appears to help members to challenge their own denial and accept they are addicts. Admitting powerlessness also appears to help members understand that they suffer from a disease; for more detail on this please see section 4.2.5 'Understanding Addiction'. By helping members to recognise how their lives in active addiction were unmanageable, this helped them accept that their lives in active addictive were unsustainable and this also seemed to create a motivation to change. Interestingly, the concept of unmanageability could be understood as more than just the form of chaotic and disruptive behaviour. It also seemed to include physically, emotionally and mentally unhealthy lifestyles that had chronic detrimental effects, such as depression and anxiety. This is particularly important for those addicts whose unmanageability was not obvious to the outsider. Those members whose addictions have not yet led them to 'rock bottom' still need to see the need for change, to recover.

Step Four is where a member makes a searching and fearless moral inventory of themselves. This is perhaps better described as the process of reviewing resentments towards other people from the past and present. Completing this step seems to help members go through a process of cathartic self-reflection that allows them to 'let go' of unhelpful emotions that have been holding them back and keeping them focused on the past. A more in-depth discussion on how letting go of resentments helps to facilitate change can be found in section 4.2.3 'Creating Change' below.

4.2.2: Connecting with Other Addicts

The processes contained under the category 'Connecting with Other Addicts' are intrinsically linked to the process of 'Going to Meetings'. This is because it is a consequence of going to meetings that newcomers meet, identify with and are helped by other members. Connecting with people like them who understand what they are going through because they have been there themselves seemed to be one of the main therapeutic recovery processes participants described. The fellowship programme itself is entirely based on the premise that "*one addict can best understand and help another addict"* (Narcotics Anonymous, 2008, p.18), therefore this is an explicit fellowship recovery process. Connecting with other addicts helped participants to feel less alone, more understood, supported by a network, and to begin to help others.

Identifying with others was one of the primary forms of connection experienced by participants. Best (2012) posited that in order to gain recovery a recovering addict needs to cultivate a 'sense of belonging' and the findings of this study suggest that through the process of identifying with others, fellowships actively foster this sense of belonging and cohesiveness. Through identifying with others, the participants described the realisation that they were not alone, an experience that Yalom (1985) terms 'universality', and this seemed to bring a great sense of relief. The process by which participants most often described finding identification is through sharing and relating to what others share at

meetings. It appeared that the more participants heard others share honestly in meetings, the more comfortable they felt self-disclosing as well; "*as we attend meetings regularly, we can find great comfort in the experiences of those travelling this path with us*" (Narcotics Anonymous, 1993, p. 8). Sharing, therefore, gives members the opportunity to hear others let out similar feelings to their own but also allows them to express their own feelings in an honest, reflective way. It provides members with opportunities for catharsis and improves self-acceptance, which have both been found to be powerful mechanisms for change in the fellowships (Lederman, 2015). The theory presented in this study also suggests that hearing other's share their stories of redemption serves the purpose of helping new members gain a sense of hope that they too will gain recovery. I will discuss more on this in section 4.2.6 'Coming to Believe'.

The experience of sharing their own stories appeared to be a healing process that helped participants come to terms with their past. By giving newcomers identification and hope, this allowed participants to transform their negative experiences into a force for good. Dossett described this as the "*transformative power of self-narratives*" (2015, p.38); by re-telling their story to help others, the member can reconstruct how they define the self. Through sharing, participants also described how they reminded themselves of the 'old-self' (Flores, 2007) that they could easily become again if they were to lose their abstinence and this helps them to challenge any complacency they may have towards their recovery.

Participants' accounts also suggest that identification with others at fellowships and the reconstruction of their self-narrative implicitly helped them develop a new positive self-identification as recovering addicts. While there is a professional discourse about the use of the term 'addict' being stigmatising (Orford, 2001), the findings in this study found no evidence of this, in fact, it seemed to be a term that members have reclaimed for themselves. Larkin and Griffiths described this as "*owning the label 'addict'*" (2002, p.300), while Dossett (2015) observes that in this context the term 'addict' appears to be

‘empowering'. This is upheld by the findings of Buckingham, Frings and Albery (2013) who found evidence that having a new recovery-based social identity increased self-efficacy, increased abstinence and reduced relapse rates.

The processes of identifying, relating and sharing with others seemed to be intrinsically linked to the process of reducing shame. Bradshaw (2005) postulates that shame is at the root of all addictive behaviours and so it is understandable that when discussing their addiction the participants often linked the two. The female participants most often mentioned shame, and while males sometimes discussed it too they did so in a different way. Men seemed to express shame at what they had done, as a form of guilt; whereas women seemed to feel shame about who they were and not being good enough. However, both these types of shame had the same effect on the participants, it kept them isolated and trapped in the cycle of addiction. This mirrored Brown's (2007) research findings on patterns of shame, which also linked shame with addiction, powerlessness and disconnection. Reducing shame was thus intrinsically linked to reducing isolation and building connection.

The theory postulated in this study suggests that the fellowships provide a safe space for members to be vulnerable enough to admit their shame and thus help to reduce the toxicity of the emotional effects shame creates. Hearing others share similar thoughts, feelings and actions also seemed to reduce shame because it helped individuals to be more self-compassionate. If these other people, whom members like and respect, have done similar things and felt the same way about themselves, then maybe they can begin to see that they too are not that bad. Flores (2007) similarly postulated that the process of identifying with others in the room helps members begin to accept those parts of themselves that they previously felt were too bad to be accepted, while Brown concluded, "*building connection with identity groups is a great way to turn the tables on the invisibility and stereotypes, which fuel shame*" (2007, p. 239). So building connection appears to

be the antithesis of shame, and thus a key component in the battle against addiction. The fellowships, therefore, appear to provide a useful space for finding this connection.

The social aspect of the fellowships appears to play a large role in reducing the isolation experienced by members because they focus on building connection with those around them. Most participants expressed having felt isolated in their active addiction; whether being alone physically, the experience of feeling different from those around them or being detached from their own feelings. The findings of this study hypothesise that the fellowships offer members the chance to be part of a community and this introduces acceptance and love into previously emotionally empty lives. Fellowships, as their name suggests, seem to counter this isolation by giving members somewhere to belong and someone to connect to. The link between recovery and increasing connection is not unique to fellowship research; several addiction theorists have also posited the use of connection as an antidote to addiction. The link between addiction, recovery and connection has been also noted by prominent theorists for some time. For example, through his seminal 'Rat Park' experiments (Alexander et al., 1978, 1981), Alexander came to believe that addiction was partially caused by the 'discomfort' of 'social dislocation'. He thus hypothesised that a "*positive social event that opens the door to renewed psychosocial reintegration*" (Alexander, 2008, p. 161) could be the pathway into recovery. Influenced by this, Hari later hypothesised that "*the opposite of addiction isn't sobriety. It's connection… If you are alone you can't escape addiction. If you are loved you have a chance*" (2015, p. 293).

A large component of the connection felt by members is posited to come from the fellowships' explicit focus on reciprocal helping. Participant accounts often described how experiences of being helped or helping others have been vital to their successful recovery. From the participants' accounts, having a helpful support network appears to provide a powerful recovery process, which explicitly helps members to achieve recovery and improve their emotional well-being. The process of helping others has a circular

effect; as participants were helped in early recovery, they now help newcomers. This social benevolence appears to help members not only to gain a social support network but also to develop a greater compassion towards others and a sense of purpose in life. Interestingly, Kelly and colleagues (2012) found that the increase in members' social support network had more positive effect on recovery than other twelve-step specific or spiritual recovery mechanism.

Support networks appear to be comprised of two types of relationships, sponsorship and peer support. From the participants' accounts, sponsorship appeared to be a positive recovery process and these relationships seem to be built on trust, understanding, encouragement and munificence. Sponsors were described as providing guidance mainly through using their experiential knowledge, rather than telling participants what to do. This seemed to work because participants were aware that their sponsors have overcome their own addictive behaviours. As such, sponsor seemed to be akin to mentors or role models. Their helpfulness for recovery is borne out by the consistency with which they have been found to have a positive effect on recovery rates (DeLucia et al., 2016; Zemore et al., 2013). Unfortunately, not all participants had an entirely productive experience with their sponsors. One participant described her first sponsor relapsing, her second one being too inexperienced to help, before finding a third sponsor who could understand and help her. Vaillant (2005) similarly acknowledged that there are some 'horror stories' from calamitous sponsorship relationships. This suggests that a critical component to whether sponsorship is helpful is the quality and suitability of the sponsor. While finding a good sponsor appears to be an invaluable recovery tool, putting one's trust in someone who lets one down has the potential to be very detrimental to a newcomer. Further understanding would benefit from research into the qualities of sponsors that are helpful and unhelpful to members.

The peer support friendships described by participants are another excellent example of the reciprocal helping relationships demonstrated by members. Importantly, the support

offered in meetings continues to function outside of meetings, whether on the phone or going for coffee after meetings. Participants often described calling up other members to either ask for or offer support. Because these 'new friends' have been through the recovery process themselves, they can understand each other's experiences better and provide deeply empathic and compassionate listening and advice. In a similar vein, Vaillant (1988, 2005) described fellowship support as a new type of caring relationship with friends who care about their well-being, as opposed to the destructive relationships newcomers might have had previously.

Helping others appears to be a mutually advantageous process; participants expressed how they also benefited from helping others. This reflects the well-known 'Helper' therapy principle, postulated by Riessman (1965), which observes that when someone helps another person, they also feel the benefit from that interaction. The findings of this study gave two pathways as to how and why this occurs. I have already discussed how sharing their story helps members change their perceptions of their addicted lives into more positive narratives because they can use them to help others and give hope. This potentially gives a new meaning to the suffering participants experienced in active addiction, or in logotherapeutic terms, a 'will-to-meaning' (V. E. Frankl, 1969). As Flores (2007, p.191) explains, "*once suffering is viewed in a personal, meaningful paradigm, it can serve as a growth process*".

The second way that reciprocal helping benefits the helper is that it seemed to give them a sense of purpose or meaning to their lives. This sense of purpose appeared to help participants recovery on an explicit level, as it meant they had useful practical tasks to complete, such as running meetings, calling newcomers, etc. But it also helped on an implicit level because it helped overcome the existential vacuum (V. E. Frankl, 1978) that participants described feeling in their active addictions. Many participants described how helping others was linked to spirituality, and I will discuss this greater detail in section 4.2.6 'Coming to Believe'. However, Tonigan and colleagues (2013) did not find

quantitative evidence that a reduction in 'selfish' behaviour increases a member's recovery chances. So narrowing down mechanisms that explain why reciprocal helping benefits recovery is another area that would benefit from further exploration in future research.

4.2.3: Creating Change

'Creating change' is a recovery process that appears to be facilitated by positive changes in the member's physical, psychological, emotional and spiritual lives. Participants explicitly expressed that because they knew their addictions had underlying causes, to have a meaningful recovery required them to create real and lasting change in their lives. The findings of this study suggest that members learn to bring about these changes by focusing on coping better with their emotions and challenging unhelpful thinking patterns, while living in the moment. This reflects Moos' (2008) conclusions that active change processes in fellowships are facilitated by increasing self-efficacy, building coping skills and enhancing motivation to change.

The theory presented proposes that the most important part of making long-lasting changes is that this process has to primarily come from within and that the responsibility for making these changes lies with each member. Participants understood that the only things they could effectively change was themselves, as they had no control over 'people, places and things' (Donovan et al., 2013). This approach is embodied by the credo contained within the serenity prayer: "*God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference*" (Alcoholics Anonymous, 1981, p.41). This focus on change coming from within appeared to help participants because it empowered them and increased their self-efficacy; which is understood to be a vital construct for achieving effective change in addictive behaviours (DiClemente, 1986). As I mentioned in the introduction one of the criticisms of the fellowships is that they reduce self-efficacy (Peele, 2011), but the

findings in this study found the opposite effect. After years of being powerless over their addiction and ineffective in bringing about change, the fellowships have helped them to take back some power over their lives. This is borne out by other research findings, for example, in a systematic review of fellowship research, Kelly (2009) found evidence that the fellowships boost self-efficacy, while DeLucia and colleagues (2016, p.818) concluded that fellowships provided support to their members to "*facilitate personal change goals*".

A significant factor in what seemed to help the participants find the strength to go through the change process was enhancing emotional awareness and building coping skills. Fellowship processes such as reaching out for support, meditating and writing gratitude lists enabled participants to strengthen their resilience to their negative emotions, as well as to increase their positive emotions. Before coming into the fellowships many participants expressed problems with self-regulating negative emotions like fear, resentment, guilt and shame. This then led to them avoiding these distressing feelings by 'self-medicating' (Moos, 2008) through their addictive behaviours. The development of active and effective coping skills in the fellowship programme has been shown correlationally to play a crucial role in relapse prevention (Humphreys et al., 1999; Kelly et al., 2009; Moos, 2008).

Building emotional resilience also consists of developing a greater awareness of what Nixon (2012) terms the 'emotional underbelly' behind addictions. Participants described that sharing at meetings and identifying with others helped them to improve their emotional self-awareness. The steps also seemed to help participants reflect on their emotions through honest and structured self-examination. This provided them with a deeper reflective understanding of their own addictive processes. Sachs (2009, p.199) conducted a psychological analysis of the twelve steps and came to similar conclusions; that the steps help to create "*intrapsychic modifications*" that can "*repair earlier developmental deficits and facilitate further emotional growth*". For a further discussion

on how the steps help self-reflection about addictive behaviours please see section 4.2.5 ‘Understanding Addiction’.

The theory presented suggests that another key process in creating change is learning to let go of resentments, which is the key concept contained in step four. Participants described how the cathartic process of reflecting upon their resentments freed them from negative thinking and this improved their ability to cope with their emotions and patterns of behaviour. So it appears that by letting go of resentments participants could move on from some of the negativity in their past as well as overwhelming intrusive thoughts of hatred and anger. The fellowships’ focus on resentments is in recognition that "*the longer we harbour resentments, the more bitter they become, eventually poisoning us*" (Narcotics Anonymous, 1991, p.261). Likewise, Sachs (2009) hypothesised that repetitive negative thinking, such as resentments, can produce ‘ego defences' that go on to become ‘character flaws', so addressing them helps reduce repetitive maladaptive patterns. However, quantitative evidence has not supported this assertion, for example, Kelly and colleagues (2011) did not find that letting go of resentments significantly correlated with improved the chances of recovery.

Another process that appeared to be particularly linked to the process of change was the principle of ‘Just for Today'. Participant accounts described how the focus on attaining recovery one day at a time seemed to help them to find making changes more achievable and sustainable. By just concentrating on getting through each day as it comes, the fear of tomorrow appeared to be reduced. This effect applied to both short term and long term recovery fears, because by re-committing each day to their recovery, eventually these days would add up to create larger chunks of time. However, if a newcomer places the focus on staying abstinent for the rest of their lives, this can feel overwhelming. Participants also described how focusing on the day enabled a change in their mentality away from projection or retrospection towards a more mindful existence that was focused on living in the moment. This mirrors findings by Black (2014) and Chiesa and Serretti

(2014) who found that mindfulness-based addiction interventions reduced consumption and cravings for substances. ‘Just for Today’ could have been included in ‘Working a Programme’ because it is an attitude for how to work the programme, one day at a time. But it is included in ‘Creating Change’ because participants described it as a process that empowered them to make and maintain change in their lives.

