University of Pretoria etd – Bain, K A (2004)

Chapter One

INTRODUCTION

To turn your back on even one person, for whatever reason, is to run the risk of losing the central piece of your jigsaw puzzle

Leo Buscaglia

1.1 INTRODUCTION

Substance abuse is a well-entrenched social reality in South Africa. While the predominant religious and social viewpoints on cocaine and heroin remain negative, condemning their use, the past few decades have seen the increasing emergence of a 'sub-culture' where the use of these substances is condoned and sometimes even expected. Commenting on this subculture, Measham, Parker and Aldridge (1998) state:

> "The availability and prevalence of drug use by young people is escalating, along with an increased range of drugs available and increased normalization of drug-related behaviour and attitudes… the experimentation and use of illicit drugs by young people from all social backgrounds spans the teenage years and extends into young adulthood" (p 9).

With specific reference to cocaine and heroin use, there are fairly defined contexts in which users are found. Cocaine in particular, due to its expense, is labeled as a designer drug and in Johannesburg considered mainly a "northern suburbs problem". However, due to its expense, cocaine users often move onto other substances like crack, which is a more affordable and more addictive form of cocaine. More so than cocaine users, crack and heroin users carry the connotation of 'junkies', as these drugs are associated more with risk-taking behaviour, criminal activity, HIV/AIDS and the sex trade (Measham, Parker & Aldridge, 1998).

Due to the fact the majority of the participants in this study were white, the circumstances that surround young white adults in a South African context are relevant to this study in that many of them are implicated in the increased incidence of substance abuse and many may exacerbate the problem of relapse. With regards to the political context, since 1994's change of government and government policy, the borders of South Africa opened, resulting in a vast influx of illegal immigrants into the country. This factor has been implicated in the increased availability of drugs. This, together with an already

stretched police force due to soaring crime rates, has made South Africa an ideal distribution point, with many of the world's drugs passing through our borders, airports and harbours. Despite laws against the possession of cocaine and heroin, the risk of being caught is not that high in South Africa, making drugs a profitable business (Rocha-Silva, 1998).

However, this increased availability does not fully explain the increased demand within the young white population. Factors like loss of cultural pride and religious values; deficient support structures due to changing family structures and interaction patterns and high levels of emigration; increased uncertainty in terms of political stability which leads to fewer career opportunities, lack of job security and ever-increasing costs of living; and loss of personal safety due to a high crime rate, all impact on young adults in the form of increased stress with less resources to cope. Concepts like identity, sense of self, self-esteem, self-efficacy, social support, coping styles, isolation and meaning in life are all affected by rapidly changing political, social, cultural and moral climates, leaving today's young adults in a completely different situation than young adults thirty years ago and possibly more vulnerable to the dangers of substance abuse.

Although slowly changing, the previous conservative attitudes of the 'Old South Africa' have led to a situation where substance abuse is still largely a taboo subject and considered a 'personality weakness' rather than an illness (Rocha-Silva, 1998). In conjunction with this there is a dire lack of education and awareness about drugs, making prevention difficult, and the stigmatization of addicts, making seeking treatment more difficult.

Although these attitudes have influenced government policy-making in the past, the severity of the substance abuse problem in this country has necessitated a response from government. In his first opening address to Parliament in 1994, South African President Nelson Mandela specifically singled out alcohol and drug abuse among the social pathologies that needed to be combatted. The seventh draft of a government initiative known as the Drug Master Plan was drawn up in September of 1998 by the Drug

Advisory Board (Parry, 2003). A Drug Master Plan is defined by the United Nations Drug Control Programme (UNDCP) as the single document adopted by a government outlining all national concerns in drug control. This document acts as a director in the fight against substance abuse. However, despite attention in this regard, the fact that the government is already struggling to provide basic primary health care, paints a gloomy picture for the future. Sadly, within the South African context, where there is already very little control of drugs and bigger problems like the economy, violent crime, and poverty as a result of long-standing social inequalities that have to be given priority by a government that is already financially stretched, the ever-increasing problem of substance abuse will worsen, ironically adding to the economic and social problems.

This leaves the burden of substance abuse squarely on the shoulders of treatment providers, who due to lack of funding are finding themselves faced with the insurmountable task of providing treatment to an increasing number of substance users in shorter and shorter periods of time. Despite improvements in treatment methods over the past decades, the problem of relapse is resulting in the "Revolving Door Syndrome", where substance users end up caught in a cycle of rehabilitation-relapse-readmission… averaging approximately 6 admissions per person (Rabinowith, Mark, Popper, Slyuzberg & Munitz, 1994). The problem this poses to our strained health services is obvious.

1.2 RESEARCH GOAL

This research aims to describe the subjective psychological experience of relapse in cocaine/crack and heroin users with the aim of identifying the significant cognitive, emotional and social themes involved in relapse in general, as well as possible differences in the experience of relapse between predominantly heroin users versus predominantly cocaine users. A better understanding of relapse may aid in providing more effective treatment for substance users.

1.3 MOTIVATION FOR THE STUDY

According to research carried out between July - December 2000 by the South African Community Epidemiology Network on Drug Use (SACENDU), an alcohol and other drug sentinel surveillance system operational in Cape Town, Durban, Port Elizabeth, Mpumalanga, and Gauteng (Johannesburg/Pretoria), substance abuse is on the increase in South Africa. Greater numbers are seeking treatment, with accident and mortality rates linked to substance use soaring. The decreasing age of people seeking treatment is of concern and the growing number of studies linking drug abuse to violent crime also attest to the seriousness of the problem. Statistics indicate that in this country, crack will soon have to be moved onto the Level One list of widely used substances, joining alcohol, tobacco and cannabis. Currently, both crack and heroin are on the Level Two list (Parry, 2003).

Cocaine in particular is the focus of much concern with its increasing availability, the links between its psychoactive properties and violent crime and its renowned resistance to treatment. Thirty-eight kilograms of cocaine powder was seized nationally between June and December 2000 by the SA Narcotics Bureau - up from 32 kg seized in the first half of 2000 - and there was also a substantial increase in the amount of heroin seized, from 1.2 kg in the first half of 2000 to over 14 kg in the second half of the year (Parry, 2003). Although these figures may reflect better policing, they may also be an indication of a greater presence of these substances in the country.

Following discussions with Phoenix House staff, it appears that despite a boom in recent years of research into cocaine and heroin abuse, treatment outcomes remain dismal, with the projected lifetime success rate for abstinence amongst cocaine and heroin users being approximately 10-20%.

A number of quantitative studies into factors predicting outcome have led to inconsistent findings, making the quest for more effective treatments difficult. Consistency was found in relation to ‘duration of stay’. Less than 90 days treatment in an in-patient facility was associated with higher rates of relapse (Simpson, Joe, Fletcher, Hubbard & Anglin, 1999). This has obvious implications for treatment success in South Africa where

funding for even primary health care is a problem and where the costs of private rehabilitation clinics results in people often only being able to afford stays of 2 to 6 weeks.

Relationships have been found between personal motivation or 'readiness' for treatment, perception of ability to cope and positive treatment outcomes, emphasizing the importance of the individual's unique experience and perceptions of their rehabilitation. Whether a person perceives the first use of cocaine or heroin after treatment a minor 'lapse' or full relapse was also found to make a significant difference to outcome (Gossop *et al*., in Broers, Giner, Dumont & Mino, 2000).

There is a dearth of studies into cocaine and/or heroin abuse within the South African context, even less that have taken individuals' perceptions into account, such as qualitative studies into the subjective experience of users during and after treatment. This makes understanding the psychological factors that cause and encourage relapse difficult.

Despite a number of improvements in recent decades in treatment for cocaine and heroin addiction, including relapse prevention and aftercare programmes, relapse rates are still disparagingly high.

> "Those persons suffering from PSUD's (psychoactive substance use disorders) who do enter treatment often apparently fail to benefit from that treatment in the long-term, with relapse being a much more frequent treatment outcome than providers would like, and as many as 30-40% or more of treated clients, depending on a variety of variables, resuming substance abuse within the first year following treatment. Outcome research continues to find high relapse rates despite increasing attempts to keep clients in contact with treatment personnel for longer periods of aftercare" (Rotgers, Keller & Morgenstern, 1996, p. 1).

According to Garavan, Pankiewicz, Bloom, Cho, Sperry, Ross, Salmeron, Risinger, Kelley and Stein (2000) craving experiences play an important role in perpetuating human drug addiction. Drug craving is a powerful motivational state or intense desire that drives the user to seek the substance. However, the specific affective and cognitive mechanisms that underlie drug craving, its determinants and its relationship to subsequent drug taking are not fully understood.

Thus, the treatment of users remains fraught with difficulties. Regarding cocaine in particular, according to Carroll (2000) a variety of pharmacotherapies have not succeeded in demonstrating efficacy against the Goliath of cocaine dependence and instead 'weak' approaches such as psychotherapy have emerged as the David of this field. However, psychotherapy for cocaine users has also been far from problem-free. Researchers and clinicians have noted how difficult it is to retain cocaine users in treatment to the point that retention has become more or less a prerequisite for treatment 'success'. An American study, CCTS (Collaborative Cocaine Treatment Study), which offered intensive psychotherapy (36 individual sessions and 24 group sessions for 24 weeks - a total of 60 sessions), reported poor retention rates. Most patients completed less than half of sessions offered and only 28% completed the treatment (Carroll, 2000).

In a number of studies done to find factors predicting poor outcomes in substance abuse treatment programmes, early drop out rates were often related to cocaine use (Hiller, Knight & Simpson, 1999; McCaul, Svikis & Moore, 2001). The unusually high relapse rates amongst cocaine users have been attributed to a variety of factors, including the nature of the drug itself. The unique physiological withdrawal from cocaine, as shown in the "neurobiological model", seems to perpetuate the unconscious belief that control over the substance can be maintained (Hohman & Butt, 2001).

As well as emphasizing the need for research in this area, the above paragraph also highlights the need for research into the differences in relapse experienced by users of different substances of abuse. The psychological factors underlying relapse may differ

from cocaine to heroin users and different emphases may accordingly be needed in treatment plans.

A number of researchers have attempted to find factors that predict relapse in general, studying the impact of factors like gender, ethnicity, marital status, age, education levels, employment status, duration of use, social support, intensity of use, mental health problems and legal involvement (Alterman, McKay, Mulvaney, Cnaan, Cacciola, Tourian, Rutherford & Merikle, 2000; Broers *et al*., 2000; Hiller *et al*., 1999; McCaul *et al*., 2001). However, when viewed together, these studies show many inconsistencies. Alterman *et al*. (2000) state that these findings underline the difficulty of identifying predictors of long term treatment response for substance dependent patients.

A possible reason for this could be that it is not so much the presence or absence of these factors that predicts outcome but that relapse has more to do with the individual's perception of the problem and the affective and cognitive states that the individual experiences just before and during relapse. Garavan *et al*. (2000) state that: "The emerging picture of widespread neuronal involvement reflects the participation of a number of cognitive and emotional processes working in concert to produce the subjective craving experience" (p. 1789). Possibly, a study of these processes will assist treatment providers in gaining clearer and more accurate insight into relapse as well as how to prevent it.

This study targets one of the most problematic areas in substance abuse treatment – relapse. The intention of the study is to identify relevant and important emotional, cognitive and social factors that contribute to relapse. This will thereby enable a clearer description of relapse after rehabilitation for heroin and cocaine dependence and subsequently, more effective focus areas for treatment. The inclusion of both cocaine and heroin users in the study will allow for a comparison of the experiences of relapse between users of these two substances – providing an opportunity to gain more specific information related to each of these substances, the users of them and the contribution of the choice of substance on the experience of relapse.

1.4 THEORETICAL FRAMEWORK

Both the intra- and interpsychic factors involved in relapse that emerge from the study will be viewed from within a broad systems theory approach. Although systems theory is an independent approach in its own right, the nature of its tenets allow for the incorporation of other approaches. This will be discussed further in Chapter Two. Thus, where possible and relevant, other theories, for example, psychodynamic approaches, which focus on the 'internal system', will be incorporated, with the aim of creating an holistic, integrated explanation of the findings of the study within the broader field of substance abuse.