4.2.4: Going to Any Lengths

‘Going to Any Lengths' meant that members put in as much effort as needed to gain recovery and keep it secure. This category was originally part of ‘Working the Programme', but in the course of theoretical development, it became clear that this was a separate, yet linked, implicit process. The theory presented suggests that recovery is enhanced by having the willingness to do whatever is required to achieve stable recovery. Participants described focusing on trying to maintain their levels of motivation in the long term, because as Nixon and Solowoniuk (2006) also point out, meaningful recovery is a process of continual evolution.

By keeping focus, participants ensured that they prioritised their recovery and did not get distracted by other stressors that they faced. The fellowships appear to provide members with the personal resources to help discipline themselves not to let external problems affect their recovery. The fellowships' focus on putting recovery first also seems to involve being continuously and actively involved with the programme well into stable recovery. Participants were very conscious that there is always the danger of relapse, no matter how far into recovery they are. Through continual attendance, participants kept hearing the stories of newcomers, and this appeared to reduce complacency and strengthen resolve because they were reminded that they do not want to go back to that existence. The link between motivation and prolonged engagement with the fellowships is supported by Kelly and colleagues (2009), who found that continuing with meetings helped individuals to maintain the motivation to change over a period.

The process of ‘Going to Any Lengths' also recognised the reality that members often combine their recovery with engagement in other forms of psychological treatment. Rather than fellowships being a sole method of recovery, the majority of participants incorporated different types of treatments and resources to ensure they made meaningful progress. This took several forms: individual psychotherapy, NHS drug and alcohol centres, NHS inpatient treatment or private inpatient treatment. For example, therapy was used by some participants to supplement their existing fellowship programme, while participants who attended inpatient treatment recognised that, once they returned to their normal lives, some form of aftercare would increase the chances of long-term recovery. The fellowships were recommended by the treatment centres to provide this aftercare. However, it appears from the two participants who did not access any other form of treatment, that members can still achieve recovery through the fellowships without external help.

One of Peele's (2011) main criticisms of the fellowships was that they were ‘jealous' of other forms of treatments. Yet in our sample, the majority of participants had quite effectively combined fellowship recovery with other treatments. This reflects the fellowship's guidance that "*we are free to seek outside professional help and continue in our program of recovery in NA*" (Narcotics Anonymous, 2010, p. 20). In a similar vein, Humphreys (2004) posited that the concepts of the fellowships integrate well with more modern psychological approaches such as CBT or group psychotherapy. The findings in this study also support other research that suggests that combining therapy and fellowships enhances the effectiveness of each approach (Fiorentine & Hillhouse, 2000; Moos & Moos, 2005; Witbrodt et al., 2014). Despite this, participants’ therapists did seem to have some misgivings about the fellowship programme. For more on this please see the section 4.3.1 ‘Problems with the Fellowships’ and section 4.5.2 ‘Implications for Counselling Psychology’.

4.2.5: Understanding Addiction

The theory presented suggests that one of the implicitly helpful recovery processes found in the fellowships is that they encourage members to educate themselves about addiction. Many participants described reading fellowship specific or other recovery literature and watching ted-talks. Through this, it seemed that participants had learnt more about addiction and how they could apply this learning to themselves. For example, ted-talks (Brown, 2010, 2012; Hari, 2015) explaining theories such as Johann Hari's Chasing the Scream (2015) and Brene Brown's (2007) research on vulnerability and shame resilience, particularly seemed to resonate with participants. In this way, the programme appears to offer members a form of psycho-education that empowers them to develop an understanding of their own addictive processes. This mirrors Flores' (2007) observations that the fellowships are an educational process that trains members to be more self-aware, while Thompson (2012) similarly explains that understanding addiction theory provides recovering addicts with a context in which they can explore how it is meaningful to their own experiences.

The main addiction theory that the fellowships extol is that of the disease model. Having an increased understanding of this concept appears to have been beneficial to the participants' recovery because it alters previously held negative self-perspectives of being 'weak'. However, while accounts acknowledged that the disease concept was not a completely accurate representation of addiction, participants described how they used it as a metaphorical tool to comprehend their powerlessness over their addiction. As such the process of understanding 'My Own Addictive Processes' is also related to the concepts from Step One outlined in 'Working the Steps' (see section 4.2.1.3).

The process of coming to understand addiction theory, in general, seemed to create an enhanced understanding of personal addictive processes. Participants described being able to recognise the part addiction plays in their lives and how their addictive tendencies

developed in the first place. For example, many participants described recognising how childhood or traumatic experiences were directly linked to their addictive behaviours. Thus they were able to develop an insight that bridged the gap between addictive tendencies and the awareness of where they stem from.

Participants explained how the fellowship's focus on self-reflection encouraged them to learn from their experiences of relapse and cross-addiction, and this reduced the chances of them making such mistakes in the future. This is important in the long term because recovery from addiction has been found to be cyclical in nature (Prochaska, DiClemente, & Norcross, 1992); these cycles can involve taking action, relapsing, contemplating and then taking action again (DiClemente, 1986). The fellowships' focus on learning from experiences of relapse appears to go some way to breaking that cycle. Some participants also described that the fellowship programme helped them to recognise cross-addiction issues in their lives, so they had started attending multiple fellowships. Accounts suggested that because all sister fellowships were based on the same principles this helped participants transfer between fellowships easily and tackle these multiple addictive behaviours in a combined approach. As there is a dearth of literature on cross-addiction this is an area that would benefit greatly from further research.

4.2.6: Coming to Believe

'Coming to believe' is an implicit process that appears to embody both experiences of seeing positive changes and a developing spirituality. These seemed to combine to create a hope in participants that they could gain recovery and improve their lives. Awakening their spirituality seemed to consist of interrelated but separate processes for participants: firstly, increasing their spirituality and secondly, connecting to a higher power. It is hypothesised that these spiritual processes are interlinked with other processes already described, such as: increasing hope through relating to others,

building meaning through helping others, creating change through building emotional resilience and increasing motivation. In light of these links, I concur with Kelly (2016, p. 5) who hypothesised that an increased spirituality may provide a "*scaffolding*" for the "*multifaceted therapeutic milieu*" of the processes that I have uncovered in this study.

The theory presented in this study postulates that by recognising the positive changes that have occurred in their own and others' lives, participants gained an increased faith in the programme. This gives them hope and the determination to carry on attending fellowships to gain and maintain recovery. These positive changes can include a collective abstinence improvement, enriched personal mental well-being and developing better relationships with others. This appears to be linked to the spiritual element of the programme as the fellowships encourage members to develop gratitude for the positive aspects of their life. Kelly and colleagues (2011) also believed that seeing improvements in their lives reinforces a member's recovery.

References to spirituality ran through the participants' interviews, and spirituality was found to be helpful for recovery. Elements of spirituality included helping others, feeling connected, having gratitude and becoming more self-aware. This illustrates how spirituality was a multi-dimensional concept that encompassed many positive elements in participants' lives. Interestingly, the spirituality described by participants seemed to be more similar to existential concepts than religious, a finding that mirrors the conclusions of Wikilund (2008a; 2008b). For example, helping others was often mentioned when participants were asked to define their spirituality. I discussed helping others in section 4.2.2 'Connecting with Other Addicts' and linked it to how participants built meaning in their suffering and created a sense of purpose in their new lives. Both of these are existential concepts that Frankl (1969, 1978) postulated help to improve psychological concerns by addressing an individual's 'existential vacuum'. This postulation mirrors the conclusions of other recent research into fellowships, spirituality and psychological well-being (DeLucia et al., 2016; Kelly & Greene, 2014).

Participants also spoke about spirituality as an implicit process where they improved their connection with themselves, the others around them and the world. They achieved this connection through becoming more self-aware and recognising what they have to be grateful for. The finding that fellowship spirituality is a connective process parallels the opinions of Kurtz and White (2015, p.58) who hypothesised that spirituality is "*reflected in experience of the beyond (transcendence) and between (connection)".* For example, some participants also described feeling a connection with their higher power, which provided them with feelings of being loved and gave them gentle guidance. This directly mirrors the findings of Vaillant (2014) who likened a higher power to a secure attachment object.

However, the concept of a higher power was the area of biggest ambivalence for the participants. Some participants mentioned their higher power regularly and believed it had a positive effect on their recovery, some mentioned their higher power occasionally, and some had serious concerns about the concept. For a more detailed discussion on the participants' concerns about the concept of a higher power please see section 4.3.1 'Problems with the Fellowships'.

The use of a traditional concept of 'God' as a higher power was not common among participants. Instead, a process of interpreting and constructing a personal understanding of a higher power was more widespread. Participants all portrayed their spiritual development as a gradual process where they learnt to be spiritual over time. This led a diverse range of concepts among the participants. Please see my reflective memo, box 3, regarding constructing higher power concepts. Kelly (2016) also explained how having a higher power that is 'self-constructed' produces a pragmatic all-inclusive spirituality that works for each individual.

All participants did describe how having some kind of improved focus on spirituality had benefited them in their recovery, even if they did not subscribe to having a higher power.

A number of studies have similarly found an increase in abstinence is linked to increased spirituality (Jarusiewicz, 2000; Kaskutas et al., 2003) and many theorists believe this to be a core mechanism of why the fellowships work (Kelly et al., 2011; Krenztman et al., 2013; Tonigan et al, 2013). However, while Kelly and colleagues (2012) found that those with more severe addictions found both the increase in support network mechanisms and spirituality to be equally helpful, those with lower severity benefited more from the social support than the spirituality. In this study it was not possible to ascertain to what degree the participants found spirituality helpful when compared to other processes, therefore this could provide an interesting area for further research and exploration.

4.3: Alternative Perspectives

As a current member of a fellowship, I ran the risk of being unduly biased. Therefore it was important to make special efforts to seek out alternative perspectives. This involved asking initial and theoretical sample participants about what had not been helpful about their fellowship experiences. Also a negative case sample was interviewed to explore the perspective of someone who did not use the fellowships in their recovery. Analysis of these raised some valid concerns about the fellowships. Problems with the fellowships outlined by participants included: having to cope with other members who acted in ways that were unhelpful or difficult to deal with, the fellowship's use of the concept of 'God', old fashioned concepts which have not been updated in light of modern scientific thinking, and the lack of awareness of the fellowships among outsiders. The ease at which participants could recount problems indicates that there are tangible problems within the fellowship structure. Therefore in order to experience the positive aspects outlined in this chapter, members may also have to mediate some of the drawbacks of the fellowship programme.

4.3.1: Problems with The Fellowships

One of the major problems with fellowships appears to be that a small minority of other members can be unhelpful in the form of being opinionated, confrontational or manipulative. Unfortunately one participant even experienced what is colloquially known as '13th stepping' (McGuiness, 2011); where an experienced member makes sexual advances to a newer or more vulnerable member. The problem of 'difficult' members has also been noted by other fellowship researchers. For example, Laudet (2003) described how, despite the majority of members being helpful, there is the possibility that some newcomers can be 'triggered' in the meetings by those who are still 'unwell'. According to the tradition, such people cannot be turned away or banned from meetings, as they too need help. From the participants' accounts it appears that it is recognised that unhelpful behaviour is often a symptom of mental health problems. This means members have to learn to be more 'socially resilient', patient and tolerant. This has obvious drawbacks but participants also observed that it has one benefit too: learning to not let such people affect one's recovery can be a helpful skill for when members have to deal with other difficult people in their 'normal' lives.

The second most common problem arising from the findings was the fellowship's reliance on the concept of 'God'. Although the fellowships are technically a non-religiously affiliated programme, because of its Christian roots there is still the use of the word 'God' in a lot of the literature and readings. The term 'higher power' is used in common parlance, and 'God' is understood by members to be a short term for that. Despite this understanding, accounts suggest that, particularly for females, the continued use of this religious male-centric word is a problem. This echoed the findings of feminist fellowship researchers such as Beckman (1993) and Sanders (2011; 2014). Furthermore, accounts suggested that the distinction between spiritual and religious was not obvious for participants as they entered the fellowships and many spoke of it being off-putting for

them. It appears from this study that future newcomers could potentially be deterred from entering the fellowships because of the use of the word ‘God’; this echoes findings by Kelly and colleagues (2006). One participant also pointed out there is also a contradiction of being told to be completely honest in recovery while at the same time being encouraged to use a word that is contrary to her beliefs.

Because of the ambivalence towards the concept of a higher power in the initial sample of participants, theoretical sampling was focused on answering the question of whether the concept of a higher power was helpful or a hindrance to participants' recovery. The results from these samples suggest that the concept is both a help and a hindrance. In early recovery, it seems to have the effect of being off-putting, but upon advancing with the programme, it appears that the search for spirituality has a potent positive effect upon recovery. Yet, it is still important to acknowledge that there is the possibility of recovery occurring without an explicit spiritual element. Many members gain meaningful recovery through going to atheist meetings or through choosing to leave out the spiritual component of the programme. In fact, Kelly and colleagues (2012) found that for those with less severe addictions, the social and cognitive affective changes were more beneficial recovery pathways than changes in spirituality. This suggests that the overtly spiritual element of the programme may not be as vital, as the fellowships believe they are.

Linked to the problem of using the word ‘God' in the fellowships is a belief among some the participants that the fellowships are old-fashioned. Just as the fellowships have not updated their language to more modern and inclusive spiritual terms, they also have not updated the recovery concepts or language to match current scientific opinions on the field of addiction and recovery. The fellowships fear that changing the language or concepts utilised by the programme could dilute the original message, which has been found to be powerful by so many. While, as Alexander (2008) observes, fellowship members are ‘smart' enough to think beyond written fellowship doctrine when needed,

the ‘quasi-religious' language and old fashioned concepts can weaken its credibility in the scientific community (Kelly, 2016). My personal view, based on this study’s findings and my own experiences, is that the fellowships in their current state help many people, but they could potentially reach and help more if they updated or modernised the programme in a targeted and discerning manner, particularly around the continued use of the word ‘God’.

The final concern uncovered was that there was poor awareness of the fellowships among outsiders; both among those who would benefit from attending them and also among the professionals who help treat addiction. Findings suggest that upon coming into the room newcomers do not have a clear idea of what the fellowships entail; this is especially true for smaller fellowships such as OA. As the fellowships do not promote their existence, this is entirely understandable, but it suggests that those who suffer from addiction issues could benefit greatly from an increased public consciousness of fellowships as a whole. If those who seek recovery had a greater idea of what the fellowships were like, they might be less reticent about attending.

4.3.2: Negative Case Sample

The negative case sample gained recovery using a private treatment centre but not the fellowships. This allowed for the exploration of the aspects of the fellowships from the perspective of someone who did not hold them in positive regard. Comparing this sample with those who had used fellowships uncovered several differences and similarities. For example, helpful recovery processes such as peer support and admitting powerlessness paralleled fellowship recovery processes. Likewise the coping strategies employed, such as taking things one day at a time, utilising relaxation techniques and remembering how bad things had been, bore similarities to the fellowship concepts of Just For Today, building emotional resilience and recognising unmanageability. This suggests that these processes are not unique to fellowship recovery. However, one must also consider that

these concepts could have been learnt in the three treatment centres that Kate attended, which were based in part on twelve step principles. It could therefore equally be argued that even though fellowships were not actively used in her recovery she benefited from aspects of fellowship recovery without realising it.

Several factors deterred Kate form the fellowships, these included: having an inauthentic cliquey atmosphere, too much emphasis on 'God', the steps being too negative, not wanting to discuss problems with other people and finally, not wanting to be defined as being an alcoholic. This mirrored the findings of Robinson and colleagues (2009, cited in Krentzman et al., 2011b), whose participants did not attend fellowships because they could not relate to others in the groups, felt there was too much negativity and that they could handle their problems on their own. Although in the purposive and theoretical sample the process of coming to identify as an addict appeared to be a helpful process, these findings suggest that not all recovering addicts feel this way.

Whilst the other participants had found the other elements of the programme to be attractive enough to keep them coming back despite the problems they encountered, Kate's account shows that not all those who try out the fellowships connect with them and that some may feel that they wish to achieve recovery in another way. It is important to acknowledge that this is the case for many addicts and that does not automatically mean that they will not find long-term recovery. For example, Rayburn (2014) found that after nineteen years the majority of her participants were currently disaffiliated from twelve-step meetings but were still sober.

4.4: Evaluation of Study

The aim of this study was to investigate the recovery processes underlying twelve step fellowships. To this end, I utilised a qualitative social constructivist grounded theory approach (Charmaz, 2006) to synthesise a rigorous conceptual theory from an insider's

perspective. This method introduces both strengths and weaknesses into the trustworthiness of the study. To ensure these have been taken into account, it is important to evaluate them and to describe the methodological steps that have been taken to preserve quality.

4.4.1: Procedural Measures to Ensure Standards of Quality

As outlined in the methodology section (Section 2.5), to ensure the quality of this study I utilised a range of methods to meet and demonstrate standards of trustworthiness and rigour (Morse, 1999). These methods were guided by the work of respected grounded theorists and qualitative researchers such as Charmaz (2006) and Morrow (2005). Table 5, below, summarises the measures I took to meet these standards in accordance with the recommended guidelines for ensuring quality.

Quality Guidelines	Measures Taken to Ensure Quality
Credibility (Internal Validity)	• Audit Trail – Memo's and Reflective Diary (Lincoln & Guba, 1985) • Negative Case Analysis – fairness (Lincoln & Guba, 1986) • Debriefing with supervisor (Lincoln & Guba, 1995) • Insider Status - Persistent observation in the field - (Morrow, 2005) • In-depth description of data (Geertz, 1973) • Fit between data and analysis, closeness to data – appropriate method used (Charmaz, 2006)
Transferability, Usefulness Generalisability and Originality (External Validity)	• Audit Trail • Rich description of research context and processes (Morrow, 2005) • Situating the sample (Elliot et al., 1999) • Information about the researcher as an instrument (Morrow, 2005)
Dependability (Reliability)	• Audit Trail • Ensuring credibility (Lincoln & Guba, 1985) • Triangulation (Lincoln & Guba, 1985) • Thorough methodological explanation (Morrow, 2005)
Confirmability, Reflexivity (Objectivity)	• Audit Trail • Supervision • Acknowledging Subjectivity (Patton, 2005) • Describing my personal and theoretical perspective (Elliot et al., 1999) • Critical Reflection (Willig, 2012a) • In-depth description of analytic processes and findings (Morrow, 2005)

Table 5: Measures taken to ensure quality

My role as an insider researcher, while bringing strengths, also had the potential for being the largest risk to the quality of this study. Therefore, the most important quality measure I took was to pay special attention to my own reflexivity. I did this through a thorough audit trail of memos and reflective diaries, through debriefing with a supervisor and through constantly challenging my own assumptions and biases in my analysis. In these ways I have tried to make sure that my findings reflect "*the situation being researched rather than the beliefs, pet theories, or biases of the researcher*" (Gasson, 2004, p.93).

4.4.2: Limitations of Research Design

For pragmatic time and resource reasons the sample size for this study was nine participants, however Morse (2000) believes a good qualitative study should have at least twenty participants. Although this sample size was sufficient to reach theoretical saturation, as Morrow (2005) points out the relatively small number of participants means that findings might not be generalisable from a positivistic standpoint. It is thus possible that this qualitative study suffers from a shortcoming in its sampling scope. Additional participants might allow for a more thorough examination of the recovery processes that fellowship members experience. However, I concur with Neale (2005) who believed that this shortcoming could be mediated by focussing on gaining a deep contextual understanding of participants' experiences, which I believe this study has.

The sample is skewed towards white middle-class Londoners who suffer from substance use or alcohol issues. Unfortunately, only two participants attended behavioural addiction fellowships. Similarly only two were born outside the UK. This means that the recovery processes experienced by those from different cultural backgrounds or those suffering from behavioural addictions have not been fully explored and so the transferability of the theory to these populations is limited (Neale, 2005). This skew in the participant demographics could be due to a self-selection bias. Those who volunteer to take part in an academic study are more likely to be female, academically inclined, achievement seeking and future orientated (Harber, Zimbardo, & Boyd, 2003). Given that a large proportion of those who attend substance use fellowships come from low income, less well-educated backgrounds (Alcoholics Anonymous Great Britain, 2010; Public Health England, 2015) this brings into doubt how representative our sample of fellowship recovery was. An area for further study would be to seek a larger, more diverse sample that could explore the experiences of a wider range of fellowship

members, allowing it to observe the multiple realities of different types of participants and adding to the generalisability of the theory.

Despite the use of NVIVO, it was difficult to integrate the large amount of data gathered into a coherent theory and this is where the constant comparative method was an essential tool for efficient categorisation of data. I have taken care to ensure theoretical coherence through thoroughly illustrating the categories and their complex relationships (Elliott et al., 1999). However, the large number of categories and subcategories points to a possible design limitation where the subject area of the research was too broad. A more specific focus might have allowed for an in-depth examination and discussion. It is important to point out, however, that grounded theory is an inductive method (Charmaz, 2006), where the researcher should allow the data to lead the direction of the analysis, rather than having pre-specified themes to investigate. It is hoped that despite this, the reader is provided with enough information to develop an improved understanding of the phenomenon under study. Further research could focus on analysing and discussing the processes uncovered in greater detail.

Another limitation of this study is the presence of two confounding variables that became noticeable during the research process. Firstly, Kate went to a treatment centre that was run on twelve step principles. Therefore, although she is not a fellowship member she does have previous experience with twelve step concepts, and this would have had an influence on her recovery. Accordingly, it was hard to separate out the recovery processes and concepts she found helpful, to see if they were fellowship or recovery specific. However, it would be hard to find a negative case sample who has not had some contact with fellowship concepts, whether they are aware of it or not, because these principles pervade the current recovery treatment model (Dosset, 2013). This leads onto a broader limitation of the study, the qualitative research methodology design utilised made it difficult to distinguish between processes that reflect more general processes of change, which may occur without fellowship participation, and those that are specific to

the fellowships. In order to identify which were fellowship specific processes, it would have been necessary to have a larger ‘control’ or negative case sample group, comprised of participants who have not had any known or unknown influences from fellowships on their recovery. Another way to truly capture entirely fellowship specific process would be to implement a quantitative randomised control trial prior to a first attempt at recovery.

Another confounding variable I experienced that has also been noted by DeLucia and colleagues (2015): it is participants giving narrative answers that could potentially be influenced by fellowship literature rather than a true reflection of their experiences. Particularly in the case of Abdul, I noticed his recounting of experiences took on a ‘script' like quality, and he used fellowship specific phrases often throughout his interview. This gives rise to the question of whether participants paraphrase these concepts because they accurately represent their experiences or if they have been ‘trained' by meetings to believe that these match their own realities. This is where my experience as an insider/outsider was invaluable. I was able to pick up on these instances and reflect whether they appeared to be authentic, based on my own familiarity with these expressions but also upon my professional expertise with establishing therapeutic congruence.

4.4.3: Strengths of the Study

Notwithstanding these limitations, I believe that this study has adequately researched the phenomenon of recovery processes experienced in twelve step fellowships. Whilst it might have some problems regarding generalisability and neutrality, it has several strengths that vindicate the methods used. Because twelve-step fellowship traditions state they must be non-professional and non-affiliated it is hard to conduct studies that meet positivist standards for rigour. Therefore it is important that fellowships are investigated using appropriate methodological paradigms (Flores, 2007) to get a full

understanding of the phenomenon. Humphreys (2004, p.99) believed that "*methodological diversity is a strength, not a weakness, of evaluation science";* so while naturalistic qualitative research might have poorer external validity than quantitative research, its internal validity is greater. I agree with Larkin and Griffiths (2002) who believe that looking at participant experiences in their own words provides a way to gain a deeper understanding of recovery processes.

The constructivist grounded theory (CGT) method used was appropriate for studying the subject matter and allowed for a systematic but phenomenological analysis. This led to a theory that I believe accurately reflects the multiple realities of the recovery experiences of participants. CGT, with its focus on researcher reflexivity, also allowed for the researcher's insider status to be used as a methodological tool rather than as a limitation to the credibility of the study. Another strength of the CGT approach is that it is an inductive approach, so while previous studies on fellowships have had pre-determined themes or specific mediators this method has inductively uncovered multiple interacting mediators for recovery. I believe this gives a more accurate representation of the complexity of the processes underlying twelve-step recovery. That being said, CGT has led to a constructivist perspective guiding the analysis and it might be valuable to conduct a similar study using a different method. Narrative psychology (J. Silver, 2013) in particular would yield interesting results as many participants described their recovery experiences in the context of changing meta-narratives and self-identity. Likewise, guided by the findings of this CGT study, an interpretative phenomenological analysis (Smith, Flowers & Larkin, 2009) or thematic analysis (Braun & Clark, 2006) would enable a closer look at participant experience of specific elements of fellowship recovery (C. Willig, 2013).

Previously, outsider perspectives have guided psychological understanding rather than encouraging an understanding of recovery from the perspective of a recovering addict (Khantzian & Mack, 1994). My insider status not only enables service user empowerment

but also accuracy. Because, as Neale (2005) points out, participants can give more detailed, honest accounts without fear of being judged or having their integrity doubted. I was also capable of understanding the language of the participants in a way that an outsider might not be.

NVIVO came in particularly useful during the study as a method to ensure equality and the reduction of bias. I could use the programme to easily store and link reflective memos to participant accounts, so as to create an audit trail. It was also useful in that it allowed me to easily store and sort large amounts of data in an efficient and organised manner. I do not doubt that this led to a better analysis than if I had relied on alternative methods.

This study has one other strength when compared to other studies: I had more female participants than male. In the past women have often been overlooked in addiction treatment research and much of the research into fellowships focused primarily on male samples (Sanders et al., 2014), meaning that much of the research has had a masculine slant. There is also a gender difference with more male members than female in both AA and NA (Alcoholics Anonymous Great Britain, 2015; NA World Services, 2016b). Because of this, there has been debate as to how much women benefit from fellowships given their male-centric recovery perspective (Sanders, 2014). Both Kelly and Hoeppner (2013) and DeLucia and colleagues (2016) found that men and women both benefit from the fellowships, but often these mechanisms of change are different between the two genders. It is therefore likely that an analysis into mechanisms of change will be skewed by any gender ratio difference. As the reader can see from my reflective diary excerpt in the personal reflexivity section (Box 5), my position as a feminist researcher (Beckman, 2014) means that I may have been more attuned to female mechanisms of change. Because of this reflective awareness of my potential bias towards feminine elements I have made efforts to ensure I give equal weight to masculine viewpoints. However, I believe it is a strength of this study that it has given greater voice to the women in

recovery who have often been overlooked in the addiction recovery paradigm (Sanders, 2011).

4.5: Implications of Study Findings

This study has contributed to an increased understanding of the recovery processes underlying twelve step fellowships. Findings suggest that the fellowships provide members with help through complex processes that interact with each other. This has implications for the perspectives that the NHS, service providers and counselling psychologists have on fellowship recovery. It also has potential implications for the future development of evidence-based practice, as these conclusions can help psychologists gain an understanding of what processes are effective in helping addicts gain recovery.

4.5.1: Implications for the NHS and Healthcare Organisations

There is a need for effective cost- and time-efficient therapeutic alternatives to NHS addiction treatment because there is a gap between the need for and the provision of help for struggling addicts. Two of the study participants explained that they had paid for private treatment because the NHS help they received had not been adequate. However, any alternatives to NHS treatment need to be assuredly beneficial to those utilising them or referred to them. As I demonstrated in the introduction, the majority of quantitative research points to their efficacy, yet the understanding of the complex recovery processes underlying the fellowships is currently limited. A deeper understanding of the mechanisms of change inherent in the fellowships could calm professionals' fears about a recovery programme based on spiritual principles, but also guide recovery understanding as a whole.

Many of the clinical professionals who came into contact with our samples, such as GPs and therapists, had a lack of awareness or a reluctance to recommend fellowships. It

seemed from accounts that participants might have benefited from the fellowships, but their GPs did not suggest them when participants went to them for help. Additionally one of the participants' therapists seemed to have misgivings about fellowships based on an over-generalised understanding of the role spirituality plays in fellowship recovery. However, those who worked specifically in addiction, such as at drug and alcohol centres and treatment centres, were the ones who predominantly suggested participants try out fellowships. Awareness of fellowships would benefit greatly from further research to see why those who might find the fellowships helpful are not being routinely signposted to such a readily available support network, as is recommended by the NICE guidelines (Department of Health (England), 2007, 2011).

Galanter (2007) believed that all professionals working in addiction would benefit from a better understanding of how fellowship recovery occurs, especially concerning the psychological mechanisms that accompany spirituality. Day and colleagues (2015) thought drug treatment services should increase education about fellowships for their workers, in particular encouraging them to attend open meetings to see what they are like. Robinson (2011, cited in Krentzman et al., 2011) urged professionals to increase their knowledge of the range of fellowships and variety of meetings available, but also to advise clients to try several meetings before deciding whether they wished to become a member.

An important factor for consideration concerning the advocacy for fellowships is their easy accessibility and cost efficiency. Fellowships offer time efficiency and convenience because due to the large number of meetings all over the UK, as well as online meetings, members can access help in their own community almost immediately. Fellowships also have a minimal cost to members, who donate whatever they can afford, with this money going only towards running costs. Fellowships could similarly reduce professional treatment costs because they can be used as a complement or alternative to professional treatment. For example, because Abdul, Claire, Alice and Oliver all attend fellowships

they have not needed to seek any further professional treatment. This suggests that through using the fellowships as a form of aftercare, long-term healthcare costs could be reduced. Emma and Ed use fellowships combined with ongoing therapy and have needed no inpatient treatment; this mirrors the findings of Humphreys and Moos (2001, 2007) and Moos and Timko (2008), who found that fellowship attendance reduces short and long term healthcare costs. Notably, because Irena and Stephanie have both exclusively utilised fellowships in their recovery, they have incurred no professional treatment costs to themselves or the NHS.

Therefore, increasing the clinical practice of promoting twelve-step fellowships could help to reduce the pressure on treatment services as well as the costs of continuing care (Humphreys & Moos, 2007). Krentzman and colleagues (2011) pointed out that encouraging twelve-step fellowship involvement while patients are still in treatment significantly increases the chances of attendance after discharge. Similarly, Timko & DeBendetti (2007) found that 'intensive referrals' that actively foster engagement lead to increased abstinence, compared to those who just 'encourage' individuals to attend. Recently in the US there have been initiatives such as Making AA Easier (MAAEZ: (Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009) that focus on facilitating an increased engagement in twelve-step fellowships and introducing patients to concepts like sponsorship, service and social support (Subbaraman & Kaskutas, 2012; Subbaraman, Kaskutas, & Zemore, 2011). The UK could potentially benefit from employing similar initiatives in its NHS addiction treatment services.