Due to the qualitative nature of the study, the context surrounding substance abuse and the substance users assumes vital importance. Studies implicating the context in relapse also emphasise its significance (Freeman, 1993). Thus, systems theory, with its basic tenet that all organisms are interdependent and can only be understood when viewed in terms of their ecological contexts, is able to provide the framework within which to understand relapse.

Being an exploratory study that aims to identify psychological and social factors that are involved in relapse, general systems theory, which emphasises the importance of interrelationships, complexities and context, allows a broad perspective to be taken that is

inclusive rather than exclusive. For this study, not only the whole system is of relevance, but also the subsystems. Units or 'parts' of the system are also significant and need to be identified, so as to allow for the recognition of patterns, functions and 'recursive feedback loops' (Keeney, 1983).

In short, systems theory proposes looking at the 'parts' – the various intrapsychic structures, the family unit, the social contexts, the drugs themselves and the biological/physical aspects – and the interrelationships between them. Together, they make up the 'whole' – which in this case would be a fuller, more integrated understanding of relapse.

Historically, a systems approach to the understanding of substance abuse has allowed for greater treatment efficacy, as all related systems and subsystems can be targeted (Bor, Miller & Perry, 1988). Not only is the focus on the individual and his/her coping skills, but also on the interaction between the individual and his/her environment. It is also a theory that appreciates recovery from substance dependence as a process rather than an event, into which the process of relapse is incorporated.

The choice of systems theory has implications for the research method, in that although the researcher's perspectives are taken into account, and interviews with participants are kept as open as possible to allow for as 'free a flow of information' as possible, both these perspectives imply a form of 'punctuation' and may only represent one particular part or 'view' of the system. This will be acknowledged and thus one of many possible co-created 'truths' is presented in this study.

1.5 USE OF TERMINOLOGY IN THE STUDY

Substance abuse is a field scattered with various terminology, covering the substances themselves, types of use and abuse, and the effects of the substances.

Firstly, the term *substance* is preferred to the term *drug*. *Drug* implies a manufactured chemical and thus does not include naturally occurring substances or substances that are not meant for human consumption (Kaplan & Sadock, 1998). However, although the term *substance* is preferred, the term *drug* is still commonly used and found in many of the texts.

Substance use falls into two categories: *experimentation*, which is episodic use that reflects a desire to see what the substance is like, where the substance plays no special role in the user's life; and *social or recreational use*, which is occasional use associated with social or recreational activities in which the user would take part regardless of whether drugs were present or not. Little or no time is spent actively seeking the drug (Janse van Rensberg, 1998).

Substance abuse is defined by the DSM-IV as the continued use of substances, which is characterized by at least one specific symptom indicating that the substance use has interfered with the person's life (Kaplan & Sadock, 1998).

Substance dependence is defined according to two concepts: behavioural and physical. While behavioural dependence emphasises substance-seeking activities and evidence of pathological use patterns, physical dependence refers to the physiological effects of multiple episodes of substance use. Psychological dependence, which is also referred to as habituation, is characterized by a continuous or intermittent craving for the substance to avoid a dysphoric state. The distinction between psychological or behavioural dependence and physical dependence is blurred, as psychological dependence undoubtedly reflects physiological changes in the behavioural centres of the brain (Kaplan & Sadock, 1998).

Within the category of *substances* falls the term *psychoactive substances*, from which organic solvents are excluded. Cocaine and heroin fall into the category of *psychoactive substances*.

Within this category, cocaine is further classified as *central nervous system stimulant.* Stimulation of the CNS has the initial effect of euphoria and results in increased energy levels, loss of sleep and appetite suppression. In excess, the use of cocaine can lead to feelings of anxiety, agitation and hypervigilance and carry the risk of the suppression of respiratory centers in the brain, cardiac arrest, convulsion and cerebrovascular accidents due to severe hypertension (Gardener, 1992). Prolonged use can also lead to psychosis. Cocaine has powerful addictive qualities. Physiological dependence does occur and due to a number of factors, psychological dependence can occur after a single use. Tolerance does occur, although its development is related to many factors and is not easily predicted (Kaplan & Sadock, 1998). Withdrawal is mild compared to that of heroin, with symptoms resembling those of a major depressive episode, such as hypersomnia and low energy levels. Within the classification of *central nervous system stimulant*, cocaine is more specifically classed as a *dopamine re-uptake inhibitor.*

Crack is a freebase form of cocaine that is extremely potent. It is sold in small, ready to smoke amounts, often called rocks. These contain chemically extracted pure cocaine alkaloid (the freebase), which is what creates the increased effect. It is a highly addictive form of cocaine and one or two uses of the drug can cause intense cravings. These cravings can then result in users resorting to extreme behaviours to obtain money to buy more. Crack abuse is also anecdotally associated with extreme violence (Kaplan & Sadock, 1998).

Heroin is also a *psychoactive substance*, falling into the subgroup *narcotics* within which it is further classified as an *opiate.* These substances either occur naturally or are manufactured synthetically. Heroin is naturally derived from the opium poppy. The initial effects of opiates include analgesia, euphoria, sedation and occasionally hallucinations. Associated side effects include constipation, apathy and appetite suppression. Opioid intoxication consists of an altered mood, psychomotor retardation, drowsiness, slurred speech and impaired memory and attention. Tolerance to opiates develops rapidly and withdrawal can be severe. Withdrawal symptoms appear when a person has been using opiates for a long time or when the cessation is abrupt, and

include: severe muscle cramps and bone aches, profuse diarrhoea, abdominal cramps, gooseflesh, yawning, rhinorrhea, lacrimation, fever, pupillary dilation, hypertension, tachycardia, temperature dysregulation, restlessness, irritability, depression, tremor, weakness, nausea and vomiting (Kaplan & Sadock, 1998).

Specifically within the field of cocaine and heroin usage, this study aims to investigate the phenomenon of 'relapse' after in-patient rehabilitation programmes for cocaine and heroin. *Relapse*, in this study, will be considered the return to drug use after detoxification and rehabilitation. Once-off, binge and continued use relapses will be included. Relapse is considered as a process and as such includes the events, cognitions and feelings leading up to the use of the substance and the events, cognitions and feelings afterwards.

Relapse is an integral part of the cycle of addiction, involving a number of biological and psychological factors, the latter being the predominant focus of this study. A number of factors already implicated in relapse include: memories of euphoria, drug reminders, a desire to attempt to regain control over drug use, dysphoric feelings or negative affect states that in the past may have been associated with drug use and the perception that the occasional 'slip' implies a complete failure and thus leads to a full-blown binge (Gold, 1994).

1.6 RESEARCH DESIGN

This brief discussion of the research design serves as a preview and a more detailed discussion is presented in Chapter Three. A qualitative research design was chosen for the study due to the fact that the aim of the study was to explore and describe the subjective experience of relapse in heroin and cocaine users and qualitative research methods are particularly relevant for studying the lived realities of people within their contexts. Qualitative research approaches allow the information gained from the study to guide the research process and thus present a description of the lived experience of relapse.

The participants in this study consisted of eight crack and heroin users who attended the in-patient rehabilitation programme at Phoenix House, a rehabilitation centre in Johannesburg, who have been through a rehabilitation process before and who were at Phoenix House due to a relapse. Seven of the participants were in the in-patient programme at the time of the interview, while one participant was in the aftercare programme. The number of participants was determined by the number of interviews that it took to reach satisfactory saturation of the data.

Due to the fact that the eight participants in this study were drawn from a semi-private rehabilitation centre, which is fairly expensive, most of the users originate from more economically affluent or middle class backgrounds, with the implication that there is still some form of familial support, at least in terms of financial support. While with regards to treatment, originating from a middle class background may seem an advantage, in the case of relapse, this may also be more of a risk factor, with users being more likely to have the financial means to attain the drugs. The predominant age group for cocaine and heroin abuse is from approximately age 19 to 30. The participants in this study consist of people who are in their early twenties to early thirties.

Culturally, statistics from SACENDU indicated that the participants would most likely be predominantly white, with cannabis abuse rather than cocaine or heroin abuse, being more predominant within the black community (Parry, 2003). Private rehabilitation centers also report a predominantly white in-patient population. This was in fact the case in this study with six of the eight interviewees being white.

The data collection technique used was that of semi-structured interviews, consisting of open-ended questions to gain the participants' subjective experience of relapse. Qualitative research interviews attempt to tap into the 'experiential world' of the participants and to gain an understanding of their 'meanings'. This method suited the exploratory aim of the study. Certain questions were asked to all participants along various broad themes relevant to the topic, but some ad hoc questioning at the

interviewer's discretion was used to explore various answers or 'meanings' more fully. The interviews were taped and transcribed.

A thematic analysis was then done to identify significant cognitive, emotional and social factors that played a role in relapse.

Although a preliminary research study was done, the results that were gained were allowed to inform the important themes for the literature study. During the discussion of results various theoretical constructs were also attached to the findings within the broad framework of systems theory, in order to come to an understanding of relapse.

Lastly, the information gathered by the study was taken back to the participants and shared with Phoenix House staff.

1.7 BRIEF DISCUSSION OF THE FOLLOWING CHAPTERS

While Chapter 1 provided a brief introduction to this study, Chapter 2 provides an introduction to the field of substance abuse, with a focus specifically on cocaine/crack and heroin abuse and relapse, through a brief exploration of various theoretical perspectives on substance abuse. Chapter 2 also includes brief theoretical discussions on relevant themes that emerged from the data. Chapter 3 presents a description of the research process of this study. It provides information concerning the research method used and the various stages of the research process. In Chapter 4 the results of the study are presented. Although certain interpretation by the author was unavoidable during the analysis of the data, very little theory is attached to the data at this stage in order to present the results in a manner as close to the lived reality of the interviewees as possible. Chapter 5 integrates the findings of the study and attaches relevant theory. The final chapter, Chapter 6, concludes the study and provides recommendations for further study.

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Chapter Two

LITERATURE REVIEW

When spider webs unite, they can tie up a lion

African proverb

2.1 INTRODUCTION

To facilitate a broadening of knowledge, one logically has to know what knowledge exists beforehand. It is therefore general practise in scientific research to first review literature regarding the phenomenon under study (Aronson, 1994). In this study, however, much of the literature review was conducted in tandem with the data collection and analysis process. This allowed the data obtained from the interviews to inform the process and direction of the study, which is consistent with the principles of qualitative research.

The topic of study, relapse, is such an integral part of the process of substance dependence that it is necessary to discuss them together. This is supported by the systems perspective's emphasis on contextualizing the topic of study. The importance of viewing relapse within the context of substance abuse as a whole is explained by Edwards' (in Zinberg & Shaffer, 1985) statement: "One could not hope to understand the English country gentleman's fox-hunting simply by exploring his attitude toward the fox" (p. 72).

Firstly, a brief discussion on contemporary understandings of substance abuse is presented, as this is necessary to contextualize the phenomenon of relapse. This is followed by a review of literature on the various themes that emerged from the data in order to gain as full an understanding of the data as possible.

2.2 A BRIEF HISTORY OF COCAINE AND HEROIN

Cocaine was extracted in its pure crystalline form from coca leaves for the first time in 1862 by Albert Niemann in Germany. Its effects were first documented in 1883 when it was stated that cocaine was useful for exhaustion, alleviating pain and enabling wounded and sick soldiers to continue to function. By July 1884, Freud had published his paper 'Uber Coca', in which he recommended cocaine be used to:

> "increase a person's physical capacity during stressful times, to restore mental capacity decreased by fatigue, to alleviate depression, to treat gastric disorders, asthma, cachexia (an ill-conditioned state of mind) and as an aphrodisiac. In other words, it was a panacea which would generally make a person more effective and their life more pleasant" (Warburton, 1992, p. 23).

Freud also recommended cocaine for morphine and alcohol withdrawal. His views eventually helped spread the use of cocaine throughout Europe and the USA, where it was widely available in wines, the soda drink Coca-Cola and a variety of other preparations. However, opposing views were also being expressed and eventually Freud stated it did have dependence forming properties, but that only 'addictive personalities' would become regular users. By 1914, its use in the United States of America was made illegal, causing almost all regular users to switch to heroin (Warburton, 1992).