4.5.2: Implications for Counselling Psychology

Kelly (2016, p.1) concluded that fellowships appear to be an "*effective clinical and public health ally that aids addiction recovery through its ability to mobilise therapeutic mechanisms similar to those mobilised in formal treatment*". The findings of this study support this assertion, and I believe the promotion of twelve-step fellowships could have

positive implications for counselling psychologists, their therapeutic interventions and their clients. Bradshaw (2005) described the fellowships as a therapist's 'greatest ally' while Bogenschutz et al. (2014) advocated for psychologists to encourage those in treatment to attend fellowships. DeLucia et al. (2016) believed that if psychologists promoted fellowship engagement then not only are their client's chances of achieving abstinence increased, but also their psychological well-being and quality of life are enhanced.

The fellowships and counselling psychology appear to be naturally compatible. When interviewed by Flores (2006 p. 11), Yalom was quoted as saying that in his group work with alcoholics he combined the approaches allowing the fellowships to do "*the work of trying to control the substance issues*" while he worked *"on the underlying interpersonal problems*". The participants in the study described a two-pronged approach where the fellowships helped them with their addiction issues, and their therapists worked on issues that required a more professional intervention. Participants in this study also described how increased social connection improved their emotional well-being, yet these are therapeutic elements that psychologists cannot offer due to the boundaried nature of our work.

Day and colleagues (2015, p.223) highlighted that *"clinicians potentially represent a major referral pathway"* to fellowships. The current NICE guidelines advocate for routine referrals to fellowships for those encountering problems with drug and alcohol problems (Department of Health (England), 2007, 2011). So why are all counselling psychologists not currently promoting fellowship attendance as a standard of good practice? As we discussed in the introduction, many clinicians have objections to many core concepts of the programme. Barriers to clinician recommendations include: the spiritual/religious element of the programme, the belief that it is not effective, concerns that admitting powerlessness and surrender decreases self-actualisation, and believing clients are not motivated to change (Day et al., 2015; Laudet, 2003; Nowinski, 2015). Ed stated he

believes his therapist's ambivalence towards the fellowship is based on the limited understanding she has of the programme. Improving awareness of the realities of the fellowship programme could help increase referrals. I have discussed the spiritual element of the programme in depth, and the choice to refer clients based on this can only be guided by each counselling psychologist's stance on whether spirituality is therapeutically beneficial. But I hope that this study has gone some way to dispelling the mistaken belief that fellowship programmes are merely 'religious' in nature when analysis shows that fellowship spirituality is far more nuanced than this.

Many of the distinct recovery processes that appear to underlie fellowships reflect existing psychological theories and therapeutic approaches. For example, Dossett (2017) points out that while psychotherapy and fellowship linguistics seem different, they are actually describing similar concepts. Psychologists use the terms existential, support networks, negative thinking patterns and mindfulness, while fellowships say spiritual, fellowship, resentments, and prayer. Kelly, Magill, & Stout (2009) published a systematic review of the research done on mechanisms of change and found that many fellowship processes are common across different types of therapeutic approaches. Grencavage & Norcross (1990) hypothesised that there were certain 'trans-theoretical' change processes that could be found to be common factors across treatments including the opportunity for catharsis, the practice of new behaviours, fostering insight and awareness, interpersonal learning, identification and modelling, contingency management, suggestion, tension reduction and education provision. All of these could be argued to be present in the fellowships, given the findings of this study. This suggests that the fellowships could work well with counselling psychology modalities as they operate on a similar conceptual dimension.

There are also more specific links between the fellowships and specific counselling psychology modalities and have these also been noted by other researchers. For example, the fellowships offer a non-judgmental, congruent and empathic environment,

much like those espoused by Rogers (1961) in his person-centred therapy approach. The focus on living in the moment and mediation is similar to mindfulness techniques (Dermatis & Egelko, 2014). There are also cognitive behavioural mechanisms inherent in the fellowships that are much like CBT, such as the emphasis on developing coping strategies and linking thoughts feelings and behaviours (Humphreys, 2004; Moos, 2008; Vaillant, 1988, 2005). Patterson & Nochaski (2010) compared the stage of change model by Prochaska, DiClemente and Norcross (1992) with the fellowship programme and found that there was a 'natural fit' between the steps and the stages of change.

The fellowships also appear to reflect and address important existential psychological themes. For example, the 'givens of existence' (I.D. Yalom, 1980) such as the confrontation of death, freedom, responsibility, isolation and meaninglessness are all processes that participants described experiencing in the course of their recovery. Likewise I discussed the links to Frankl's (1969, 1978) logotherapeutic method when I described how the fellowships help bring meaning to the lives of its members. Yalom (1985) postulated that several curative factors of group therapy were present in fellowship meetings: instilling hope, guidance, universality, altruism and group cohesion. However, I have demonstrated that other curative factors such as catharsis, increasing self-understanding, relating to and trusting others, existential factors and identification are also present.

This could mean that the fellowships are offering specific therapeutic elements that fit with a counselling psychology perspective. So while the fellowships are not a professional psychology treatment they could offer some of the benefits of counselling psychology to those who cannot afford treatment, cannot wait for NHS treatment or wish to supplement treatment. Psychologists can feel reassured when referring clients to the fellowships that they will find some established therapeutic benefits there. Likewise, counselling psychologists could potentially learn ways to improve their own practice from fellowships, especially some of the therapeutic group dynamic processes.

It is hoped that this research will increase understanding of how fellowships work from a counselling psychology perspective, as well as inspiring counselling psychologists to research fellowships as a complementary form of recovery help. The lack of counselling psychology's input in this field is unfortunate because the reflectivity of counselling psychologists makes them uniquely suited to researching such relational-based phenomena as fellowships. Like Khantzian and Mack (1994), I believe that given the current state of NHS treatment provision and the pervasiveness of addiction, counselling psychologists simply cannot afford to continue to ignore the usefulness of the fellowships.

4.5.3: Implications for Addicts

Despite the wealth of research done so far, researching the effects of fellowship is still pertinent because as Lederman (2015) points out, any research into the process of recovery sheds light on how we can help those who still struggle with the disease of addiction. This research was important because it focused on exploring recovery processes but also on giving voice to the experiences of addicts. I believe that focusing on empowering addicts is crucial to the furthering of recovery research. For this reason the use of my own insider status was not only practical but also essential for uncovering recovery processes in a deep and empathic manner.

Public and patient experience and engagement (PPEE) involves empowering and understanding the experiences of service users through involving them in the design and provision of healthcare (Department of Health, 2009). Both the Government (HM Government, 2012) and the NHS (Department of Health, 2015) have thus made it their policy to take into consideration the views of people who use these health or social care services. The NICE guidelines (NICE, 2013) also require practitioners to ensure that service users are involved in clinical activities such as conducting research and developing clinical guidance. This focus on service user involvement serves two

purposes: firstly it means that treatments have a greater relevance for the people who need them; secondly, it reduces the stigma felt by such individuals (Corry, 2008). The more that research is guided by service user perspectives, the more effective and attuned future treatments will be to the needs of those they aim to help. It is thus hoped that this research can add to the body of insider fellowship research and service user involvement initiatives, as well as encourage other recovering addicts to become more actively involved in research.

4.6: Personal Reflexivity

By researching the phenomenon of fellowships from an insider's perspective I have inevitably played a part in the construction of the findings laid out. I utilised the constructivist grounded theory method (Kathy Charmaz, 2006) primarily because it enabled me to do this in a way that was theoretically sensitive but also ensured quality and credibility. I was able to position myself as a researcher not just an insider and view the data from an analytical viewpoint. I made concerted efforts to remain as unbiased as possible when conducting interviews and the analysis. Through the use of memo and reflective diaries, I took pains to view alternative perspectives to my own.

For example, because of my tendency towards feminist perspectives, I became keenly aware through my reflective diaries that this was an area I needed to address as I was in danger of unconscious bias towards the females in my sample. Please see box 5 for a reflective diary written during my analysis regarding this. Despite my efforts to remain unbiased, it may well be that I unconsciously felt theoretically drawn to feminine perspectives. For example, I was drawn to the concept of shame because of my own experiences with it. Similar to other researchers (Beckman, 1993; Sanders, 2011; Kelly & Hoeppner, 2013), I also shared the concerns of some of the female participants who struggle with the male-centric literature and the concept of 'God' using a male pronoun.

This may have been another area to which I gave more attention than a male researcher might have.

Being a Feminist Researcher

16th September 2016

I am a female and I have got a sample that is skewed towards females so I feel it is important for me to reflect upon how my gender might affect this study.

As I am in the midst of my focused coding it is imperative that I acknowledge my own biases towards female perspectives. I have noticed that the females' experiences reflect my own thoughts and feelings in many ways. That is not to say that I haven't also felt an affinity with the males and empathised with their experiences too.

However, I think in order to do the male's experiences justice I must be critically self-reflective and ensure that during theoretical coding the perspectives of the male participants are not subsumed or overwhelmed. Could I be placing greater importance on these issues in my analysis and discussion than they deserve? Or could I be giving voice to females who have been traditionally been under-represented in fellowship research so far? The line between these too viewpoints are narrow and I must navigate carefully to avoid bias but also remain theoretically sensitive.

Box 3: Reflective diary on the possibility of gender bias in this study.

Not only have I had an effect on the findings of this research but the process of conducting this study has also impacted upon me. I have learned an incredible amount, both academically and personally. My recovery has been strengthened because many of the participants expressed profound and valuable concepts that I choose to incorporate into my own recovery journey. This study has helped me to maintain my emotional well-being through practicing the principles of fellowship recovery that my participants outlined. The findings of this study therefore not only reflect the experiences of my participants but also my own. I am deeply grateful to every one of my participants for the gift they gave by sharing their experiences with me. I hope to have done justice to their experiences because their stories were inspirational and important to advancing

the field of recovery research. I hope that through sharing their stories, they will help effect positive changes in the way counselling psychologists and other professionals view twelve-step fellowships. I also hope that these findings can guide potential members and newcomers in their own recovery journey. This experience has left me determined to continue studying fellowship recovery, as well as ways in which it can be combined with professional counselling psychology treatments.

4.7: Conclusions

This study set out to research the recovery processes underlying the fellowships. I have demonstrated that there are several mechanisms of change involved, which interact to create a positive compounding effect. The theory presented brings together the elements of recovery into a cohesive whole. My conclusions are supported by similar findings from other well-respected researchers and have shown that the fellowship programme is based on valid psychological principles. I have also shown how fellowships can be relevant to addiction recovery in the current healthcare climate, especially because they provide cost efficient, easily accessible community-based recovery support for individuals struggling to get sufficient help to overcome their addictions (Donovan et al., 2013). Although fellowship concepts are eighty years old, many of them seem as relevant today as they were when they were devised. Fellowships help millions of people around the globe and have grown and adapted to the modern world (Nowinski & Baker, 1992). This continual membership growth alone gives witness to their effectiveness and versatility in helping recovering addicts.

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Appendices

Appendix A: Introduction to Twelve-Step Fellowships

Twelve-Step fellowships began with Alcoholics Anonymous (AA), which was founded in the USA in 1930's, by two alcoholics trying to gain sobriety, Dr Bob and Bill W. They developed a programme of recovery that consists of the 'fellowship' of recovering addicts, who help each other to overcome their addictions. Coming together to "*share their experience, strength and hope, that they may solve their common problem and help others to recover*" (Alcoholics Anonymous, 1947, p.1). The fundamental tenets of this programme are laid out in the main text, 'Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism', also known as the Big Book, which was first published in 1939 and reached its fourth edition in 2001. Later in 1952, 'Twelve Steps and Twelve Traditions' (Alcoholics Anonymous, 1981) was also published; this formalised the suggested twelve-steps that addicts should make for long term recovery as well as the guidelines by which meetings, and the fellowship as a whole, should be run. These main elements of the programme remain the same today after almost 80 years.

AA is now one of the longest running and commonly sought recovery management programmes (Compton, Thomas, Stinson, & Grant, 2007; Kaskutas et al., 2005; Orford, 2013). AA worldwide membership has reached over 2 million with 115,00 groups being held in different countries all over the world (AA World Services, 2014) and the Big Book has been translated into 28 languages (Laudet, 2008). The fellowships have been described as a major international 'social movement' (Emrick, Tonigan, Montgomery, & Little, 1993); for example, a recent US national survey found 3.4% of US adults had attended a TSF (Grant, Dawson, Stinson, Chou, Kay, 2003).

AA's popularity and success has spawned a large number of 'sister' fellowships (Nowinski, Baker, Carroll, & Mattson, 1992), which work on the same principles and philosophy as AA, the only difference being the specific addiction that members identify

as having. All these TSF's share the same general meeting format, steps, traditions and organisational structure (Laudet, 2008). Many of these fellowships use the same literature, replacing alcohol with the relevant word (Ronel & Libman, 2003). Kelly and White (2012) observed that these sister fellowships focus on a diverse range of addictions and confer similar benefits to AA, but have yet to receive as much notice.

White & Madara (2002) found that there are approximately ninety-four different verified TSF's covering a range of addictions, both substance-related and behavioural. The most popular substance related programmes are Narcotics Anonymous (NA) and Cocaine Anonymous (CA). Behavioural addiction fellowships include Overeaters Anonymous (OA), Gamblers Anonymous (GA), Sex and Love Addicts Anonymous (SLAA), as well as many others. There are also fellowships for those 'affected' by addiction, such as Al-Anon (Nowinski et al., 1992). Cross-addiction is when someone suffers from multiple addictive behaviours at the same, or at different, times (Nowinski et al., 1992). Because of this, some individuals choose to attend multiple fellowships (McIntire, 2000; Weiss et al., 2000).

Fellowships not only help millions of people around the world but also have had a great influence on the professional addiction treatment community. However, both Borkman (2008) and Nowinski (2015) pointed out that it is inaccurate to describe the fellowships as a treatment method, believing that they are better understood as a programme that gives a suggested pathway for ongoing recovery. This is because they are entirely run without professional involvement (Laudet, 2003); instead, they are run by volunteers whose experiential expertise is valued more than theoretical knowledge or professional expertise. For the purposes of this paper though we shall sometimes liken them to a treatment, using the analogy for pragmatic purposes, as this is how their efficacy has been researched.

The Steps

The Twelve Steps are a set of guiding principles that an addict is recommended to follow in their recovery process (Kaskutas et al., 2002), to gain abstinence, as well as emotional and spiritual growth. The steps are 'worked' by members in their journey to recovery; this involves answering questions laid out in specific fellowship texts (Alcoholics Anonymous, 1981; Narcotics Anonymous, 1993, 1998; Overeaters Anonymous, 1994), but also the process of reflecting upon the recovery concepts encompassed by these questions. Box 1 contains the twelve steps in their original form, as developed by Alcoholics Anonymous.

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

Box A1: The Twelve Steps of AA (Alcoholics Anonymous, 1939, 2001)

The first step involves members admitting 'powerlessness' over the object of addiction and the 'unmanageability' that this creates in their lives (Alcoholics Anonymous, 2001). It may seem to be a paradox that in order to gain control over one's drinking, one must admit that one has no control over their drinking. However, as Orford (2013) points out, powerlessness is a concept to which anyone struggling with addiction can relate. Most

addicts who come to the fellowships have already come to see that they have lost control of their addiction and that their own willpower has failed to solve the problem (Nowinski et al., 1992). Interestingly, the first step is the only one that mentions addiction; the rest of the steps focus on other elements of recovery (Donovan, Ingalsbe, Benbow & Daley, 2013).

The twelve steps can be broken down into four recovery themes, where steps one to three focus on gaining abstinence by overcoming self-will through connecting to a high-power. Steps four to seven focus on character change (Borkman, 2008) by recognising one's ‘shortcomings', resentments and ‘character defects'. Steps eight and nine are about repairing one's relationships with others by identifying regrets and wrongdoings, then making ‘amends' for these. Finally, steps ten to twelve involve maintenance of one's recovery through taking responsibility for daily actions, focusing on spiritual growth and helping others.

The Traditions

Traditions were developed through the hard-earned experiences of the founders of AA to ensure the healthy running and independence of the fellowships. Box 2 contains the twelve traditions as originally published by AA in 1952.

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

Box A2: The Twelve Traditions of AA (Alcoholics Anonymous, 1952)

Although all the traditions have value, for pragmatic reasons I shall only explain the traditions that are particularly pertinent to this study. Tradition twelve, anonymity, protects members who worry about being publically identified as an addict. Also, members can feel free to share honestly in meetings because confidentiality is upheld faithfully (Narcotics Anonymous, 1993). Tradition one upholds that ‘common welfare' is more important than personal needs; members must always consider the needs of everyone. This ultimately protects individual recovery because it maintains unity and ensures the healthy functioning of each group.

Tradition three states that the only requirement for membership is a desire to stop. This means everyone can feel welcome; “*you are a {sic} member if you say so. You can declare yourself in; nobody can keep you out*” (Alcoholics Anonymous, 1981, p. 139).

Traditions four and seven state that each group should be autonomous and self-supporting; this encourages members to take responsibility for the conscientious running of their group. These principles can then also be applied to personal recovery (Alcoholics Anonymous, 1981).

The fellowships also do not advertise to spread their message, per tradition eleven: they rely on attraction rather than promotion, hoping that members are drawn to recovery, rather than enticed. Because of traditions six, eight and ten Nowinski and colleagues (1992) have pointed out that since fellowships have no professional opinions and are non-affiliative, they also hold no prejudice against other forms of addiction treatments, allowing for members to seek out as many forms of help as they feel they need. All these traditions serve to help uphold tradition five, not to be distracted from the 'primary purpose', which is helping those who are still struggling with addiction.

Meetings

The heart of the twelve-step programme is in the meetings (Nowinski, 2015), which are run by the members who attend them. Meeting structure adheres to a prescribed format (Laudet, 2008) but the main part of all meetings consists of members sharing their experiences. "*In any meeting, anywhere, AA's share experience, strength, and hope with each other, in order to stay sober and help other alcoholics*" (Alcoholics Anonymous, 2001, p. xii).

Borkman (2008) explained that it is during the meetings that newcomers learn the fellowship 'belief system', observe peers with more recovery who then can become role models, and also learn to talk about their own experiences. Members are expected to respect each other and not interrupt or make disparaging comments about each other's shares (Nowinski, 2015). Instead, members are encouraged to identify with what they

have heard, focusing on the ‘similarities' between them rather than the ‘differences' (Narcotics Anonymous, 2008).

Typifying what meetings are like is hard as there is such a wide range of formats (Humphreys, 2004) helping members get specific needs met. There are newcomer, speaker, meditation, step and topic discussion meetings. Since there is also a large diversity of members there are women's, men's, LGBT, young people's and foreign language meetings to meet more specific needs. Every meeting has a slight variation on the experience and atmosphere, so members can choose which meetings suit them best. Often members will choose to have ‘home groups' which are meetings that they feel comfortable in and attend regularly.

Mutual Aid

Helping others in their recovery is a large part of the programme (Dossett, 2013; Nixon & Solowoniuk, 2008). Members are encouraged to help others, as doing so will increase the strength of their own recovery. This is evidenced by the often-used phrase "*we keep what we have by giving it away*" (Narcotics Anonymous, 2008, p. 9). The meetings rely on members volunteering to do ‘service' (Nowinski, 2015) such as taking on roles as the meeting secretary, treasurer, literature, or tea person. However, the term ‘doing service' can equally apply to helping a newcomer, giving the main share, or being a sponsor.

Newcomers are members who have just joined the fellowships, or who have just come back from a relapse. It is common practice for newcomers to be given extra help and attention by more experienced members, in recognition of how difficult it is at the beginning (Borkman, 2008). A sponsor is akin to a recovery mentor; they are usually someone who is experienced with the fellowships and with a lengthy period of stable recovery. Not only do sponsors offer care and support; they also guide their sponsee’s through the working the steps (Narcotics Anonymous, 1998). It is recommended to

newcomers to get a sponsor as this guidance can be particularly helpful in the early days of trying to gain abstinence. It is important that a newcomer chooses a sponsor whom they feel comfortable with because as part of working the steps sponsee's share private, confidential information with their sponsor (Makela et al., 1996).

The Twelve-Step Model of Addiction and Recovery

The TSF philosophy is based on its views of addiction and recovery. Addiction is conceived as a threefold disease, of the body, mind, and spirit (Miller & McCrady, 1993a). "*We are convinced to a man that alcoholics of our type are in the grip of a progressive illness. Over any considerable period, we get worse, never better*" (Alcoholics Anonymous, 2001, p.30). This is also often characterised by denial of these symptoms; "*denial of our addiction kept us sick, but our honest admission of addiction enabled us to stop using*" (Narcotics Anonymous, 2008, p. 7). Inherent in the fellowship approach to the disease of addiction is the belief that no addict is ever 'cured'; "*We are never cured, and that we carry the disease with us for the rest of our lives… But we do recover*" (Narcotics Anonymous, 2008, p8.). The only effective remedy for recovery is believed, through the members' own experience, to be complete abstinence from the object of addiction; "*If you are like us you know that one is too many and a thousand never enough*" (Narcotics Anonymous, 2008, p18).

According to fellowship philosophy, abstinence is not the only requirement for a meaningful long-term recovery; members are also committed to self-improvement (Dossett, 2015). Addiction causes chronic negative cognitive, emotional, social and spiritual effects (Nowinski et al., 1992). So the evolving process of recovery requires the individual to improve their psychological, interpersonal and spiritual functioning (DeLucia et al., 2016) over time. Borkman (2008) describes recovery as a journey towards healing the self through developing a new way of living.

Spiritual Growth

Recovery is a spiritual journey, and members are encouraged to integrate spiritual principles into their lives (DeLucia et al., 2016). Along with the focus on helping others, three spiritual principles which are particularly emphasised are honesty, open-mindedness and willingness (Narcotics Anonymous, 2008).

The fellowships also suggest that members come to believe in a 'power greater than themselves' (Alcoholics Anonymous, 2001), as something to they can look to for guidance, strength and hope. This 'Higher Power' is something that provides a source of help, rather than relying solely on the self and their own will-power (Humphreys, 2004), which has so far proved to be inadequate to combat their addictions (Nowinski et al., 1992). However, this need not be a predefined deity; members are encouraged to conceptualise their higher power in any way they choose, as long as it is a power outside of themselves. Often members choose to believe in the group as a higher power (Laudet, 2008); "*if you wish, make AA itself your higher power… they are certainly a power greater than you*" (Alcoholics Anonymous, 1981, p27).

For some, the concept of a higher power is a positive element that sets the fellowships apart from other approaches to addiction recovery. But for others, the suggestion to surrender their will over to 'God', is the most controversial aspect of the programme, with critics likening it to a cult (Vaillant, 2005; Wright, 1997). The fellowships have their roots in Christianity, and the word God is utilised throughout the Big Book, yet the fellowships maintain that the twelve-step programme is not religious but spiritual. The Big Book was partially shaped by atheist influences such as William James and Carl Jung (Makela et al., 1996; McCabe, 2015) and has a chapter entitled 'We Agnostics' written by agnostics and atheists (Dossett, 2015). The introductory readings at meetings reiterate this religious secularism; "*We are not connected with any political, religious or law enforcement groups."* (Narcotics Anonymous World Services, 1986, p.2).

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Appendix B: Advertising Poster

CITY UNIVERSITY LONDON

Northampton Square
London
EC1V 0HB
Tel: 020 7040 8500

Recovery Through 12-Step Fellowships

- ***Are you an active member of 12 step fellowship groups?***
- ***Have you gained more than 3 months recovery?***
- ***Do you have a sponsor?***
- ***Would you like to be part of study on how 12 step fellowships help people gain recovery?***

We are looking for people to be interviewed as part of an exciting and important study on 12 step fellowships. You may be eligible to participate in this study, and we would love to hear from you.

By taking part in this study you will contribute to research that may provide a deeper understanding of how and why fellowships help addicts to gain meaningful recovery.

Please email the researcher, Clemmie Jacques, for more details.

[redacted]

Department of Psychology
Social Sciences Building
City University London
Whiskin Street
EC1R 0JD

Appendix C: Participants Information Sheet

CITY UNIVERSITY LONDON

Northampton Square
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Tel: 020 7040 8500

Participant Information Sheet

What Are the Nature of the Therapeutic Processes Experienced by Recovering Addicts Attending Twelve Step Fellowships?

My name is Clemmie Jacques and I would like to invite you to take part in a research study. I am a Trainee Counselling Psychologist and as part of my professional doctorate in Counselling Psychology at City University London, I am conducting a research project to explore what it is like to recover from addiction with the help of 12-step fellowships.

Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. If you do agree to take part the researcher will go through this information sheet with you and answer any questions you may have.

What is the purpose of the study?

The researcher aims to investigate the nature of the therapeutic processes experienced by recovering addicts attending twelve step fellowships.

This study will be carried out as part of a doctoral thesis, but also in the hopes that it will help lead to a greater understanding of how and why the principles of 12-step fellowships help people with addictions on their journey to recovery.

It is the hopes of this study that a deeper understanding of how the concepts behind fellowships work successfully will, in turn, help those who are starting out on their recovery journey or are struggling to maintain abstinence. Also a greater understanding will help benefit those supporting recovering addicts, in a professional or sponsorship capacity.

This study has been designed so that it is line with the 12 traditions, it is not affiliated with any particular fellowship and personal anonymity will be maintained at all times. If you have any concerns around this then please feel free to discuss it with the researcher, your sponsor, or contact the advice services provided by your 12 Step fellowships.

Why have I been invited?

You have been invited to take part in this study because you attend 12-step fellowship meetings in your journey towards recovery. Your understanding and experience is invaluable as a resource to help those who wish to gain stable recovery.

You will be included in the study if:

- You are 18 or over.
- You have been **abstinent of your addictive substance or behaviour for 3 months** or more. But you are still in the first 2 years of your recovery.
- **You have been attending 12-step groups, or have been in a 12-step rehabilitation centre, for over 3 months in total.** This is to ensure you have a good understanding of the principles on which they work.
- You have a **sponsor and have completed working the first step**.
- You feel **stable in your recovery and overall emotional state**.

Do I have to take part?

- Participation in the interviews is entirely voluntary.
- It is also completely confidential.
- It is up to you to decide whether or not to take part. If you do decide to take part you will be taken through and asked to sign a consent form. **If you decide to take part you are still free to withdraw at any time and without giving a reason.**
- You do not have to answer any question you feel uncomfortable with, or if you feel it is too personal or intrusive.
- If you have any questions about participating in the research you can contact INVOLVE, a national advisory group that supports greater public involvement in public health and social care research. 023 8065 1088, admin@invo.org.uk

What will happen if I want to take part?

- You can contact me on [redacted] or [redacted] to discuss this further and if we agree to go forward then you will be asked to take part in an audio-recorded interview.
- Before the interview you will be taken through the information sheet, and consent form, to ensure you understand the process.
- The interviews will last approximately 60mins, depending on how much you wish to discuss.
- You do not have to fill in any questionnaires or tests; and there are no 'right' or 'wrong' answers.

What happens with the recordings of the interviews?

- I am using a qualitative analysis – which means that the data I gather will be your experiences, this will be done by audio-recording the session, then transcribing the interview and picking out themes from all these transcriptions.
- Transcriptions will be carried out by a professional transcription service, that will also be bound by confidentially and who will not have access to any identifying information about you.
- Any information gathered will be strictly confidential, and will be kept in accordance with the Data Protection Act, 1998. All information gained from you will have the name and any other identifying features removed so that you cannot be recognized.
- The only time I would have to break confidentiality is if the interview raises ethical concerns regarding the current or future endangerment of yourself or another person, which I will discuss with you before we begin.
- Short quotes from the interview may be used in the results of the study to illustrate the findings but would not be identifiable to you in any way.
- The results of the study will be used for my doctoral research project, and it may be also submitted for publication.
- A summary of the results will be made available to you, this can be emailed to you or sent via post. Please contact the researcher if you wish to be informed of the results.

What if there is a problem?

If there are any problems before, during or after interview then we will explore this with you, and help you access any help or support needed.

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: **What Are the Nature of the Therapeutic Processes Experienced by Recovering Addicts Attending Twelve Step Fellowships?**

Ethical Concerns

This research has been reviewed and granted approval by the ethics approval committee for City University London. If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Anna Ramberg, (Email: [redacted], the Secretary to Senate Research Ethics Committee and inform them that the ethics approval code is: PSYETH (P/F) 15/16 166

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been approved by City University London Research Ethics Committee.

Further information and contact details

If you have any further concerns about the research then please do not hesitate to contact the researcher or the research supervisor.

Researcher information:

Clemency Jacques – [redacted]

Research Supervisor information:

Dr. Jacqui Farrants – [redacted]
Consultant Psychologist
Psychology Department
City University London
Northampton Square
London EC1V 0HB
020 7040 0172

Thank you for taking the time to read this information sheet.

Appendix D: Consent Form

Version 4/6/2015

CITY UNIVERSITY LONDON

Northampton Square
London
EC1V 0HB
Tel: 020 7040 8500

CONSENT FORM

Title of Study: ***What is the Nature of the Therapeutic Processes Experienced by Recovering Addicts Attending Twelve Step Fellowships?***

Ethics approval code: PSYETH (P/F) 15/16 166

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and have had the opportunity to ask questions. I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audiotaped • making myself available for a further interview should that be required • being interviewed in City University buildings.	
2.	This information will be held and processed for the following purpose: • To answer the research question of 'What is the Nature of the Therapeutic Processes Experienced by Recovering Addicts Attending Twelve Step Fellowships'. • Will be used as part of a doctoral research thesis. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. I understand that my interviews will be transcribed by a professional transcription service that will also be bound by these confidentiality rules. They will not be given any identifying information apart from the recording but in the course of transcription they may inadvertently have access to identifying information. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way. I understand that I will be given a transcript of data concerning me for my approval before it is included in the write-up of the research. If you wish to withdraw your data you can do so at anytime.	