Heroin was described as the "bastard child of mother opium and the laboratory chemist" (Tyler, in Strang, 1992, p. 202). It was synthesized as diacetylmorphine for the first time in 1898 by Heinrich Dreser, of Bayer in Germany. It was marketed by Bayer as a sedative for coughs. It was more effective than morphine and did not have the side effects of nausea and constipation like morphine. After discovering dependence on heroin developed more quickly than with morphine, Bayer ceased to market it (Warburton, 1992). However it was legally available in the United States of America until 1924, due to the popular medical opinion that only constitutionally weak people and those lacking in will power would become dependent on it (Berridge & Edwards, 1987).

2.3 CURRENT THEORETICAL CONCEPTUALISATIONS OF COCAINE AND HEROIN ABUSE AND RELAPSE

"Substance abuse is not a phenomenon attributable to a single cause or even to

> a small number of causes. The reasons why a given individual engages in substance abuse are as varied as the range of substances available to abuse; as varied as the social, psychological, and biological makeup of the individual who abuses; and as varied as the families within which abuses develop" (Ho, 1993, ix).

In an attempt to grasp at least some of the possible understandings of substance abuse, five theoretical perspectives' understandings and approaches to the problem of substance abuse and relapse are discussed in this section. These perspectives are: systems theory, with specific reference to the family systems approach; the medical model; the cognitive-behavioural approach; the psychodynamic perspective; as well as an archetypal-mythological approach. The amount of information that could be included in this section is enormous, but due to space constraints, only a brief discussion is presented on each.

2.3.1 Systems perspective of cocaine and heroin abuse and relapse

2.3.1.1 Introduction

According to Guttman (1991) a system is: "a unified whole that consists of interrelated parts, such that the whole can be identified as being different from the sum of its parts and any change in one part affects the rest of the system" (p. 41). This section explains the basic assumptions of general systems theory as they apply to family systems. These assumptions show how systems operate and explain how problems such as addiction can develop within families.

2.3.1.2 Cybernetics

All systems function through communication and self-regulation through communication (Wiener, in Guttman, 1991). This process whereby information regarding the results of past performance is integrated back into the system where it then influences future

behaviour, is known as self-corrective feedback. Cybernetics is the study of these self-corrective phenomena (Guttman, 1991).

Within this cybernetic framework, Bateson (in Guttman, 1991) described processes, which can account for both the uniformity and variability of human behaviour. He described a process called schismogenesis, which he defined as: "a process of differentiation in the norms of individual behaviour resulting from cumulative interaction between individuals" (Bateson, in Guttman, 1991, p. 42). Within this process he states that each member or part of the system, reacts to the reaction of the other, and that these forces are in constant dynamic equilibrium with each other. Bateson (in Guttman, 1991) recognised two types of behaviour: symmetrical behaviour and complementary behaviour. In symmetrical behaviour, the inputs into the system or behaviours are equal (or the same) and thus escalate, which in turn results in disruption or destruction of the relationship or the system. This is an example of positive feedback, which is information that increases change in the system (Guttman, 1991). Complementary behaviour is where the behaviours or inputs into the system are opposite to each other, which allows the system to stabilize. This behaviour is an example of negative feedback, which is information that decreases deviation and maintains homeostasis (Guttman, 1991). Both these behaviours form part of the process of self-governance through feedback that keeps systems in equilibrium.

Keeney (1983) modified this perspective to avoid the dualism created by 'positive' and 'negative' feedback, by viewing all feedback as negative feedback. In terms of this perspective, what Bateson termed positive feedback, which changes systems, Keeney sees as higher order negative feedback. Thus, what may appear as an escalation of a system due to symmetrical behaviour, is merely a part of a greater arc or sequence in the process of a more-encompassing system self-correcting. Thus, a system that 'self-destructs' due to unchecked escalation, which is due to a lack of self-correction, can be viewed as a system that lacked feedback of feedback. In other words, symmetrical behaviour occurring within a system may be due to lack of feedback from a higher

system. By the same notion then, in order for the subsystem to cease escalating, feedback from a higher order is necessary.

Keeney (1983) sees all systems as arranged in a recursively hierarchical structure, which suggests that all systems are part of a higher or bigger system and that all systems consist of smaller subsystems. All of these systems and subsystems are interrelated and are all in the process of striving for a sense of constancy. This constancy or homeostasis, however, is not static and is maintained through change (Bateson, in Keeney, 1983). Since change within a system can only be achieved through what Bateson termed as 'positive' feedback, by implication this suggests that change in the way a system functions can only occur when there is higher order feedback. Hence, the interdependence of the various systems and subsystems can be seen. However, boundaries between these systems exist. Thus, a system that is escalating due to a lack of higher order feedback could be due to boundaries between the systems that are too rigid or impermeable, or even boundaries that are too permeable. In these instances, the feedback is inadequately structured (Keeney, 1983). Inadequate feedback between systems is associated with various types of escalation:

> "A cybernetic system may be amplifying deviation in one direction or amplifying deviation in an ever-widening range of oscillations. Runaways in one direction…are usually triggered by efforts to maximize or minimize one variable. Wild range oscillations…are usually the result of uncoordinated feedback" (Keeney, 1983, p. 70).

In conclusion, the process of escalation in a system due to a lack of adequate higher order feedback, which is associated with problematic boundaries between systems, can be viewed within the recursive cybernetics perspective as merely part of a larger system attempting to self-correct. Due to Haley (in Guttman, 1991) and the Palo Alto group (see paragraph 2.3.1.4), this cybernetic concept of self-governance was applied to family systems and has since then become embedded in family systems thinking.

2.3.1.3 Family systems approach

Substance abuse is a problem of multiple interactions within and between systems, and the family can be viewed as the most important part of these systems. According to Ho (1993) biological, social, or psychological theoretical explanations of substance abuse are important, however, it is the family in which all of these factors are transmitted, reinforced and modified. For this reason, this section focuses specifically on family systems theory.

The definition of what constitutes a family has changed dramatically over the past few decades. According to Freeman (1993) the idea of the 'vanishing family', is perhaps an extreme characterisation but emphasizes the fact that families have changed in important ways in the last thirty to forty years. The very definition of a family has had to change to reflect the changing nature of families, as definitions provide guidelines for determining what is normal and what constitutes a problem within a family. This is particularly relevant to South Africa where the newer family structures are developing at a faster rate. These include single-parent, cohabiting, intergenerational, same-sex, childless, homeless, foster parent and matched families. Matched families consist of a group of individuals who previously did not know one another who are brought together by a third party to meet the needs of the members, such as halfway houses.

Freeman (1993) states that each of these families has a unique set of needs and resources available to cope with the problems of daily living and for giving meaning to the lives of its members. Within this context the problem of substance abuse has become increasingly prevalent. Freeman (1993) states:

> "Substance misuse and abuse distort and complicate the families' problems of daily living, while draining the unit's creativity and other resources necessary for meeting its basic and developmental needs. Furthermore the chronic nature of addiction gradually diminishes the quality of life and hope among the members. It is this sense of diminished hope and self-esteem in

> families with an addicted member that makes substance abuse treatment and recovery extremely complex…other authors have clarified how the family's shame, dysfunctional roles, and inadequate communication patterns enable not only the addicted member but also the whole unit to remain co-dependent" (p 1).

In terms of substance abuse, there are certain assumptions related to general systems theory and family systems theory. According to Freeman (1993) the first of these principles is that systems seek to maintain the status quo or 'homeostasis' even if the current circumstances are dysfunctional and painful such as when one of the family members is dependent on crack or heroin. In terms of this principle, relapse can be viewed as negative feedback, which seeks to maintain the status quo of the system. The second principle is that within these family systems transitions and milestones can represent opportunities for growth as well as for crises due to the fact that transitions can be threats to the status quo. In these cases, the maintenance of the system becomes associated with maintenance of addiction/co-dependency patterns (Freeman, 1993).

The third principle of general systems theory is that open systems are changed by positive feedback and use negative feedback to correct deviations by family members from the family rules, which maintains homeostasis (Freeman, 1993). In terms of cybernetics, all systems are open due to the interrelatedness between them, however, there are boundaries between systems that regulate the flow of information. If these boundaries are rigid, the flow of information between the system and other higher order or subsystems is disrupted, as such systems show greater disengagement within themselves and between themselves and other systems. Family members may, foe example, become more isolated from one another (see principle six).

The fourth principle is that change with regard to systems is circular rather than linear. This suggests that addiction and other problems are both responses to and influences on the family system (Freeman, 1993).

The fifth principle is that a system's 'health' is based on its ability to initiate change as needed. A healthy system will give indications that it needs help in resolving the addiction for example, and will seek and use help. They will then use internal and external resources to maintain the necessary changes (Freeman, 1993). In terms of cybernetics, this principle refers to the system's ability to incorporate higher order feedback in order to change (Keeney, 1983).

The sixth principle is that problems develop in boundary areas within and between systems, for example, within the family and between the family and other systems (Freeman, 1993). This may include diffusion of boundaries or the development of relatively impermeable boundaries.

The seventh principle is that problems such as addiction are a response to the system's needs for survival, although they may be contradictory to the member's individual needs (Freeman, 1993). For example, the substance use of a member of the family fulfils a function for the system as a whole and helps to maintain the homeostasis of the system.

This is similar to principle number eight, which states that symptoms or problems such as addiction serve a function for the system and are thus not viewed as the cause of its problems (Freeman, 1993).

Principle nine is that when the marital system's boundaries become too permeable, generational boundaries may be crossed to stabilize the system and this is when triangulation occurs. In this scenario, triangulation usually refers to the focusing of the couple's attention on another component of the system, for example a child in distress, in order to distract from the problem between them (Freeman, 1993).

The tenth principle is related to principle nine in that an entire system can also use triangulation. When a system is threatened, it can stabilize itself by triangulating an issue such as addiction, financial worries, or sexuality. In this way the issue becomes the focus

of the family's energies and is maintained as part of the system while distracting the members from focusing on more threatening problems (Freeman, 1993).

Freeman (1993) states that the eleventh principle is that in families that are too inflexible, hypersensitive to feelings, and unable to tolerate emotional closeness without anxiety, a lack of differentiation occurs. This implies that members of addicted and other dysfunctional families become fused in their mutual efforts to maintain the system. The last principle is that this lack of differentiation, as well as unresolved family issues, dysfunctional patterns such as addiction, and losses are often passed down to future generations (Freeman, 1993).

These assumptions show how systems operate and explain how problems such as addiction can develop within families. They also demonstrate the central paradox – that as much as families are the impetus for initiating change they are also an important resource in maintaining the status quo (Watzlawick, Weakland & Fisch, 1974).

Most family systems approaches are based on general systems theory, the ecological perspective and the biopsychosocial theories and provide specialized information on the role of substance abuse in the family as a system. At the moment three categories of models dominate contemporary family substance abuse treatment. These include the family disease models, the family systems models and the behavioural models. While family disease models emphasise co-dependency and addiction as a disease, family systems models focus on communication, dysfunctional family roles and family equilibrium. Family behaviours are examined as antecedents and reinforcers to substance use in the behavioural models. Most often though, a combination of these three models is used. While co-dependency is explored, the function the substance use serves for the family is also looked at. Communication and problem solving are often focused on and attempts are made to change family roles, rules and boundaries. At the same time, direct behavioural treatments are applied to facilitate abstinence (McCrady & Epstein, 1996).

According to Ho (1993) a family systems perspective allows for the inclusion of a number of factors such as family structures, communication and processes, life-cycle changes, inter-generational issues and cultural-economic-societal changes. This provides for a more detailed explanation of the various aspects of substance abuse. "Family systems theories also are called *bridging theories* because they highlight the connections among the life domains of the individual (e.g. the biological, social and psychological) and connections among the individual, the family, and the larger environment" (Freeman, 1993, p 2).

Usher, Jay and Glass (in Freeman, 1993) emphasize the role that addiction plays in the family system, in that within the system, the family unit and the individual members' needs become secondary to the addicted member's compulsion for substances and the maintenance of the system. This exacerbates the situation as then members don't receive the critical nurturing and support required during various stages of individual and family life cycle development, which stunts members' potential for becoming self-actualised individuals and non-addicted families in the next generation. Bowen (1974) named this intergenerational addiction pattern a family projection or transmission process.

2.3.1.4 The Medical Research Institute approach

As briefly mentioned above, the Palo Alto group was responsible for applying the principles of cybernetics to family systems and the above discussion on the principles of family systems approaches indicates the contribution this group made to the direction of family systems thinking. This group also developed a model of problem formation and resolution at the Mental Research Institute in Palo Alto, which was named the MRI Brief Therapy Approach. A full discussion of this model is beyond the scope of this study, but a few important concepts generated from this model become relevant to the study later and thus warrant mention.

Problem formation or clarification of the problem is an essential element of this approach. The MRI model regards the presenting complaint as the problem and avoids

searching for the 'underlying cause' of the complaint, rather focusing on what maintains it in the here and now (Segal, 1991). This model sees problem behaviour as being inextricably linked to problem-solving behaviour. Although the model does not exclude biochemical or neurological explanations, interpersonal communications and behaviours are the main focus of diagnosis and intervention. The model proposes that the client's original difficulty becomes a problem when mishandling of the problem leads the client to use more and more of the same solution in an attempt to solve the problem (Segal, 1991). In this way a vicious cycle is set in motion, which produces a problem that may be very different from the original difficulty. Thus, the solution becomes the problem.

The MRI model identified three ways in which the solution can become the problem. The first of these is that no solution is applied, the problem is denied, and action is not taken when necessary. The second way a solution becomes a problem is when action is taken when it should not be, for example, a change is attempted regarding a difficulty that is unchangeable or non-existent. The last way is when an error in logical typing is committed and a game without end is established. This is when a solution from the wrong level is attempted, for example, action from within the system is attempted (first order change) when action from a higher system (second order change) is needed, or vice versa. The game without end refers to the fact that problems tend to increase or escalate when no solution or the wrong solution is repeatedly applied (Segal, 1991).

2.3.1.5 Conclusion

A family systems perspective allows for the inclusion of a number of factors, which allows for a more detailed understanding of the various aspects of substance abuse. Systems theories highlight the connections among the biological, social and psychological aspects of an individual, as well as the connections between the individual, the family, and the larger environment.

2.3.2 The medical model

2.3.2.1 Introduction

The medical model focuses specifically on the biochemical and physiological aspects involved in substance abuse and views substance dependence as a disease in terms of the physical symptoms people with substance dependency display. Although a comprehensive discussion on this model is beyond the scope of this study, a few important concepts are highlighted.

2.3.2.2 The psychopharmacological effects of cocaine and heroin

Psychoactivity is the term given to the ability of certain substances to change central nervous system functions. These substances impact on memory and information processing and psychomotor function (Hindmarch, Kerr & Sherwood, 1992). Heroin and cocaine are both considered 'euphoriants' as they typically produce feelings of euphoria. Euphoria is described as "a positive experience of feeling right with oneself and the world" (Blum in Warburton, 1992, p. 45).

Cocaine, which is a psychomotor stimulant, has a major effect on the brain dopamine systems. It increases the effect of synaptically released dopamine by blocking the inactivation of dopamine. This is achieved by inhibiting its presynaptic reuptake (Bozarth, 1992).

Research identifying the neural basis of opiate (heroin) reward has been controversial, but it is now widely accepted that heroin activates the same brain reward system as cocaine. Although it does not appear to affect dopaminergic synaptic activity directly, it stimulates dopamine neurons by an action at the cell body region in the ventral tegmentum (Bozarth, 1992).

2.3.2.3 Addiction as a biological process

Addiction is viewed by the medical model as being the extreme end of a continuum of substance use. Substance use starts casually and can develop to more intensive drug use with time. The founders of Alcoholics Anonymous (AA) found that anyone could become addicted and that once addicted, all of the 'patients' had similar symptoms. They also noticed that recovery from addiction was feasible. From these observations it was assumed that this 'condition' was a 'disease' (Fine & Juni, 2001).

2.3.2.4 Environmental cues

Environmental cues play an extremely important role in the process of relapse. "Even after drug addicts beat their habits, they face a daunting challenge: simply returning to the place where they took drugs can trigger irresistible cravings that may lead to relapse… even after months of abstinence" (Schubart, 2001, p 2). Much like Pavlov's dogs, when confronted with environmental cues like seeing the drug, hearing music previously associated with drug-taking, seeing drug paraphernalia or being in a certain environment where the drug was previously used, dopamine-rich regions in the brains show chemical signs of increased neural firing. In imaging studies in humans, these brain regions are 'turned on' when people are suffering from cocaine craving (Schubart, 2001).

2.3.2.5 Conclusion

Although the scope of the medical model is fairly narrow, the influence of biochemistry and the physical changes that occur in substance users is significant, especially in the later stages of substance dependency, and cannot be separated from the more psychological and social aspects of the condition. Viewed from a systems theory perspective, the physiological aspects of substance use that the medical model encompasses, can be seen as a subsystem of the larger system that is a substance using individual. This subsystem is integral to and interrelated with other psychological and social subsystems.

2.3.3 The cognitive-behavioural approach

2.3.3.1 Introduction

The behavioural model encompass a wide variety of approaches, including classical conditioning, operant conditioning, cognitive theory and social learning theory (SLT), all of which share a number of theoretical principles (Rotgers, 1996).

2.3.3.2 Cognitive-behavioural approach to substance abuse and relapse

According to Rotgers (1996) the basic principles of behavioural theory as they apply to psychogenic substance use disorders are:

- Human behaviour is learned more than determined by genetic factors.
- The learning processes that create problematic behaviours can also be used to change them.
- Contextual and environmental factors largely determine behaviour.
- Thoughts and feelings (covert behaviours) can also be changed through the application of learning principles.
- An important element of behaviour change is actually engaging in the new behaviours in the context in which they are to be performed.
- Each person is unique and must be assessed within their particular context.
- Adequate treatment is dependent upon a thorough behavioural assessment.

Pavlov's (in Rotgers, 1996) classical conditioning is learning that affects both voluntary and involuntary behaviours. It is most often associated to substance abuse with regards to 'craving', which can lead to relapse, where processes of physiological arousal become conditioned to occur in response to external cues. These cues can be direct, for example, drug paraphernalia or even symbolic, such as money, which is used to buy substances. Whether the conditioned response of 'craving' is elicited by a cue depends on the frequency with which the cue (unconditioned stimulus) has been paired with the

conditioned stimulus (substances), the intensity of the conditioned stimulus when it is presented and the motivational state of the user when it is presented (Rotgers, 1996).

Skinner's (in Rotgers, 1996) operant conditioning is the learning of primarily voluntary behaviours, which are increased or decreased depending on the environment's response to them. Environmental stimuli that are positive following a behaviour are known as reinforcers, while environmental stimuli that are negative are punishers. Reinforcement can be both positive and negative. A positive stimulus after a behaviour is a positive reinforcer e.g. the powerful positive affect experienced by users when using substances, while the removal of a negative stimulus is a negative reinforcer e.g. the removal of subjectively negative affects. The closer in time a reinforcement or punishment is to the behaviour, the more effective the learning that takes place. This explains why users continue to use substances despite long-term negative consequences. When using operant learning in the treatment for substance use disorders, reinforcement has been found to be more effective than punishment. Punishment can elicit negative feelings and retaliatory behaviour from the user, which can interfere with the behaviour changing process (Rotgers, 1996).

Bandura's (in Rotgers, 1996) theory of modelling falls under the Social Learning Theory (SLT). Modelling involves observational learning, where a cognitive representation of behaviour patterns is formed. Whether behaviour learned through observation will be performed or not depends on a number of factors. These include: the adequacy with which a cognitive representation is made; the characteristics of the model (whether the observer holds the model in esteem); whether the model is seen to be reinforced or punished for his/her behaviour; and whether the observer expects to be reinforced in a similar way if they perform the behaviour (Rotgers, 1996).

The role of modelling in the process of substance abuse is most clearly seen in the drug subculture or user group, where substance use is modelled. The sense of belonging within the group that models are seen to receive serves as reinforcement for using behaviour. However, modelling is also used in treatment, most often to teach users

effective coping skills so that they can cope with situations that previously would have evoked substance abuse. This includes assertiveness skills, communication skills, relaxation techniques, coping self-statements and anger management (Rotgers, 1996).

SLT suggests that through the processes of classical conditioning, operant learning and modelling, human behaviour is developed, as well as patterns of thought and feeling which guide and shape behaviour. SLT approaches to treatment revolve around the central concept of reciprocal determinism, which states that as much as humans are influenced by their environment, they can influence the environment and in this way plan and change their own behaviour (Rotgers, 1996).

SLT also emphasises the role of cognition in the control and performance of behaviour. Beck's (in Rotgers, 1996) cognitive therapy views cognition as the primary causal factor in emotion and the theory regards substance use as an effort to cope with negative affective states that arise from illogical or distorted thinking.

The way a person thinks and feels about a particular behaviour will influence its performance (Rotgers, 1996). This introduces the idea of self-efficacy. According to Rotgers (1996): "Self-efficacy refers to the person's expectations that he/she will be able to perform a coping response in a given situation, coupled with the expectation that performance of that response will be reinforced" (p. 184). Thus, if users have low self-efficacy with regard to various coping skills, they will be likely to choose another coping skill e.g. substance use, with which they feel more comfortable. According to Abrams and Niaura (in Rotgers, 1996) psychoactive substance use disorders are a failure of coping, which is a result of any combination of inappropriate conditioning and reinforcement, modelling of inappropriate behaviour and reduced self-efficacy with regard to coping skills. Users may not possess effective coping skills or if they do have them, choose not to use them due to low self-efficacy. A number of other physiological, emotional and cognitive factors, such as neurological damage due to substance use and anxiety, can also interfere with effective skill performance. SLT-based approaches to

treatment address all these issues in order to provide the user with alternative coping skills (Rotgers, 1996).

2.3.3.3 Conclusion

In conclusion, at the heart of behavioural treatment lies the notion that any behaviour that is learned can be reshaped, reduced or eliminated by learning (Krasner, in Rotgers, 1996). In terms of systems theory, this learning can be seen as positive feedback that brings about change in a system. Cognitive-behavioural treatment for substance use disorders includes an analysis of the substance use behaviour, it's triggering and maintaining factors, the user's skills deficits and environment, and the internal emotional states and thoughts that trigger use (Rotgers, 1996). Maintaining factors can be seen as negative feedback in terms of systems theory, the aim of which is to maintain the current homeostasis of the system.

2.3.4 The psychodynamic approach

2.3.4.1 Introduction

Psychodynamic theories focus largely on the role of internal processes in the etiology of substance dependency. Adults who experienced various forms of emotional deprivation as children, learned as children to resort to fantasy process to partially satisfy their primitive drives and emotional needs (Firestone, 1993).

2.3.4.2 Psychodynamic understandings of substance abuse and relapse

According to Zinberg and Shaffer (1985) the personal histories of substance users usually contain a certain degree of trauma e.g. the early loss of a mother or the break up of the family system through death, divorce or mental illness. Even without early trauma, users usually experience a deep sense of being unloved and rejected by significant others.

> "Such powerful, unfulfilled longings for love, acceptance as a worthwhile and lovable human being, and a sense of basic trust in another or in one's self can lead to overwhelming feelings of desolation and rage; these are the emotional forces over which drug-using individuals have been unable to develop reliable internal controls" (Zinberg & Shaffer, 1985, p. 60).

Zinberg and Shaffer (1985) then suggest that the substances assist the users in controlling these debilitating conflicts by providing containment and removal of the frustration that they did not get as infants. Rado (in Frosch, 1985) also stated that substance users tend to have an intolerance for frustration and pain, constantly needing to change their lows into highs, which he states may be a result of a lack of early satisfying object relations.