Appendix E: Debriefing Sheet for Participants

CITY UNIVERSITY LONDON
Northampton Square
London
EC1V 0HB
Tel: 020 7040 8500

Debriefing Sheet

Thank you for participating in this research.

What am I hoping to achieve with this study?
I am trying to tap into the themes that run through people's recovery when they adhere to twelve step principles; to find out what exactly is the nature of the therapeutic processes experienced by recovering addicts attending twelve step fellowships

It is the hope of the researcher that a greater understanding of what processes underlie the success, or shortcomings, of the 12 step principles in helping recovering addicts, will then allow for a increased ability to understand what it is like for the addict to recover, and what thinking is helpful or unhelpful for them. Which in turn will lead to the chance for further appropriate therapeutic support and a more complete and stable recovery.

If you have found this research has raised any concerns for you then please contact your sponsor or keyworker as soon a possible.

Alternatively below are some support lines you can contact if you are feeling immediate distress:

Samaritans - 0845 790 9090 www.samaritans.org Provides a 24hr confidential telephone service offering emotional support.

MIND - 0300 123 3393 www.mind.org.uk Provides advice and support on all aspects of mental health and offers local counselling services in many areas.

Saneline - 0300 304 7000. SANE runs a national, out-of-hours mental health helpline offering specialist emotional support and information to anyone affected by mental illness, including family, friends and carers. Open every day of the year from 6pm to 11pm.

NHS direct - 0845 4647 www.nhsdirect.nhs.uk

Also if you do feel that you need someone further to talk to then please contact your GP, who will be able to refer you to local relevant mental health services or support groups.

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Appendix F: Original Interview Guide

Semi-Structured Interview Schedule:

Preamble:
I am interested in your experiences of recovery utilizing 12-step principles. I want to stress that there are no right or wrong answers, as everyone's experience is individual to them.

Your confidentiality is strictly protected and no one will know that you have taken part in this study, apart from myself, yourself and your sponsor. Likewise any data will have all identifying features removed. This is to protect your anonymity, but also so you feel comfortable sharing openly and honestly, without fear of judgment. Your interviews will be recorded and transcribed, by a professional transcription service, which will be unaware of your identity, and so please try to remember not to disclose any identifying information whilst the recorder is on.

I have a number of questions I am going to ask, and since I am trying to get rich detail, I may ask for further explanations of what you have said. Please feel free to share or explore anything that you feel is relevant and may help me understand your experiences. Also any specific examples you may wish to give me would also be helpful.

Do you have any questions before we begin?

- Have you been attending meetings
  - How did you hear about meetings?
  - What made you start going to meetings?
  - How soon in your recovery did you start attending meetings?
  - How many fellowships do you attend?
  - How often do you go to meetings?
  - How important have they been in your recovery?

- What support have you received through attending meetings/treatment centre?
  - Practical, Emotional, Physical
  - Sponsor
  - Key Worker
  - Friendship network

- For you, is recovery just about abstinence?
  - What else is there?

- What have you found most helpful when you were beginning recovery?
  - To help you gain abstinence?
  - To help you cope emotionally?
  - What was unhelpful?

- What has helped, or hindered, you maintaining your recovery?
  - To maintain abstinence?
  - To maintain a healthy mental state?

- Is there anything specifically about the fellowships that has helped or hindered your recovery?

- What has been the most difficult part of recovery?
    - Have you struggled to maintain abstinence?
    - Have you struggled with your emotional state?
    - Has it been hard to change your lifestyle?
    - If so, what have been the most difficult aspects?

- Have you ever relapsed?
    - If so what did you learn about the experience?
    - What helped or hindered, you gaining abstinence again?

- What in your opinion have been the most important concepts that have helped in maintaining your recovery?
    - What concepts have not been helpful?
    - Have these concepts that are helpful or unhelpful, arisen at different times in your recovery?

- Why did you get a sponsor?
    - What has been helpful or unhelpful about having a sponsor?
    - How important in your recovery has having a sponsor been?

- Have you been working the steps?
    - Why did you start working the steps?
    - What step are you on?
    - What did you learn on step 1-12?
    - What has been helpful about working the steps?
    - What has not been helpful?

- What is your understanding of the 12 traditions of the fellowships?
    - Do you think the traditions are important and/or helpful?
    - Which traditions do you believe are the most important? Why?
    - What do you think of the 'primary purpose' and the 'only requirement for membership'?

- What other concepts and principles of the fellowships have been helpful or unhelpful to you in your recovery?
    - What is your understanding of Just for Today?
    - What is your understanding of Service?
    - What is your understanding of the Serenity prayer?
    - What is your understanding of a Higher Power?
    - What is your understanding of addiction as a disease?

- What does your recovery mean to you?

- Do you have any further points you would like to discuss that we haven't had the chance to go over?

Appendix G: Revised Interview Guide

Semi-Structured Interview Schedule:

Preamble:

- I am interested in your experiences of recovery utilizing 12-step principles.
- I want to stress that there are no right or wrong answers, as everyone's experience is individual to them.
- I have a number of questions I am going to ask, and since I am trying to get rich detail, I may ask for further explanations of what you have said.
- It may seem that I am asking you to repeat yourself but this is just because I want to make sure that I explore every aspect of the topic.
- Please feel free to share or explore anything that you feel is relevant and may help me understand your experiences.
- Also any specific examples you may wish to give me would also be helpful.
- I'm trying to focus on your recovery experiences rather than your addiction experiences, but I understand that sometimes you may have to mention some of your using experiences to illustrate your recovery processes.
- Your confidentiality is strictly protected and no one will know that you have taken part in this study, apart from myself, yourself and your sponsor.
- Likewise any data will have all identifying features removed.
- This is to protect your anonymity, but also so you feel comfortable sharing openly and honestly, without fear of judgment.
- Your interviews will be recorded and transcribed, by a professional transcription service, which will be unaware of your identity, and so please try to remember not to disclose any identifying information whilst the recorder is on.

Do you have any questions before we begin?

Questions:

- What fellowship/s do you attend?
  - How did you hear about meetings?
  - What made you start going to meetings?
  - How soon in your recovery did you start attending meetings?
  - How many fellowships do you attend?
  - How often do you go to meetings?
  - How important have they been in your recovery?
  - Did you have any reservations about attending meetings?

- For you, is recovery just about abstinence?
  - What else is there?

- What have you found most helpful when you were beginning recovery?
  - To help you gain abstinence?
  - To help you cope emotionally?
  - What was unhelpful?
  - What has helped you maintain recovery?

- What is your understanding of
  - Fellowship?
  - Just for Today?
  - Service?
  - The Serenity prayer?
  - Higher Power?
  - Addiction as a disease?
  - Similarities not differences?

- What do you think of the literature?

- What has been the most difficult part of recovery?
  - Have you struggled to maintain abstinence?
  - Have you struggled with your emotional state?
  - Has it been hard to change your lifestyle?
  - If so, what have been the most difficult aspects?

- Have you ever relapsed?
  - If so what did you learn about the experience?
  - What helped or hindered, you gaining abstinence again?

- Why did you get a sponsor?
  - What has been helpful or unhelpful about having a sponsor?
  - How important in your recovery has having a sponsor been?

- Have you been working the steps?
  - Why did you start working the steps?
  - What step are you on?
  - What did you learn on step 1-12?
  - What has been helpful about working the steps?

- What has not been helpful?

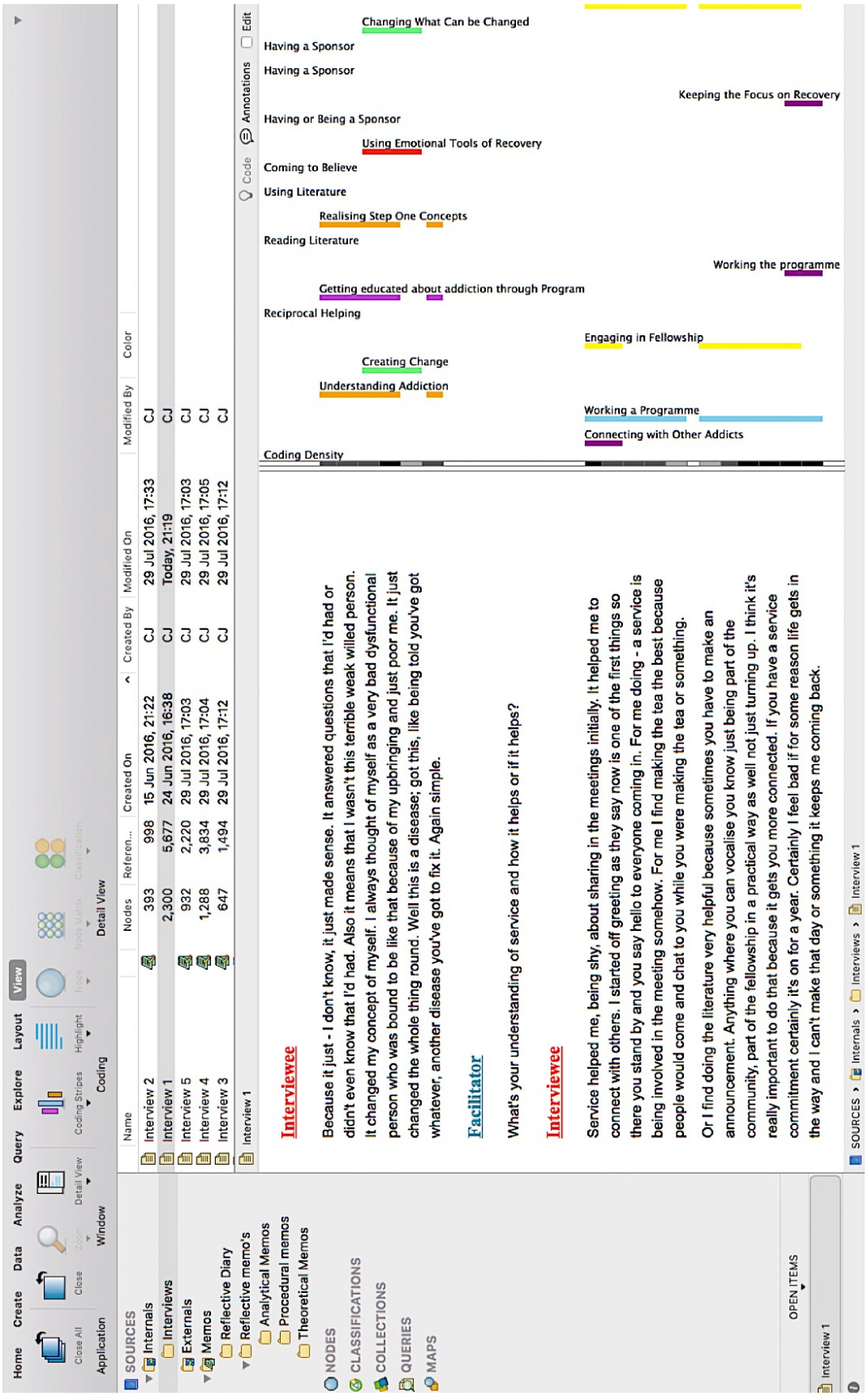
1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral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

- What is your understanding of the 12 traditions of the fellowships?
  - Do you think the traditions are important and/or helpful?
  - Which traditions do you believe are the most important? Why?
  - What do you think of the 'primary purpose' and the 'only requirement for membership'?
  - Anonymity
  - Everyone is welcome, no one is turned away.

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

- What other concepts and principles of the fellowships have been helpful or unhelpful to you in your recovery?
- What does your recovery mean to you?
- Do you have any further points you would like to discuss that we haven't had the chance to go over?

Appendix H: Example of Transcript and Early Coding using NVIVO



Appendix I: Example of Main and Sub-categories on NVIVO

Appendix J: Example of Memoing using NVIVO

Appendix K: City University Psychology Department Research Ethics Application

CITY UNIVERSITY LONDON

Psychology Department Standard Ethics Application Form: Staff, PhD Students, MRes Students

This form should be completed in full. Academic staff should email it to psychology.ethics@city.ac.uk. Students and research assistants should email it to their supervisor who should approve it before submitting it to psychology.ethics@city.ac.uk. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? ***For each item, please place a 'x' in the appropriate column***	**Yes**	**No**
Persons under the age of 18 *(If yes, please refer to the Working with Children guidelines and include a copy of your DBS)*		X
Vulnerable adults (e.g. with psychological difficulties) *(If yes, please include a copy of your DBS where applicable)*	X	
Use of deception *(If yes, please refer to the Use of Deception guidelines)*		X
Questions about topics that are potentially very sensitive *(Such as participants' sexual behaviour, their legal or political behaviour; their experience of violence)*	X	
Potential for 'labelling' by the researcher or participant (e.g. 'I am stupid')		X
Potential for psychological stress, anxiety, humiliation or pain	X	
Questions about illegal activities		X
Invasive interventions that would not normally be encountered in everyday life (e.g. vigorous exercise, administration of drugs)		X
Potential for adverse impact on employment or social standing		X
The collection of human tissue, blood or other biological samples		X
Access to potentially sensitive data via a third party (e.g. employee data)		X
Access to personal records or confidential information		X
Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort or stress to participants.		X

If you answered 'no' to all the above questions your application may be eligible for light touch review. We aim to send you a response within 7 days of submission. However, review may take longer in some instances, and you may also be asked to revise and resubmit your application. Thus you should ensure you allow for sufficient time when scheduling your research.

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review and will need to be reviewed at the next Psychology Department Research Ethics Committee meeting**.** These take place on the first Wednesday of every month (with the exception of January and August). Your application should be submitted at least 2 weeks in advance of the meeting you would like it considered at. We aim to send you a response within 7 days. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. If the research is considered very high risk, or the committee does not feel it has the expertise to review it, we may ask you to submit your application to the Senate Research Ethics Committee.

If you are unsure about any of above, please contact the Chair of the Psychology Department Ethics Committee, Katy Tapper [redacted].

Is this project supported by external funding?	**Yes**	**No**
		X
If you answered yes, please provide the name of the funding body and the amount awarded.		

Which of the following describes the main applicant? *Please place a 'x' in the appropriate space*	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	X
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s).

Clemency Jacques

2. Email(s).

[redacted]

3. Project title.

What is the Nature of the Therapeutic Processes Experienced by Recovering Addicts Attending Twelve Step Fellowships?

4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)

Addiction, in its various forms, is showing itself to be a major problem in society. For example, Public Health England (2014) published findings that in the UK between 2013-2014, an estimated 1.6 million were identified as suffering from alcohol dependence and around 250,000 are believed to be moderately or severely dependent and may benefit from structured alcohol treatment; of these 114,920 adults (46%) actually received alcohol treatment through the NHS in 2013-14, up from 109,683 (4.8%) the year before. Public Health England, (2014) also published data stating that 193,198 clients, aged 18 and over, were in substance misuse in treatment contact during 2013-14, but there aren't figures on how many individuals were identified as suffering from substance dependency, only those who received treatment. Adult substance misuse statistics published the next year by Public Health England (2015) showed that 295,224 individuals were in contact with drug and alcohol services in 2014-15; of these, 141,646 (39%) started treatment within the year. This was the first time that reports had combined alcohol and drug misuse in one report and this was done because many people experience similar dependency problems with both and receive interventions for both (Public Health England, 2015). What these figures show is that while the NHS is providing treatment for people with addiction issues, and this provision is increasing, there is a shortfall in the provision of treatment for people identified as needing help. It is important to note that these are only figures for those they could measure with alcohol and substance misuse dependency, it doesn't include all the people out there who never seek help, who hide their addictive behaviours, and also the other people who identify as suffering from addictions of a different nature, for example gambling, sex and love, food, etc. We may never be able to get the exact picture of how many people need help overcoming their addictive processes, but we do have enough of a picture to know that there are some who may need to seek help outside what the NHS can provide.

One alternative to NHS or other privately funded treatment methods are '12-Step fellowships', which are gaining increasing popularity and are expanding in the types of addictions for which they can provide a program for help with recovery. The philosophies behind the program worked by 12 Step Fellowships were developed in the USA in 1930's, by

two alcoholics trying to gain sobriety, Dr Bob and Bill W. They went on to found Alcoholics Anonymous, a self-help group of recovering alcoholics helping other alcoholics to stay sober. In doing so they formalised a program that consists of 'carrying the message to the still suffering alcoholic' (Alcoholics Anonymous, 2001); the main aspect of which is attendance at meetings where alcoholics at all stages of recovery can share their 'experience, strength and hope' (Alcoholics Anonymous, 2001). The program also consists of 12 steps that an individual should gain and 12 traditions that each group should adhere to (AA, Big Book, 1939). The steps and traditions emphasise that for recovery it is important to not only gain personal abstinence, but also to engage in emotional growth, giving back to the community and helping others who suffer from similar problems. These main elements are still the same today, even though AA worldwide membership has reached over 2 million (Alcoholics Anonymous, 2001). In Britain alone Alcoholics Anonymous has approximately 4400 group meetings each week throughout the UK (Alcoholics Anonymous (Great Britain) Ltd (2016).

Key concepts emerging from the fellowship literature include: acceptance, courage, wisdom, sharing thoughts, feelings and experiences with others, freedom from the powerlessness over addiction, overcoming unmanageability of one's lifestyles, taking it one day at a time, ending isolation through becoming part of a non-judgemental community, getting clean as part of society not apart from it, self-reflection of our personality strengths and defects choices and the personal responsibility for behavioural change, exploration of an individual's spirituality, making amends, mindfulness, and developing a more meaningful existence (Alcoholics Anonymous World Wide Services, 2001; Alcoholics Anonymous World Wide Services, 2002).

The principles of the AA fellowship program has been adopted by other groups set up to help people suffering from other addictive processes, including, but not exclusive to: Narcotics Anonymous, Cocaine Anonymous, Overeaters Anonymous, Gambling Anonymous, Co-dependency Anonymous, Sex and Love Addicts Anonymous. For example, Narcotics Anonymous has over 1,000 regular weekly meetings, with over 140 meetings in treatment or detox units; more than 20 in hospitals, along with meetings in 13 young offender institutions & secure units and dozens of prisons; while the NA National Helpline handles over 10,000 telephone calls each year (UKNA, 2016).

However it must also be mentioned that there are many addicts who experience recovery without formally utilising fellowships, whether with the help of outpatient and inpatient treatment centres, or on their own. Many addicts also fail to gain long lasting and meaningful recovery even if they regularly attend and engage in fellowship programs. More research is required before conclusions can be drawn into the efficacy of these fellowships, especially when seen in comparison to other addiction treatment methods. Conducting research on the fellowships is complicated by the organisational principles on which they are founded; as laid out by the 12 traditions, which were developed in 1953 (Alcoholic Anonymous Worldwide Services, 2002), and have stayed the same since then. These twelve traditions lay out ways in which the overall structure and philosophy behind the fellowships is maintained, and some of them make it difficult for formal quantitative research to be conducted, yet are deemed important for the continued productive running of each group

In line with tradition 3, anyone can attend, members are self-referred and the 'only requirement for membership is the desire to stop using' (Alcoholic Anonymous Worldwide Services, 2002); any one who identifies as an addict can come to any meeting, no booking is necessary, no sign in required, and no numbers are kept on how many people came to meetings. Also anyone can go to as many or as few meetings as they like, and many attend more than one fellowship at a time; so it is impossible to judge how many people utilise the fellowships. In line with tradition 6, each fellowship 'ought never endorse, finance, or lend its name to any related facility or outside enterprise, lest problems of money, property or prestige divert them from their primary purpose' (Alcoholic Anonymous Worldwide Services, 2002); this means that no official research is conducted by or with, the fellowships, as they wish to focus fully on 'carrying the message to the addict who still suffers' (Alcoholic Anonymous Worldwide Services, 2002). Finally, in line with Tradition 11 and 12, 'anonymity is the spiritual foundation of all our traditions' and a member 'must always maintain personal anonymity' (Alcoholic Anonymous Worldwide Services, 2002); which means members keep

their membership status anonymous from others who aren't in the fellowships. Traditions 11 and 12 are kept, to ensure that each meeting in each fellowship is a safe place for people to go and share without fear of being exposed, but it means that formalised quantitative fellowship research is difficult to carry out, as members will not disclose to outsiders, their membership status. However this does not mean research cannot be conducted, and the fellowships do encourage it, as long as it doesn't violate the traditions (Alcoholics-anonymous.org.uk, 2016).

Despite the complexity of conducting quantitative research into the efficacy of fellowships, there has been some research done on 12 steps groups and its outcome measures, with mixed results (Project Match Research Group, 1997; Moos & Timko, 2008). More research continues to be done and the two most popular fellowships, Alcoholics Anonymous and Narcotics Anonymous, are now calling for their members to take part in membership surveys that will help to address the need for more formal information of who and how people utilise the fellowships. But there is still a lack of research completed on what therapeutic processes underpin these fellowships that are helpful, and unhelpful, to those who suffer from addiction. Qualitative research on this topic might give a better picture of what it is actually like to take the journey to recovery by following fellowship programs. With this in mind, this study aims to explore the nature of the key therapeutic processes of the fellowship philosophy, that are purported to help people in early recovery; but also those that aren't as helpful. It is hoped that by doing so this will give a greater understanding of the elements of how and why 12 step fellowships are helpful to some addicts, which can then in turn help future addicts who start their own personal journey to recovery.

References:

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Public Health England, 2014. *Alcohol Treatment in England 2013*-14. Retrieved from http://www.nta.nhs.uk/uploads/adult-alcohol-statistics-2013-14-commentary.pdf

Public Health England, 2014. *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 2013-2104.* Retrieved from http://www.nta.nhs.uk/uploads/adult-drug-statistics-from-the-national-drug-treatment-monitoring-system-2013-14.pdf

Public Health England, 2015. *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 2014-2015.* Retrieved from http://www.nta.nhs.uk/uploads/adult-statistics-from-the-national-drug-treatment-monitoring-system-2014-2015.pdf

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5. Provide a summary of the design and methodology.

In accordance with the researcher's ontological (Critical Realist, Guba & Lincoln, 1994) and

epistemological stance (Interpretivist, Crotty, 1998), and given the complexity of the topic for study as well as there being a gap in the theory around the specific research slant it focuses on, this study will use a social constructivist grounded theory methodology laid out by Charmaz in 2006. The grounded theory is a qualitative methodology that allows for exploration of the area and theory generation, which it is hoped will lead to a meaningful understanding of recovery from an existential viewpoint. Grounded theory also enables the research to be flexible and fluid, so that the research focus can go where the data leads, so it can develop as the study unfolds, rather than being theory led. Constructivist grounded theory is the best suited, rather than the more classical Grounded Theory method laid out by Glaser & Strauss in 1967, because it allows for the understanding that by conducting this research, the researcher is inherently and unavoidably part of the research, that is it is subjective in nature. That any research conclusions made will be the researcher's interpretations, of the participant's interpretations, of the phenomenon of recovery.

The study will consist of looking at people, who identify as addicts, in the stage of early recovery (first 2 years), who are actively engaging in one or more 12-step fellowships. Participants will be encouraged to talk about their experiences of recovery and what has been the most helpful and unhelpful, aspects of the 12 step fellowships for them.

Constructivist grounded theory occurs in several stages, as laid out by Glaser & Strauss, 1967, and reformulated by Charmaz, (2006; 2015):
Brief Initial Literature Review – To evaluate the relevance of the research and to guide the interview question focus. But this will not be an exhaustive review in order to limit any bias the literature may impose on the analysis and theory development.
Data collection – Semi-structured interviews for the initial data, as theoretical sampling demands. These will be audio recorded and transcribed to provide the data set for analysis
Initial open coding – Line by line action orientated coding of the transcripts of the interviews, which allows for closer study of the data to begin conceptualising the data.
Focused coding – This is where the data is separated and sorted. The data is put into hypothetical thematic categories, which are then refined into more core categories as analysis goes on.
Memo writing – Throughout the process of data collection and analysis, memos are written to keep track of the researcher's analytic processes, explore ideas about coding, to direct further data-gathering and to ensure reflexivity.
Constant comparative analysis - Comparisons of the data will occur throughout the collection process, which will guide the researcher to formulate and reformulate theory as data collection continues, in order to ensure that there is sufficient variety and representation of the processes at play.
Negative case analysis – The researcher will seek out instances that don't fit with the emerging theory. This is to try to ensure that the researcher remains unbiased but also to give the analysis depth and diversity.
Theoretical sampling – This involves seeking out further participant samples as the theory development demands.
Theoretical saturation – Data analysis will continue until theoretical saturation has been reached, that is until the theory is deemed complete enough to have explored the phenomenon under investigation and no further categories will emerge from the data. Given the complex nature of the research area and of human experience, it is pragmatic to acknowledge that this is a goal rather than a reality (Willig, 2008), since each individual has such a varied and unique experience it may be impossible to get a complete saturation.
Focus Group - Then a second phase of data collection will occur in the form of a focus group, to test out the theory that has been generated. This will allow for a dynamic group discussion and rich data gathering to explore the validity and credibility of the findings of the research (Willig, 2008).

This project aims to utilise a computer-assisted qualitative data analysis software program (CAQDAS), either NVIVO or ATLAS.ti; the nonlinear design of these CAQDAS programs facilitates iterative approaches, like grounded theory (Bringer, Johnston & Brackenridge, 2006).

Ethical considerations are at the core of the research design in order to ensure that all

participants are treated with respect and dignity. The ethical standards are required to meet the principles set out by the British Psychological Society (BPS) and the Health and Care Professions Council (HCPC).

References:

Bringer, J.D., Johnston, L.H. & Brackenridge, C.H. (2006) Using Computer-Assisted Qualitative Data Analysis Software to Develop a Grounded Theory Project. *Field Methods vol. 18 no. 3 245-266*

Charmaz, K. (2006) *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* London: Sage.

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Glaser, B.G. & Strauss, A.L. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln. Eds. *The Sage Handbook of Qualitative Research*. London: Sage.

Willig, C. (2008) *Introducing Qualitative Research in Psychology.* UK: Open University Press, McGraw-Hill

6. Provide details of all the methods of data collection you will employ (e.g., questionnaires, reaction times, skin conductance, audio-recorded interviews).

- A pilot interview will take place, in order to give an idea of how long it takes to ask the questions proposed and if there are any changes that need to be made, such as taking questions out or changing the order.
- Then data will be collected by firstly conducting audio-recorded semi-structured individual interviews, lasting approximately 60 minutes. The amount of interviews that will be conducted will be judged by using theoretical sampling, until theoretical saturation has been reached. Pragmatically this is estimated to be between 6-10, to ensure sufficient diversity, validity and reliability.
- Then a Focus Group will be conducted with different participants in order to discuss and evaluate the theory generated from the data analysis.
- These interviews will be conducted by the researcher, they will then be transcribed, by a professional transcription service and coded into categories using a computer-assisted qualitative data analysis software program according to grounded theory methodology.
- Memo-writing and a reflexive diary will also be kept by the researcher to help guide analysis and reduce researcher bias.

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g. emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.

Since all participants will have to be self-identified addicts who are in recovery and abstinent for at least 3 months, some of the disclosures could possibly be concerning. With this in mind, all participants will be required to be engaging with a sponsor or key worker, who can give support to the participants before and after the interview process.

Three factors will protect against the occurrence of emotional distress: Firstly, as a member of 12 step fellowships the participants will have grown used to sharing their experiences, either in the meetings or with a sponsor or key worker. Secondly, it is not the focus of this study to ask about upsetting experiences, rather to focus on the journey of their recovery. Thirdly, the researcher is a counselling psychology trainee with experience of working with

complex and emotional needs, enabling the early detection of possible heightened and distressed emotional reactions. The data will be collected using semi-structured interviews to allow the researcher to sensitively explore the participants' experiences. It is hoped that the interviews will be a therapeutic experience for the participants, as they will encourage the participants to reflect on the journey of their recovery.

If there are any concerns before, during or after the interview process, for example, if a participant reveals concerning information during the course of the interview, then the data collection will be suspended until the researcher is satisfied that the interview process poses no risks to the mental state of the participant. If it is judged that it is best to stop the interview entirely emotional support will be given, as well as possible referral back to relevant support, confidentiality allowing. If any concerning information comes out as a result of the interview they will be encouraged to contact these people and address the concerns with them. In the participant debrief form, contact details for other sources of support will be provided, in case they do not wish to share to their sponsors or key-workers. In the interests of confidentiality, this cannot be enforced: for example if they have recently relapsed but don't want to tell their sponsor, I can only encourage them to refer this to them.

However in accordance with BPS and HCPC guidelines, there are some exceptions to the limits of confidentiality, which the participants will be informed on verbally before the interview takes place, and also on the consent form which they will be required to read fully before signing. These instances are if there are any serious concerns about: the safety of the participant, the safety of other persons who may be endangered by the clients' behaviour, the health and safety of children or vulnerable adults.

It is inherent in the recruitment of the participant sample, that only individuals in stable recovery are to take part in this study, in the understanding that whilst discussing potentially upsetting experiences, they have the capacity to do so without this negatively affecting their mental state or jeopardising their recovery.

8. Details of participants (e.g. age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.

Inclusion criteria:

- Any age (above 18) or gender.
- Must have been attending 12 step meetings, and/or in a 12 step rehabilitation for 3 months – this is so they have an adequate amount of time to become fully immersed in the principles and philosophies of the 12 step movement.
- May be attending any 12 step fellowship(s).
- May attend more than one fellowship – for example AA and NA.
- Must report that they are 3 months clean from their addictive processes – this is to ensure that they are stable enough to be able to discuss their recovery without it being put at risk. In the 12-step understanding, an addict must always be vigilant that they could relapse at any time but after 3 months they are deemed to no longer be a 'newcomer'.
- It is preferable that participants have a sponsor with whom they can seek support and discuss any issues bought up by the interview process. However it is possible that some fellowship members have still not have found a suitable sponsor yet, if this is the case then, as long as they have a key worker or therapist from a treatment centre, then they will not be excluded, as these professionals can take on a similar role of guidance and support for the participant. This cannot be enforced by the researcher, but will be listed as desirable for participants during the recruitment process.
- It is preferable that participants have worked through the process of step 1 of the 12 steps, with a sponsor or key worker, using either written or verbal formats and in accordance with the literature of their fellowships, this usually takes the form of answering questions about the extent of their addiction. This is the step that addresses the powerlessness over their addictive substances or behaviours. Once this step is completed they are deemed to have fully faced the extent of their

addictions, and have accepted the need for recovery. Again this can't be enforced, but will also be listed as highly desirable for participants during the recruitment process.