Freud (in Strachey, 1961) noted the way substances were a chemical means to avoid suffering and discussed the role of substance use in creating a feeling of 'pseudo independence' and how fantasy plays a similar role: "…by making oneself independent of the external world by seeking satisfaction in internal, psychical processes…one can try to re-create the world, to build up in its stead another world in which its most unbearable features are eliminated and replaced by others that are in conformity with one's own wishes" (p. 81).

Emotionally deprived children learn to 'self-parent', where they are both the parent and the object of parenting, firstly through fantasy, and later in the case of users, through substances as a more direct form of self-feeding. These self-parenting techniques partly reduce tension and act as a painkiller (Firestone, 1993). Blatt, McDonald, Sugarman and Wilber (1984) also emphasised the role of opiate addiction as a painkiller, stating that it provides assistance in the modulation and regulation of intense, painful depressive feelings, including feelings of inadequacy, guilt, worthlessness, and hopelessness.

This self-parenting process consists of two aspects: self-nourishment and self-punishment. The self-punishment manifests in the form of internal destructive 'voices', attitudes that are self-critical and behaviour that is harmful to the self (Firestone, 1985).

Szasz (in Firestone, 1993) used the term superego for this 'voice' and also stated that its function in addiction is to persecute the user. The self-parenting process can also be externalized in interpersonal relationships where the partners act out the roles of punitive parent or helpless child (Firestone, 1985).

However, these internal fantasy processes become progressively incapacitating as the more individuals indulge in them, the less likely or able they are to productively engage in external relationships and achieve gratification from them. Thus the very defences that the child learned to protect him/herself from overwhelming anxiety can lead to the development of an inward, addictive lifestyle (Firestone, 1993). The users end up lacking affectionate and meaningful object relations in the external world. They attempt to overcome this through "pseudocloseness and fusion with other drug takers during their common experience" (Rado, in Frosch, 1985, p. 31). Also, reliance on internal fantasy gratification begins to interfere with goal-directed behaviour. This sets in motion a progressive downward spiral of frustration, fantasy, addiction, and then more frustration. Afraid of trusting and risking again in the interpersonal sphere, they become more and more reliant on internal fantasy processes, which in turn leave them less capable of real external relating (Firestone, 1993). According to Rado (in Frosch, 1985):

> "The artificial technique of maintaining self-regard and satisfaction with drugs, of avoiding painful affects, and alleviating symptoms results in a change from reality-oriented to a pharmacothymic-oriented regimen. This leads to severely disturbed ego functions and ultimately to conflict with reality. Eventually, the drug-taking becomes a way of life" (p. 31).

This 'way of life' also has significant psychodynamic meaning for the users. As Wieder and Kaplan (in Frosch, 1985) state, symbolic importance is attached not only to the substance itself, which may represent object or part object, but also to the act of using and the pharmacogenic effect. The act of using may partly serve to satisfy wishes to control, attack or influence the object or the self, while the pharmacogenic effect represents

changes in cellular biochemistry whose psychic expression appears as a change in the energy equilibrium of the personality structure or cathectic shifts.

In terms of relapse, Firestone (1993) states: "It is important to note that the process of gratifying oneself in fantasy and that of seeking satisfaction in the external world are mutually exclusive. Thus, real satisfaction represents a threat to the fantasy process" (p. 337). Thus any emotional disequilibrium, such as success or failure in the external world, may send the person running back to his/her 'fantasy solution'.

According to Freud (in Strachey, 1961) substance abuse can be 'ego-syntonic', which is when it is in consonance with the person's ego and thus arouses little conflict with normal ego functioning. Only when the use of these substances becomes obviously self-destructive and dangerous does it become unacceptable to the self and cause deep inner conflicts. Although these conflicts may cause the person to once again return to substances for relief, this is also usually the time when the individual presents for treatment.

According to Wheelis (in Keller, 1996) "The symptom does not afflict the patient, it is the patient" (p. 86), thus the focus of treatment in psychoanalytic therapy is to investigate and attempt to alter the characteristic ways in which the substance user acts, feels and relates to others. In this way users can begin to see that their substance dependency, which is what motivated them to seek treatment in the first place, is the result of the ways in which they act, feel and relate to others. Although this 'way of being in the world' may have been brought about by initial conflicts with parents and insight into these initial conflicts may be useful as a basic formulation, treatment focuses on exploring how this and other unconscious conflicts affect and interfere with the user's current situation in life (Keller, 1996).

2.3.4.3 Common defences within the psychodynamic perspective

Denial, repression and suppression are all defences that operate to keep the knowledge of various realities out of conscious awareness. They are, however, often confused with one another. Denial is considered one of the narcissistic or most primitive defences. It is commonly used in both normal and pathological states. It is formally defined as: "Avoiding the awareness of some painful aspects of reality by negating sensory data" (Kaplan & Sadock, 1998, p. 220). Repression is defined as "Expelling or withholding from consciousness an idea or feeling" (Kaplan & Sadock, 1998, p. 221). Thus, while repression is the avoidance or 'denial' of affect or drive states, which are internal, denial "abolishes external reality" (Kaplan & Sadock, 1998, p. 220).

Repression is considered a neurotic defence and is divided into primary and secondary repression. While primary repression refers to the withholding of ideas and feelings before they have reached consciousness, secondary repression expels what was once conscious and excludes it from awareness. The feelings and thoughts that are repressed are not really forgotten because their effect can still be seen in symbolic behaviour that is performed (Kaplan & Sadock, 1998).

Suppression is considered one of the mature defences and is defined by Kaplan and Sadock (1998) as: "Consciously or semiconsciously postponing attention to a conscious impulse or conflict" (p. 221). Although these thoughts are cut off deliberately, they are not avoided indefinitely. The discomfort that accompanies these thoughts is acknowledged but through this process, minimized.

Suppression and repression can be easily confused as they both entail the blocking of certain information from conscious awareness, however the difference between the two is that repression entails the unconscious inhibition of impulses to the point they are lost, while suppression merely allows for the postponing of these impulses (Kaplan & Sadock, 1998).

Splitting is another defence that is often referred to in psychodynamic theory. Klein (in Schneider, 2003) considered splitting a primitive defence used to manage danger posed

by the threat of internal destructiveness and thus as a part of the pathology of infantile psychosis. While it is a defence most evident in the paranoid-schizoid position, in the depressive position the polar opposites of the good and bad breasts or objects are brought closer together as the capacity for ambivalence develops. Less reliance on splitting is necessary when the ability to hold positive and negative feelings about a 'whole' object is gained.

Classically, splitting is characterized as a defensive mental activity used to protect an individual against thoughts and feeling that are experienced as dangerously at odds with one another. However, it can also be characterized as a way of organizing experience. By splitting the good breast (mother) from the bad breast (mother) the infant achieves order and safety. "At birth, infants' physiology is more advanced than their psychical processes. By separating what they cannot yet tolerate psychically and projecting it into the mother for safe-keeping – thus buying psychic time – they protect themselves from being emotionally overwhelmed" (Schneider, 2003, p. 34). By providing this for the infant, the mother assists in creating an interpretive space in which primitive symbolic communication can begin to take place. Thus, although splitting is usually a pathological process antithetical to integration, it can also be viewed as a healthy step in the process of learning to relate to others (Schneider, 2003). According to Schneider (2003):

> "At its most basic level, splitting involves a simple binomial sorting of experiences that is similar in nature to most basic animal defence systems. The simplicity of binary processing is beneficial in terms of self-preservation as well as the preservation of the species. For example, on the Serengeti Plains of Tanzania, animals make split-second decisions to fight, flee, or stay by distinguishing between danger and safety, predator and prey. Life and death hang in the balance of reaction times measured in minute fractions of a second. A binary signal system needs only to make a determination concerning the perception of danger and does not involve the complicated, cumbersome, time-consuming decision work of interpretation" (p. 33).

Schneider (2003) states that there are two kinds of splitting: pathological splitting and immature but healthy splitting. He suggests that healthy splitting, although primitive, represents an important developmental step. It serves as a transition into more mature forms of defence, expression and communication. Splitting is an important facet of ambivalence and mature integration of the self. While healthy splitting, due to its polarizing effect, can create a 'generative space' in which "contrasts can be brought into relationship with one another in imagination…in pathological splitting, no space is opened through symbolization for consolidation of disparate elements" (Schneider, 2003, p. 33). Healthy splitting involves separating things and keeping them apart, which avoids a defensive or premature closure. The 'generative space' contains a tension between the two sides from which something new is allowed to happen. Through this process Schneider (2003) believes individuals can regain parts of the self or face intolerable anxieties. In the 'generative space' communication begins to take place between formerly disconnected feeling states and other aspects of the self. Thus, healthy splitting can represent a healthy change.

2.3.4.4 Conclusion

In conclusion, much like systems theory's focus on the system's attempts to maintain homeostasis despite pathological patterns of interaction, the psychodynamic approach focuses on the internal system's attempts to maintain homeostasis even if this internal system is pathological. In terms of this view, the defences of repression, denial and suppression can also be seen as examples of negative feedback, the aim of which is to maintain the homeostasis of the system. Due to the fact repression, suppression and denial all entail a sense of distance, this negative feedback takes the form of attempts to establish boundaries between themselves and others and themselves and their emotions, where they felt there were none. According to Frosch (1985):

> "Psychoanalysis is a psychology of conflict, of how an individual finds the best possible solutions in life, of the path to psychological homeostasis,

and of the ways we learn to seek compensation and comfort for our hurts. For a variety of reasons, some we all share and some idiosyncratic, many of us use drugs in this process, at times with maladaptive consequences. It is important to study the details of this psychological pathway so that we may learn to avoid the pitfalls" (p. 35).

2.3.5 Archetypal-mythological approach

2.3.5.1 Introduction

According to Jordaan and Jordaan (1985) four subsystems constitute an understanding of human beings: two internal, known as the 'inner world', which make up the person as a psychobiological unit; and two external, known as the 'world out there', which is represented physically and symbolically. The two internal systems are the intrapsychic part-system and the biological part-system, while the two external systems are the ecological part-system and the metaphysical part-system. The metaphysical part-system concerns human beings' urge to know the meaning behind their experience. While religion constitutes a large aspect of this subsystem, there is also a mythical dimension, which refers to stories, tales and legends, which although not necessarily true, were designed to imaginatively teach certain basic truths in which individuals believe. According to Westerman (in Jordaan & Jordaan, 1985) myth should be regarded as a reflection of what actually happened in the past due to the fact that in the early period of mankind it was impossible to pass down what had happened in any other way.

Many psychiatrists and social scientists have found similarities between the themes found in myths and the themes found in patients' narratives of their experiences (Lukoff, 1985). Jung (in Lukoff, 1985) states: "In insanity we do not discover anything new and unknown: we are looking at the foundations of our own being, the matrix of those vital problems on which we are all engaged" (p. 123). Thus, it is also important to view substance abuse in its historical and mythological contexts.

2.3.5.2 The mythological context of substance abuse

Often in mythology the metaphor of the cripple is used to symbolically represent those in psychological crisis. Often broken in spirit or on their knees, they are unable to function in their usual ways. However, paradoxically, being crippled, blind or otherwise disabled in mythology is also associated with wisdom. These people are often heroes who have conquered some insurmountable suffering (Sharp, 1998).

The hero is usually associated with an unusual fate where his task is to do something out of the ordinary. The goal of the journey is to survive a dangerous ordeal "to find the treasure, the ring, the golden egg, the elixir of life – psychologically, these all come to the same thing: oneself – one's true feelings and unique potential" (Sharp, 1998, p. 108). According to Jung (in Sharp, 1998) this journey is analogous to the psychological "attempt to free ego-consciousness from the deadly grip of the unconscious" (p. 110). "In the language of the mystics it is called the dark night of the soul" (Sharp, 1998, p. 110). This experience usually entails feelings of despair, loneliness and a desire to escape or hide.

Campbell (1972) studied the patterns of themes in mythology across time and cultures and identified the theme of a journey, which he termed 'The Hero's Journey'. Within this journey there are three stages: Separation, Initiation and Return. Separation entails the protagonist receiving the 'call to adventure' upon which he/she begins to move from the world he/she knows to the unfamiliar or unknown. Initiation is where the hero enters the unknown, the world of the supernatural where he/she meets demons and dragons and must survive a series of tests with newly acquired powers. Return is where the hero has survived and must now return to the world he/she knew before, relinquishing his/her powers but keeping some new qualities, with which things are set in order (Lukoff, 1985). In other words, the journey entails the overcoming of a struggle and the subsequent integration of the new information gained from it into their old framework.

Campbell's 'Hero's Journey' explains the relevance of myth to mental illness. The battles and ordeals of princes and dragons are a metaphor for the venture into the psyche and thus are helpful in understanding the process of mental illness (Lukoff, 1985). Campbell (1972) believed that mystics, yogis, psychotic individuals and substance users are "all plunged into the same deep inward sea" (Lukoff, 1985, p. 123). However, Campbell (1972) states:

> "The mystic, endowed with native talents for this sort of thing and following stage by stage, the instruction of a master, enters the waters and finds he can swim: whereas the schizophrenic [or substance user], unprepared, unguided, and ungifted, has fallen or has intentionally plunged, and is drowning" (p. 216).

Campbell's (1972) 'Hero's Journey' can be used to symbolically understand the process of mental illness and more specifically, the process of substance dependence and recovery. This will be discussed further in Chapter 6.

2.3.5.3 Archetypes of substance abuse

Campbell (1972) also spoke of archetypes. Archetypes are Jung's term for the content of the collective unconscious (Drever, 1969) and can be viewed as the shared symbols of the human unconscious. Campbell (1972) discusses the archetypes in his 'Hero's Journey': "The archetypes to be discovered and assimilated are precisely those that have inspired, throughout the annals of human culture, the basic images of ritual, mythology, and vision" (p. 18). Wallace (in Lukoff, 1985) reports that the theme of the journey is also frequently found in 'trickster' mythology, where the journey is often interpreted as a symbol for inner development.

The 'trickster' archetype is often described in relation to addicts and is described as sly, sneaky and manipulative (Rutsky, 1998). The Navajo Indians call this archetype the 'coyote' and describe an illness caused by this archetype:

> "'Coyote sickness' is known by a number of signs including: nervous malfunctions; a shaking of the head, hands, or entire body; a twisted mouth; poor vision; loss of memory; fainting; sore throat; stomach trouble; and occasionally, loss of mind…And while those under the influence of Coyote are considered neither inherently evil nor morally lacking, like alcoholics and addicts, they suffer from a disease that infects the soul as well as the body" (Luckert, in Rutsky, 1998, p. 20).

Rutsky (1998) explains how the characteristics of the trickster can be seen by psychotherapists treating those still using substances, newly clean or even many years into recovery. He states that just as stories talk about the wolf or coyote in sheep's clothing, the coyote or trickster slips into the therapist's office under the cover of denial. He states that addicts often appear to be wearing the skin of another animal, presenting with depression, anxiety, marital, work or health problems. Folk tales involving the coyote also describe trouble caused by the coyote that he then blames on other animals. This is a common characteristic of addicts. They are quick to blame their using on work, stress or a lack of understanding in others (Rutsky, 1998).

According to Rutsky (1998):

> "Coyote has another problem similar to that of many practicing alcoholics and addicts. He is virtually incapable of reflecting on the pain he causes himself and others because he has a difficult time admitting his own flaws and failings…[This] difficulty may be due to inebriation, the discomfort and confusion from a hangover, memory loss due to blackouts, or in chronic late-stage patients, permanent brain damage. Or it may be related to the tendency to hide one's use and it's associated problems for fear of being arrested for using an illegal substance or the cultural stigma associated with their habit" (p. 24).

2.3.5.4 Conclusion

While it is important to view substance use as a phenomena constituted of both physical and psychological origins, taking into account the uniqueness of the individual's experience, it is also beneficial to view it from a wider, symbolic perspective. An archetypal-mythological approach to substance dependency allows for a deeper understanding of the individual's experience in terms of its similarities and differences to the experience of other humans from time immemorial and may thus be viewed as providing a glimpse of a history of the meta system of substance abuse.

2.4 INTEGRATION OF COCAINE AND HEROIN ABUSE MODELS

2.4.1 Addiction as a biopsychosocial process

Historically, the medical profession's management of substance dependence has been less than faultless. The early psychodynamic assumption that there must be something wrong with a person for him/her to engage in self-destructive habits, led to a tendency in the past, to assume recovery lay in finding 'just what is wrong' in order to alleviate the symptom of substance abuse. However, this did not seem to work and thus insight did not necessarily lead to behaviour change (Fine & Juni, 2001). As a reaction to this, the medical model presented the theory of 'addiction as a disease', which disregarded etiology in favour of treating the presenting symptoms. While the reasoning behind this was to destigmatize substance dependence, that is, remove the belief that substance users are weak and immoral, the idea of addiction as an illness seemed to add a new stigma. Berridge and Edwards (1987) state:

> "Disease theory was perceived by the medical profession as a move to throw the light of scientific theory into an area characterised by outmoded moral judgements. Their medical ideology retained more than a trace of its moral ancestry…It acted not simply as an agency of social control, but as one of social assimilation, in which symptoms were defined in terms of

> deviations from the norm and treatment involved inculcation in the values and norms of conformity and self-help" (p. 170).

Other approaches emerged in response to this and substance abuse and recovery were destigmatized by viewing them as a journey into the self in a process of transformation and self-discovery. On the opposite end of the scale to the predominating scientific models of the day, authors like Lukoff (1985) began stating: "Our society stands in need of more contact with and appreciation for the non-rational (mythic, mystic, psychotic) states of mind" (p. 3). Viewing the process of substance dependency, relapse and recovery within an archetypal context implies a quality of fundamental sameness to each unique process (Mudd, 1990). However, this approach, much like the psychodynamic model of substance abuse still failed to address the behavioural element involved in this condition.

The realization that viewing a problem as complex as substance dependency from only one perspective seemed to be creating further problems, led to a shift toward integrating approaches. Out of this emerged the biopsychosocial approach to substance abuse, where a number of factors are incorporated into an integrated understanding of this problem. An example of this is provided by Bozarth (1992) who states that before the first experience with a drug, the direct neurobiological rewarding effects of substance use are largely irrelevant in governing an individual's behaviour. Expectancies developed from social interactions, for example, media exposure, conversations with users, are more likely to influence an individual's behaviour. Thus, it appears that initiation of drug-taking behaviour is governed by intrapersonal and social processes, for example, curiosity about a substance's effects or peer pressure to try a drug. However, Bozarth (1992) states that after initial exposure to the drug, pharmacological variables become relevant and influence subsequent drug-taking behaviour. This does not entirely discount the important role of intrapersonal and social factors in continued drug use, but these factors become less significant as the powerful physiological rewarding effects are repeatedly experienced. Thus, according to Bozarth (1992) at a certain stage there is a shift in significance from intrapersonal/social to pharmacological factors in the

motivation behind drug-taking behaviour. This shift seems to be more rapid when the motivational strength of the drug is high. A progression from casual to compulsive drug use and ultimately to drug addiction occurs very rapidly for some drugs, such as heroin or free-base cocaine, and much more slowly for other drugs, such as alcohol (Bozarth, 1992).

Although this model allows for the inclusion of psychological, social and biological factors in the maintenance of substance abuse, it seems to oversimplify the issue. It may not be possible to separate biological or chemical factors from psychological factors. As Bozarth (1992) states:

> "Obviously, psychological events have some basis in brain physiology, but a strictly reductionistic approach to behaviour frequently ignores important cognitive processes. Physiological processes affect/produce cognitive events and cognitive events affect/produce physiological processes. What is considered 'psychological' and what is considered 'physiological' in nature is largely determined by one's perspective" (p. 131).

Related to this opinion, which stresses the role of cognition as the mediator between the psychological and physiological, is the developmental approach. This approach states that substance abuse can prevent users from engaging in vital developmental tasks and as a result they may be arrested developmentally. This can result in inadequate reasoning and decision-making abilities, which can result in users making poor judgements regarding the consequences of their behaviour, having poor interpersonal skills and thus experiencing difficulty attaining necessary support from significant others (Freeman, 1993). Freeman's (1993) statement, however, highlights the problematic nature of linear concepts of cause and effect, as developmental delays could just as well be implicated in the etiology of substance abuse. Thus, the systemic concepts of interrelatedness and circular causality seem more applicable.

Thus, it appears that the distinction between what is physiological and what is psychological are difficult to draw. Substances affect psychological events and this can be seen in changes in desires and motivation (Bozarth, 1992). Khantzian and Schneider (1985) agree with this view:

> "Does an initial chemical deficiency result in addiction or vice versa? Alternatively, a chemical deficiency could be psychogenic in origin. Understanding how ego and self-structures interact with chemical regulators may help bridge, or even render unnecessary, the duality of mind and body" (p. 128).

This debate over the roles of various factors in the initiation and maintenance of substance abuse led to a number of new explanations. Attempts were made to integrate the medical model, with its focus on pathology, and the psychodynamic approach, with its emphasis on etiology. Fine and Juni (2001) state: "While research on the etiology of any disease is useful, it is nonetheless stressed that the bulk of medical science (including almost all of intervention and treatment) focuses on pathogenesis or pathology" (p. 296). Thus, according to Fine and Juni (2001) in order for treatment to be successful it must find the structure in which the pathology resides. Fine and Juni (2001) propose that the ego is the structure in which pathology resides. They state: "The ego is suggested as the specific locus of the disease, while the symptoms are seen as indicative of the process of atrophy and regression" (Fine & Juni, 2001, p. 296). This again stresses the importance of holistic treatment. Even if the assumption is made that the ego had no role to play in the path to substance dependence, it is affected by substance use and therefore needs to be treated.

However, there were still problems with the psychodynamic approach in terms of treatment. According to Keller (1996):

> "Despite the fact that no other therapy has yet evolved which permits so full an exploration of the total personality, there remain significant problems in

> recommending such unmodified psychoanalytic therapy as the central form of treatment for addictive disorders" (p. 88).

The belief that insight into intrapsychic conflict must precede behaviour change can cause the therapist to enter into a collusion with the patient, reinforcing the user's belief that they need to feel better before they can change – thus causing them to retain the wish for a magic solution (Keller, 1996).

The cognitive-behavioural approach then emerged which directly addressed the behavioural, cognitive and environmental factors associated with the maintenance of substance use disorders. However, according to Marlatt and Gordon (1985) cognitive-behavioural therapy (CBT) still rests on the assumption that once the substance use has reached a certain severity and chronicity, behavioural, cognitive, environmental and biological factors assume most of the responsibility for the maintenance of the disorder. Personality factors, although a significant contributor to the development of the disorder and still having a role to play in sustaining the disorder, tend to be considered peripheral in the task of behaviour change.

Although the following concept will be elaborated further, later in this chapter, it is necessary to draw attention to it here, as this discussion highlights how each approach seems to focus on specific types of feedback into the substance using system. While psychodynamic approaches focus on how personality factors and intrapsychic defences maintain the system, the medical model focuses specifically on physiological forms of feedback and their role in the maintenance of the system. The cognitive-behavioural approach attempts to address more types of feedback, focusing on how certain thoughts, behaviours and environmental situations maintain the system of substance use. The realisation that these various types of feedback all function in an interconnected way to maintain the same system, finally prompted theorists to combine treatment approaches in order to address substance dependency at all its levels.

2.4.2 Combining treatment approaches

One of the most popular combinations has proved to be that of the cognitive-behavioural approach together with a psychodynamic understanding of the user. To combat the problem of relapse it was suggested that by having a psychodynamic understanding of a substance abuser while conducting primarily CBT, it allows the therapist to pay attention to the significant meaning the therapeutic relationship acquires for the patient and the nuances of the interpersonal process in therapy. This enhances the therapist's understanding of the patient's defences, resistances and unconscious conflicts as they are expressed in the therapeutic relationship and which often contribute significantly to exposures to risky situations and irrational thoughts and feelings, which also predispose the person toward relapse (Keller, 1996).