Exclusion Criteria:

- Persons under the age of 18
- As mentioned above participants without a sponsor, key worker or therapist will not be included in this study, as they must have access to a reliable source of support.
- Participants whose sponsors or key workers deem it to be detrimental for their mental state to participate in the study.
- Participants who appear to be in active and serious emotional distress.
- Participants with longer than 2 years clean time will not be sought as participants for the focus of this study is to examine people in 'early' recovery. By 2 years someone in the fellowships is deemed to be in their 'maintenance' phase, and the experiences of early recovery will no longer be as fresh and salient in their minds.
- Anyone who has come into contact with the researcher, personally or professional, prior to the recruitment stage, as they may introduce bias into the study.

9. How will participants be selected and recruited? Who will select and recruit participants?

For the interview stage:

- Participants will be recruited through fellowship meetings not affiliated with the researcher.
- Participants will be recruited from leaflets that will be distributed after meetings, advertising the study (see attached) and by word of mouth through the 12 step networks, and they will be invited to contact me.
- Interested potential participants will be preliminarily interviewed and screened over the phone to explain the research, check they meet the criteria, assess their mental state and the suitability of taking place in the study. Then they will be sent participant information sheets, by email or post, and if they are still interested, and meet the inclusion and exclusion criteria, will be considered for final selection as participants by the researcher.
- Telephone screening will take the form of an informal conversation during which the study will be explained in more detail and the inclusion and exclusion criteria will be directly assessed. During this procedure their mental state will also be assessed to ensure they are coherent to time and place, display no disordered or paranoid thinking, and that they have the capacity to understand what taking part in the study entails. They will be asked if they currently suffer from any mental health issues which may affect their ability to take place in the interviews.
- Participants will be asked to email the researcher if they are interested and then a time will be arranged for the researcher to call the participants at a specific time. This is to ensure they do not have to pay for the call themselves, as many of them are of low income.

For the focus group:

- This will be an audio recorded discussion group.
- This will occur at a secondary care treatment facility in Ashford, Kent, which has agreed to allow the researcher to approach possible participants.
- This is a private treatment centre which offers their former patients, the chance to live and work there as volunteers. As long as they have been sober for more than three months.
- Recovering addicts in a program of sober living will be invited to take part in the focus group and participate in the discussion of the findings of the study.
- Participants will be recruited by an advert for the focus group, which will be distributed prior to the event.
- These participants will be provided with the same information, debrief and consent forms that were provided for the semi-structured interviews.

- Participants will be recruited by an advert for the focus group, which will be distributed as handouts by staff there prior to the focus group, and in the form of posters, which will be posted on notice boards.
- The staff there will inform the possible participants of the focus group, at the daily planning meetings, in the days leading up to the group. Then they will provide the participant information sheet to those who are interested.
- Also in the morning of the focus group the researcher will be on site and available to answer any queries that the possible participants may have.
- Possible participants will be assured that their participation is not compulsory.

10. Will participants receive any incentives for taking part? (Please provide details of these and justify their type and amount.)

Other than the chance to share their experiences there is no incentive for the participants to take part. They will be reimbursed their travel expenses as they are of low income.

11. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)

- Informed consent will be sought and must be obtained from all participants before the interviews begin to ensure that they are aware their interviews will be audio recorded and that this will provide data for a doctoral research project.
- Participants will be given information to read through prior to the study and before the interview there will a verbal debrief to check they understand what the research entails and what will happen during their interviews.
- It is important that it also assures the participants that their participation is voluntary and they can withdraw from the study at any time.
- This consent form will also explain that their data will be anonymised and inform them what happens with their data, that interviews are transcribed and the data kept in accordance with the Data Protection Act 1998.

12. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)

- Participants will be given an explanation of the study and what it entails by phone during the screening process, then they will be provided with a participant information sheet, as well as being verbally briefed before and debriefed after the interview.
- This debrief will be both verbal and they will have a form to take away with them to read in their own time.
- The researcher's contact details will be provided if they have any further questions and the participants will be offered the chance to be sent a copy of the final research report if they wish to read it for their own interest.

13. Location of data collection. (Please describe exactly where data collection will take place.)

Interviews will take place in rooms in City University.

13a. Is any part of your research taking place outside England/Wales?

No	x	
Yes		If 'yes', please describe how you have identified and complied with all local requirements concerning ethical approval and research governance.

13b. Is any part of your research taking place outside the University buildings?		
No		
Yes	X	If 'yes', please submit a risk assessment with your application or explain how you have addressed risks.
The focus group will take part in a private secondary care treatment centre.		
13c. Is any part of your research taking place within the University buildings?		
No		
Yes	X	If 'yes', please ensure you have familiarised yourself with relevant risk assessments available on Moodle.

14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

As mentioned above there is the possibility in the course of the interview of the participant recounting potentially distressing memories, thoughts and feelings, or concerning behaviour. Although the study will not directly ask about, or seek out, potentially distressing information, it will be made clear to the participant in the information sheet, consent form and debriefing that they can stop the interview or withdraw from the study at any time. If any upsetting information is disclosed in the course of the interview, and the participant wishes to stop or appears to be unduly distressed, the interview will be stopped and the researcher will provide emotional support. Since the participants will be in the first 2 years of recovery, it is important that participants are encouraged to discuss the interview with their sponsor, before and after the interview. Only participants with 3 months abstinence or more will be interviewed in order to reduce the possibility of a relapse; however since the interviews will focus on recovery, it is the hope of the researcher that the process will serve to strengthen the understanding of their own recovery.

As part of the selection criteria, and in order to assess the emotional risk, participants must be deemed to be presenting as mentally stable. An initial assessment will take place over the phone when selecting participants; since the researcher is a counselling psychology trainee, they have experience conducting informal risk assessments and deciding on the probability of a participant behaving in an appropriate manner.

In order to reduce the risk to both the researcher and participant and make the participant feel more comfortable, it will be encouraged that the participants disclose to another person, most likely the participant's sponsor or key worker, when and where the interview will take place, as well as giving them the details of the researcher.

The majority of the research will take place in City University buildings but the focus group will take place in a secondary care treatment centre, in Ashford, Kent. This treatment centre is regularly inspected by the Care Quality Commission and the centre carries out thorough risk assessments on those who take part in their sober living program. In order to reduce the emotional risk to these participants, these individuals will all be required to meet the inclusion and exclusion criteria set out for the semi-structured individual interviews.

15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

Participants will be risk assessed, as part of the initial telephone assessment. If there are any concerns they will not be selected for the study.
As per the lone worker risk assessment guidelines a record of the name of the person the researcher is meeting and the location will be emailed to the research supervisor, and a copy will be left in a sealed envelope for the researcher's identified safety contact, in case of emergency. The researcher will call their safety contact before entering and again when they leave, giving them a rough estimate of how long the meeting should be as well as arranging a codeword with this safety contact, which can be used to alert them to high-risk situation and the need for assistance.

16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)

Please place an 'X' in all appropriate spaces

Complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)	
Anonymised sample or data (i.e. an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	
De-identified samples or data (i.e. a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)	X
Participants being referred to by pseudonym in any publication arising from the research	x
Any other method of protecting the privacy of participants (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only.) ***Please provide further details below.***	

The audio recordings will be sent to a professional transcribing service, which will also be required to sign a confidentiality agreement and the participants will be informed of this before they consent to take part in the study. Also, with this in mind, the participants will be encouraged not to disclose any personal information, such as their names or where they live, in their interview.

Data will be kept on a password-protected computer or external data storage devices and any paper copies will be kept in the locked filing cabinet. Any identifying information will be removed from transcripts and analysis; pseudonyms will be used to distinguish between participants.

17. Which of the following methods of data storage will you employ?

Please place an 'X' in all appropriate spaces

Data will be kept in a locked filing cabinet	X
Data and identifiers will be kept in separate, locked filing cabinets	x
Access to computer files will be available by password only	X
Hard data storage at City University London	
Hard data storage at another site. *Please provide further details below.*	

18. Who will have access to the data?

Please place an 'X' in the appropriate space

Only researchers named in this application form	X
People other than those named in this application form. *Please provide further details below of who will have access and for what purpose.*	x

Professional transcribing service – as yet unknown.

19. Attachments checklist. *Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.

Please place an 'X' in all appropriate spaces

	Attached	Not applicable
***Text for study advertisement**	X	
***Participant information sheet**	X	
***Participant consent form**	x	
Questionnaires to be employed		X
Debrief	x	

Copy of DBS	**x**	
Risk assessment	**x**	
Others (please specify, e.g. topic guide for interview, confirmation letter from external organisation)	**X Interview questions**	

20. Information for insurance purposes.

(a) Please provide a brief abstract describing the project

Addiction is a problem that affects many people throughout the UK. While the NHS provides treatments for thousands of these people, there is a still a number of people who seek help from other sources. Individuals suffering from alcoholism have been utilising 12-step fellowships since 1939; and since then, new fellowships, using the same principles and steps, are attended by those seeking help with many other types of addiction throughout the UK. This study aims to explore the therapeutic processes behind the core concepts of these principles to identify what have been the most helpful, or unhelpful, aspects of the fellowships for those who are in early, but stable, recovery. This will be achieved by conducting a study using a constructivist grounded theory approach, where recovering addicts between 3 to 24 months clean, will be interviewed and these interviews will be analysed to identify emergent themes using coding and theoretical sampling. It is hoped that any findings will add to the body of knowledge around addiction, recovery and the 12-steps, as well as providing a deeper understanding of what it is like for an addict on the journey of recovery using the fellowships, and these in turn can lead to theory-orientated therapeutic interventions. Any findings will also be useful for counselling psychologists as it will enable them to interact in greater depth with clients they have who might be engaging in, and finding helpful, 12-step fellowships.

Please place an 'X' in all appropriate spaces

(b) Does the research involve any of the following:	**Yes**	**No**
Children under the age of 5 years?		**X**
Clinical trials / intervention testing?		**X**
Over 500 participants?		**X**
(c) Are you specifically recruiting pregnant women?		**X**
(d) Is any part of the research taking place outside of the UK?		**x**

If you have answered 'no' to all the above questions, please go to section 21.

If you have answered 'yes' to any of the above questions you will need to check that the university's insurance will cover your research. You should do this by submitting this application to anna.ramberg.1@city.ac.uk, before applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university's insurance.

Name …… Date……

21. Information for reporting purposes.

Please place an 'X' in all appropriate spaces

(a) Does the research involve any of the following:	Yes	No
Persons under the age of 18 years?		X
Vulnerable adults?	X	
Participant recruitment outside England and Wales?		X
(b) Has the research received external funding?		x

22. Declarations by applicant(s)		
Please confirm each of the statements below by placing an 'X' in the appropriate space		
I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.		x
I accept the responsibility for the conduct of the procedures set out in the attached application.		x
I have attempted to identify all risks related to the research that may arise in conducting the project.		X
I understand that **no** research work involving human participants or data can commence until ethical approval has been given.		x
	Signature (Please type name)	**Date**
First applicant	**Clemency Jacques**	**5/2/16**
Supervisor *(For students and research assistants only. Please ensure the supervisor submits the form.)*	**Jacqui Farrants**	**5/2/16**

Reviewer Feedback Form

Name of reviewer(s).			
Committee			
Email(s).			
Psychology.ethics@city.ac.uk			
Does this application require any revisions or further information?			
Please place an 'X' the appropriate space			
No Reviewer(s) should sign the application and return to psychology.ethics@city.ac.uk		**Yes** Reviewer(s) should provide further details below and email directly to the applicant, ccing to psychology.ethics@city.ac.uk	x

Revisions / further information required
To be completed by the reviewer(s). PLEASE DO NOT DELETE ANY PREVIOUS COMMENTS.

Date: 3rd March 2016
Comments:

1. Section 9. Please clarify the nature of the secondary care treatment facility, noting the need for NHS ethics approval if this is an NHS facility. Please also clarify how participants will be invited to take part in the focus groups.

2. Section 9. Please provide more details of the telephone screening procedure.

3. Section 13. The committee felt that interviewing participants in their own homes represented an unnecessary risk and would recommend conducting all interviews at City University. If this is not possible, the committee would recommend contacting Chantal Hill for advice on safety.

Consent form

4. Can the applicants guarantee anonymity? If not this should be rephrased in line with the wording on the university template.

Participant information sheet

5. Please include a timeline for data withdrawal

Other comments (no need for a response)

Whilst the committee felt that ethical issues had been clearly considered, and the application carefully completed, it did note that the lay summary exceeded 1,400 words. Please try to keep within the 400 word limit for this section in future.

Applicant response to reviewer comments
To be completed by the applicant. Please address the points raised above and explain how you have done this in the space below. You should then email the entire application (including attachments), with tracked changes directly back to the reviewer(s), ccing to psychology.ethics@city.ac.uk

Date:
Response:

Reviewer signature(s) To be completed upon FINAL approval of all materials.

	Signature (Please type name)	**Date**
First reviewer		
Second reviewer *(If applicable.)*		

Appendix L: Lone Working Risk Assessment

Psychology Department Risk Assessment Form

Please note that it is the responsibility of the PI or supervisor to ensure that risks have been assessed appropriately.

Date of assessment: 02.02.16

Assessor(s): Student and supervisor Clemency Jacques and Jacqui Farrants

Activity: Doctorate in Counselling Psychology research - Lone Working

Date of next review (if applicable):

Hazard	**Type of injury or harm**	**People affected and any specific considerations**	**Current Control Measures already in place**	**Risk level** Med High Low	**Further Control Measures required**	**Implementation date & Person responsible**	**Completed**
Lone working in the community Private homes of participants, in order to conduct the research interviews. Clinic Rooms at City University Social Science Building.	Personal security/safety compromised Violent or threatening persons	Researcher	-The researcher's mobile number will be given to a safety contact. -The researcher will notify their safety contact of the date, time and location of the meeting with the participant. -Researcher will call the safety contact before and after the meeting so they know the researcher is safe. -The researcher will be seated closest to the exit should they need to exit in an emergency. -Obstacles obstructing the exit will be moved. -The researcher will have relevant emergency telephone numbers on quick dial should it be needed in an emergency. -The researcher will be carrying a personal alarm at all times.	Low	If the researcher's feels that her safety is at risk, the interview will be terminated immediately and she will remove herself from the situation.	Clemency Jacques	

Appendix M: City University Psychology Research Ethic Approval

Psychology Research Ethics Committee
School of Arts and Social Sciences
City University London
London EC1R 0JD

8th April 2016

Dear Clemency Jacques and Jacqui Farrants
Reference: PSYETH (P/F) 15/16 166

Project title: What is the Nature of the Therapeutic Processes Experienced by Recovering Addicts Attending Twelve Step Fellowships?

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval
Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments
You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants
(b) Change, or add to, the research method employed
(c) Collect additional types of data
(d) Change the researchers involved in the project

Adverse events
You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee ([redacted], in the event of any of the following:

(a) Adverse events
(b) Breaches of confidentiality
(c) Safeguarding issues relating to children and vulnerable adults
(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Hayley Glasford
Course Officer
Email: [redacted]

Katy Tapper
Chair
Email: [redacted]

The Professional Practice Component of this thesis has been removed for confidentiality purposes.

It can be consulted by Psychology researchers on application at the Library of City, University of London.