In Kaufman's (1994) three-phase approach to treating substance abuse disorders, the first two stages consist mainly of CBT and 12-Step principles (see paragraph 4.3.1), with a psychodynamic understanding of the patient being used merely to address patients with personality disorders and those who are experiencing a temporary intrapsychic conflict that may threaten sobriety. However, the third phase of recovery or 'advanced recovery' is where therapy becomes more classically psychodynamic and where conflictual themes usually include those such as mourning the loss of the substance and issues around intimacy and autonomy (Kaufman, 1994). Marlatt and Gordon's (1985) Relapse Prevention (RP) Model is another example of the combination of CBT and psychodynamic therapy. The focus is on identifying the high-risk situations, triggers and maladaptive thought processes that increase the chance of relapse. RP also addresses the user's tendency to make 'apparently irrelevant decisions', where psychodynamic therapy assists in the understanding of the patient's unconscious motivation to unwittingly expose themselves to high-risk situations (Marlatt & Gordon, 1985).

Family therapy approaches are also common in the treatment of substance using individuals. These therapies use a predominantly systems theory approach, however a psychodynamic understanding of the various family members is also useful. The earliest models that looked at families with a substance abusing member in this way were derived

from a theory that stated that the wives of alcoholics were disturbed women who resolved neurotic conflicts through marriage to alcoholic men (McCrady & Epstein, 1996). These theories have come a long way since then and are no longer quite so simple, but in short, each member's internal object relations can be considered a micro system of the bigger family system and these micro systems also interact in such a way as to maintain the status quo of the system.

2.4.3 Conclusion

It appears as if substance dependency is determined and maintained in a circular manner by a variety of factors on a number of systemic levels. The users' personality structures contribute on an individual intrapsychic level, while patterns of family interaction seem to contribute on an interpersonal level. Social attitudes towards substance abuse also make a contribution on a macro level. Genetic determinants and the biochemical effects of the substances themselves also play a role on an individual physiological level. Developmentally, all these factors are interrelated and appear to influence each other.

However, before a full integration of these approaches can be presented, a few other relevant concepts that emerged from the data need to be discussed. An understanding of these concepts contributes to a fuller understanding of substance abuse and relapse.

2.5 CONCEPTS IMPLICATED IN RELAPSE

Due to the reflexive process of qualitative research, this section of the literature study was conducted in tandem with data collection and analysis. A literature review of the following concepts is necessary for the final integration and theoretical interpretation of the results of the study.

2.5.1 Craving

Craving has been defined as: "an urgent and overpowering desire" (Mardone, in Gossop, 1992, p. 240). "The drug is assumed to exert a power over a user who often becomes its victim" (Cohen, 1992, p. 212). Craving as a desire is identified in simple acts of behaviour and in subjective experience. At an operational level, craving for a certain drug can be inferred from the repeated use of that substance (Cohen, 1992). However, disagreement exists over whether craving is a positive or negative feeling state. While science seems to regard it as a positive affective state: "…the subjective desire to experience the effects or consequences of a given act…craving experiences are assumed to be mediated by the anticipated gratification (immediate pleasure or enjoyment) associated with the indulgent act and its affective consequences" (Marlatt & Gordon, 1985, p. 241); addicts describe craving as a predominantly dysphoric condition (Meyer & Mirin, in Gossop, 1992). Gossop (1992) states that craving is a phenomenon that occurs frequently and that it seems to be most intensely experienced during the times when the user is trying to avoid using substances (Gossop, 1992). Thus, the internal conflict that results from desiring something they wish to avoid is possibly the reason craving is experienced as dysphoric.

Historically, craving has been a controversial term that has shown remarkable persistence despite the problems that surround it (Cohen, 1992). According to Gossop (1992):

> "The term 'craving' has provoked considerable debate over many years…the confusion surrounding the term has been exacerbated by the lack of any agreed definition and by the way it has been indiscriminately used to refer to different physiological, psychological and behavioural states. It has been especially unhelpful and, indeed, tautologous, to suggest that craving may be an integral part of the relapse to drug taking, as well as a cause of that relapse. In addition, the term has been criticised on the grounds that is overloaded with connotations and assumptions, from outdated theories of addiction, in which the disease model and the physical dependence models of addiction played a more prominent role than they do today" (p. 240).

The debate continues today with theorists warning against the use of the term 'craving' and others stating that it should be used, as it precisely captures the essence of addiction in terms of its compulsive qualities. Gossop (1992) suggests that the confusion around the term originated from the lack of a clear and explicit separation of the various issues surrounding craving. These include: craving as a phenomenon in its own right; the mechanisms underlying or resulting in craving; and the use of craving as an explanatory concept for relapse.

Thus, while craving is regarded as the scientific term for 'desire' for drugs and it is seen as an inevitable physical or pharmacological effect of a drug, which can result in users not being able to withstand it and continuing their use of the substance despite negative or even life-threatening consequences; as well as being a central aspect in the process of relapse (Cohen, 1992), other studies suggest that psychological and social factors may also be involved.

Although the neurological basis of craving or 'strong desire' has been found, some studies have shown that the existence of a strong desire to use cocaine in 35% of daily users only exists some of the time. The fact that craving only exists during a limited period of time amongst daily users, suggests the physiological desire to use is not strong enough to maintain itself. The majority of users report periods of abstinence that occur in spite of strong feelings of desire. These findings suggest that cravings may be the result of other psychological and social factors and not just the simple pharmacological product of a drug (Cohen, 1992).

Bozarth also (1992) states:

> "Desire and craving can be elicited by physiological events. Through this process a drug's pharmacological action can alter feelings of the 'self' and enter the realm experientially labelled the 'mind'. The desire for the drug can develop from repeatedly experiencing its rewarding effects; this desire is phenomenologially within the 'self' and not distinguishable as externally

> controlled behaviour anymore than feelings of hunger or thirst are considered under the control of external factors. What may not be immediately apparent is that cognitions and social interactions can also affect 'physiological' processes" (p 131).

Thus, craving appears to be a combination of physiological, social and psychological factors and is most likely best understood within the biopsychosocial model of substance abuse.

2.5.2 Identity

Identity can be defined as a stable sense of knowing who one is and what one's ideals and values are (Erikson, 1968). Erikson's (1968) stage of 'identity versus role diffusion', which usually occurs between the ages of 11 and 20, is the period during which the developmental and psychosocial tasks facing adolescents is to incorporate past experiences and present goals into a coherent sense of self. However, children who have experienced difficulties mastering previous stages and their accompanying expected developmental tasks are unlikely to succeed in establishing a well-defined identity during adolescence. This tendency for problems to compound can be likened to a system, which has a tendency to perpetuate itself.

Erikson (1968) describes a normative identity crisis that occurs during the stage of 'identity versus role diffusion' which includes severe doubting, an inability to make decisions, a sense of isolation and inner emptiness, an increasing inability to relate to others, disturbed sexual functioning, a distorted time perspective and a sense of urgency. If this crisis is successfully resolved the result is a stable and positive identity, however, if not resolved, the ultimate assumption of a negative identity ensues. According to the DSM-IV, 'identity problem' is not recognised as a disorder, but is described as "uncertainty about issues relating to identity, such as goals, career choice, friendships, sexual behaviour, moral values, and group loyalties." (Kaplan & Sadock, 1998, p. 1263).

Kaplan and Sadock (1998) state that problems with identity formation seem to be linked to life in modern society, where children and adolescents experience a great deal of instability within the family, conflicts between peer group values and those of their parents and society, and exposure through the media and education to various moral, behavioural and lifestyle possibilities. Thus, changes in the macro system of society, the family system and the individual's intrapsychic system seem to be closely related, emphasising the interconnectedness of systems.

According to Freeman (1993) when identity confusion occurs in adolescence it can be associated with heightened vulnerability to drugs and alienation. Paradoxically this stage of adolescence is when they have a strong need to affiliate. Alienation is a concept that seems to be associated with the identity problems carried through to adulthood by substance users. According to Zinberg and Shaffer (1985) the fact users tend to have fairly stimulus-deprived relationships with others (interaction with family and friends often consists of pleas to stop using and interaction with other users revolves around using) and the fact larger society condemns users as deviants, contribute to the user gaining a entirely negative view of him/herself from external inputs. Zinberg and Shaffer (1985) state:

> "The heroin addict's dependence on the environment is consolidated by the need to continue coherent relationships with the external objects that remain available to their interactive efforts. Thus, suffering considerable doubt about their ability to maintain these relationships, heroin addicts readily accept society's deviant stereotype as their own identity" (p. 65).

Luzzato (1987) conducted a study into the internal world of drug-users with specific reference to self-object relationships, from an object relations perspective. From this study, four types of 'self-images' emerged with various types of relationship with the external world:

The first was the 'vulnerable self', where the boundary between self and the external world is not clear. The self has no 'inner space' and the world becomes overwhelming and the self loses identity. The second was the 'objectless self', where a relationship with the outside world is denied or rejected or there is a clear indifference towards the world. A 'barrier' against the outside world is mentioned and this is often related to the substance abuse itself. A sense of the lack of a world outside seems to be maintained by substance abuse. The third was the 'divided self' where good and bad are split, and the self is threatened by either a 'bad object outside' and the world is perceived as 'explosive', 'aggressive' or 'meaningless'; or a 'bad object inside', which is described as 'cold', 'indifferent', 'irresponsible', 'aggressive' and is usually associated with substance abuse. The last 'self-image' was the 'integrated self', where the self and the world are clearly separated, there is an awareness of complexity in both self and the world, and this does not block positive interaction and growth between the two. Interestingly the majority of substance users in the study had a 'self-image' that fell into either the 'objectless self' or the 'divided self' (Luzzatto, 1987).

The problems with identity that users seem to experience appear to be related to the concept of boundaries. Boundaries between themselves and others, as well as boundaries between various parts of themselves, are either too rigid and impermeable, or non-existent. According to systems theory, problems usually develop when the boundaries between systems have these characteristics (Freeman, 1993).

This 'fragmented self' concept has been further explored in psychodynamic theory. The process of identification, or lack of it, has been associated with the way unresolved conflicts and impulses from early childhood manifest as a disorganised and poorly functioning internal psychic structure, a low self-esteem and poor self-image (Zinberg & Shaffer, 1985). Within substance abusing families, the intergenerational transmission of substance use disorders has been associated with a lack of identification with reasonable parental figures. Unmet needs for closeness and acceptance from a parent are unconsciously expressed through wanting to be like the parent (although the thought of wanting to be like a substance abusing parent they hate in order to be close to him/her,

seems strange to most users). The intergenerational transmission of substance use disorders is also a good example of systems' tendencies to perpetuate themselves.

Kohut (1977) also proposed a theory of identity development, in which he suggests that each person's narcissism is a separate line of development from other aspects of the personality structure and that within this self-system, substance use serves a particular function. This perspective suggests that people with narcissistic personality problems use substances in order to avoid directly expressing their desire to merge with a longed-for, idealized self-object, which in turn, allows them to avoid the possible reactivation of pain associated with traumatic rejection. This is supported by Firestone's (1985) suggestion that substance use is an attempt to create a pseudoindependence, which was discussed previously in this chapter. Kohut's (1977) views on the self-system explains the 'divided self' concept, which is also prevalent amongst users. Within the self-system, at the time of intoxication the self is able to function as the longed-for, idealized self, but when the intoxication has receded the function of the self changes, usually to that of the despised, unlovable self. According to Kohut's (1977) theory it was this despised, unlovable self that began the search for substances and so it is logical that after use, the experience of this aspect of the self will spark the desire to use again.

In conclusion, whereas failure to establish a stable and positive identity seems to play a role in the development of various psychopathologies, it seems to be one of the crucial elements in substance use disorders. However, as with most phenomena in the field of psychology, it is impossible to determine a linear, causal relationship between the lack of a stable identity and substance abuse. Most likely the relationship between the two is reciprocal, in that they influence and exacerbate each other.

2.5.3 Coping styles

Carver, Scheier and Weintraub (1989) state that coping should be viewed as a dynamic process that changes in nature in different stages of a stressful transaction. This suggests that the development of a coping style would be counterproductive, because it locks an individual into one style of responding rather than allowing him/her the freedom and flexibility to change responses with changing circumstances.

Two types of coping have been distinguished: problem-focused coping and emotion-focused coping. Problem-focused coping seems to predominate when people feel that something constructive can be done, while emotion-focused coping is used more when people feel that the stressor they face must just be endured. While problem-focused coping involves several distinct activities, such as planning, taking direct action, seeking assistance, screening out other activities and sometimes delaying or waiting before action, emotion-focused coping is a diverse concept. It is a coping tendency aimed at managing distress emotions rather than at dealing with the stressor per se and it can involve denial, positive reinterpretation of events and also seeking out social support. Although this can be adaptive in some circumstances, there are a number of emotion-focused coping techniques that are maladaptive (Carver *et al*., 1989).

According to Carver *et al.* (1989) one emotion-focused coping technique that can be problematic is 'focusing on and venting of emotions', which is the tendency to focus on whatever distress or upset one is experiencing and to ventilate those feelings. They state that although such a response may sometimes be functional, such as mourning the loss of a loved one, focusing on negative emotions (particularly for long periods) can impede adjustment, since the salience of the distress may exacerbate the distress.

There are two other coping tendencies that Carver *et al.* (1989) feel may be maladaptive in many circumstances. The first is 'behavioural disengagement', which is when one reduces one's efforts to deal with a stressor, to the point of giving up the attempt to attain goals with which the stressor is interfering. Behavioural disengagement is associated with phenomena such as helplessness and is most likely to occur when people expect poor coping outcomes.

The second tendency Carver *et al*. (1989) identified is that of 'mental disengagement'. Mental disengagement occurs through a variety of activities, which are used to distract a person from thinking about the behavioural dimensions or goals with which the stressor is interfering. In other words, alternative activities are used to take one's mind off a problem. Both behavioural and mental disengagement are reflected in the MRI approach, which states that one of the ways a solution can become a problem is when a solution is not applied where one should be.

Carver *et al*. (1989) place 'alcohol and substance use' in the cluster of coping tendencies which tend to be maladaptive. Their study showed that alcohol and substance use as a coping technique was inversely related to the more adaptive active coping and planning tendencies. Denial and behavioural disengagement were also inversely related to the more adaptive coping techniques.

According to Freeman (1993) the substance use itself can be viewed as a coping style. Prostitution and other crimes become both a way for the user to earn money for drugs and a reason to continue using drugs as a form of self-medication. The drugs mask the emotional pain and the stress that is inherent in the drug-using lifestyle that users experience.

Substance use can also be viewed as a coping style that incorporates avoidance techniques, because the use of substances can be seen as a process of 'running away'. It often involves emotional detachment from significant others, which can be viewed as a psychological leave-taking. This may be characterized by a rapid escalation of conflict within a family system or a lack of communication, with less time being spent with significant others. Sometimes this involves less time physically being spent at home. This can happen at times when the conflict in the home is at a peak or during a lull in the conflict when relationships seem to be well. Generally speaking it can be construed as a means to escape a hopeless situation (Freeman, 1993). However, as a coping style, substance abuse is obviously not effective in the long-term, as it seems any attempts to

avoid the reality of a situation result in an escalation of the negative feelings surrounding it. As Carver *et al*. (1989) state: "Although disengaging from a goal is sometimes a highly adaptive response, this response often impedes adaptive coping" (p. 269). In terms of systems theory, it appears as if the above-mentioned kinds of attempts to change the system constitute symmetrical behaviour and only result in exacerbating the way the system currently functions.

Social support is a term often associated with the topic of coping styles. In most literature seeking social support is considered a positive means of coping, however Carver *et al*. (1989) state that although seeking social support could be functional, it can also be associated with focus on and venting of emotions, which in turn is linked to such strategies as denial and disengagement. This suggests that the tendency to seek out social support may thus have both adaptive and maladaptive components, and that the other coping processes that are occurring along with it determine into which category it falls.

Another term closely associated to coping is that of self-efficacy, which is the person's perceptions of his/her ability to cope. Hodgson (1992) states that anxiety is a function of perceived low self-efficacy. Rist and Watzl (in Hodgson, 1992) found that recovering substance users whose efficacy expectations were higher, that is they expected to be able to cope in a variety of high risk situations, were less likely to relapse during the three months after discharge. "Whether addicts relapse after treatment is a function of severity of dependence but…a self-efficacy measure turned out to be a better predictor of outcome than measures of degree of dependence" (Hodgson, 1992, p. 224).

When substance use is viewed as a coping technique it brings into question the coping styles of users in general. An important aspect of treatment and rehabilitation of substance users includes training in more adaptive coping techniques. This also aids in increasing the user's self-efficacy, an important factor in relapse.

2.5.4 Control and Powerlessness

According to Morf and Mischel (2002) control, as a concept, has a variety of forms that differ in psychological meaning and which have different implications for adaptation and psychological health. While control beliefs play a significant role in the relationship between stress and depressive symptoms, economic and family stress can maintain an individual's perceived inability to control and this in turn seems to maintain their symptoms of depression (Deardorff, Gonzalez & Sandler, 2003). The two forms of control discussed in this section are: locus of control and self-control.

Rotter (in Ashby, Kottman & Draper, 2002) states that locus of control is the perceived ability to exercise control over the outcome of life events and that it is strongly related to mental health. Locus of control can be considered to lie along a continuum, with an internal locus of control on the one end and an external locus of control on the other (Levenson, 1973). Taylor (1982) states: "Individuals perceiving an internal locus of control tend to view themselves as having more control over and personal responsibility for the direction of their lives than do externals, who are likely to feel themselves powerless to control events" (p. 319). Thus, individuals who believe their own actions and behaviours can influence the outcome of their life events are better adjusted than those who believe the outcomes are entirely dependent on external factors (Rotter, in Ashby *et al*., 2002). However, while a completely external locus of control can leave an individual feeling powerless, in certain situations an external locus of control can be useful, such as when a person indeed cannot control the outcome of an event. Hence, functioning entirely from either extreme can be maladaptive. The ability to shift between the two is most likely optimal.

Depression has been negatively correlated with an internal locus of control and positively correlated with an external locus of control (Jaswal & Dewan, in Ashby *et al*., 2002). An external locus of control is also associated with a higher prevalence of anxiety disorders and the diagnosis of personality disorders, and is inversely correlated with a subjective sense of well-being (DeNeve & Cooper, in Ashby *et al*., 2002). Also, individuals with an external locus of control display increased risk-taking behaviour, even when the

possibility of death is high (Miller & Mulligan, 2002), which suggests that substance users most likely have a predominantly external locus of control.

A further distinction can be made in the category of external locus of control. Levenson (1973) proposed two subtypes within this category: control by chance and control by powerful others. Levenson (1973) states: "…people who believe that the world is unordered (chance) would behave and think differently than people who believe that the world is ordered but that powerful others are in control" (p. 398). Wheeler and White (1991) suggest that external locus of control is related to hurt in the family of origin. This could be related to the fact that in the life of a child, parents are central figures, and could be considered 'powerful others'.

Self-control is considered a basic aspect of self-regulation. It involves dominant responses, for example, surrendering to momentary temptation, being inhibited. This is normally achieved by transforming the stimulus or distracting attention from it. This process allows for less accessible subdominant responses, which are more appropriate for long-term well being and goals, to be enacted. Thus, it is apparent that self-control is a prerequisite for adaptive social, emotional and cognitive functioning. Extremes of self-control, under or over control, are associated with negative outcomes and are thus maladaptive for psychological health (Eisenberg, Spinrad & Morris, 2002).

According to Morf and Mischel (2002):

> "…self-control is multiply determined by interactions among temperamental-biological and motivational psycho-social factors. It is generally considered to be at least in part a volitional or intentional executive function, and it is effortful. Further, self-control crucially depends on the availability of the necessary competencies that allow the individual to overcome dominant response tendencies and to generate alternative responses" (p. 193).

The competencies needed for effective self-control involve the ability to re-focus attention. This is done to assist in the inhibiting and overcoming of the initial dominant response to the 'stimulus pull' (Morf & Mischel, 2002). This can be achieved through self-distraction and attentional shifting to other stimuli (Derryberry, 2002). An attentional shift can also be achieved through modifying how the event is cognitively framed. However, whether or not these attention control techniques are used effectively depends on a variety of motivational, cognitive, and emotional-temperamental factors that interact within the larger self-system (Morf & Mischel, 2002). Another factor that seems to impact on the success of self-control efforts is the amount of self-control previously exercised. Baumeister (2002) states that as a resource, self-control is limited and seems to be used up quickly when an individual is faced with a number of situations in succession where self-control is required. Nevertheless, Derryberry (2002) states that flexible, positive and adaptive coping is possible even in people with a high vulnerability to poor self-control when good control strategies are available.

According to Morf and Mischel (2002) "Optimal levels of control and self-regulation are characterized by flexibility and thus also by discriminativeness: they contrast with the extremes of generalized over-control or under-control which virtually by definition are rigid and maladaptive" (p. 194). Most rehabilitation programmes allow users the opportunity to develop a more balanced and adaptive style of control, through therapy groups and individual psychotherapy. The emphasis that is placed on *self*-control by users tends to be a rigid style that actually aids in the process of relapse. Hodgson (1992) states:

> "We often imagine that successfully resisting temptation occurs when good self-control skills enable a person to live with a high level of desire. My own clinical experience indicates that learning self-control skills actually reduces desire because expectations, which are at the heart of desire, are modified" (p. 224).

This notion is also explained by Bateson (in Keeney, 1983), who suggests that dependency problems originate from "a dissociated epistemological premise, usually some variation of self versus environment or body versus mind" (p. 163), in which the substance dependent person is engaged in a battle arising from a separation between mind and body. The person's 'will' to resist the substance, which arises from the conscious mind, is used in an attempt to control the body's 'hunger' for the substance, which creates a symmetrical battle.

Bateson (in Keeney, 1983) views the idea of self-control, or the idea that one part of a system can have unilateral control over other parts, as an erroneous epistemological premise. The challenge to attain abstinence provides the motivation to do so, however, as soon as abstinence is achieved, the challenge that generated it is destroyed. Thus, the more the user attempts to stay clean, the more likely he/she is to use and a vicious oscillatory pattern is set in motion. With each oscillation, the intensity steps up and eventually the user is merely trying to stay alive. As soon as the notion of self-control is acknowledged as an illusion, it becomes clear that the user is part of a more-encompassing self-corrective system, in which symptoms can be viewed as communication regarding higher order cybernetic processes. This realization is often achieved by users when they hit 'rock bottom' and then realize they do not have control over the situation, which in turn leads to self-corrective behaviour due to reconnection of the dissociated dualism between symptom and self (Keeney, 1983).

Thus, in conclusion, attempts to control the environment and the self can be viewed as a system's attempts at self-regulation. The success the system has in this regard seems to depend on the nature of the recursive feedback loops and the system's reaction to the feedback. A situation of over-control, where the individual overreacts to feedback can lead a system into oscillations, and may be indicative of a system whose boundaries are too permeable, while under-control may indicate a system engaged in a symmetrical battle due to lack of feedback from a higher order system, due to rigid, impermeable boundaries.

2.5.5 Loneliness

Moustakas (1996) differentiated two types of loneliness: existential loneliness, which inevitably is part of human experience, and loneliness of self-alienation and self-rejection. While the former he considered necessary for a person to become fully aware of himself as an isolated and solitary individual, the latter he considered a vague and disturbing anxiety: "…in loneliness anxiety man is separated from himself as a feeling and knowing person" (p 24).

Existential loneliness is considered an unavoidable and even valuable element of humanness. Wolfe (1941) discusses the inevitability of real loneliness as a part of genuine experience and an intrinsic condition of existence. He believed that it is necessary because out of these depths of despair and feelings of complete impotency comes the discovery of unique ways of being aware and expressing experience.

However, the loneliness anxiety that Moustakas (1996) describes is considered 'pathological' and is attributed to early childhood deprivation as well as social ills. Loneliness anxiety or a fear of loneliness is often attributed to changes in social patterns. May, Angel and Ellenberger (in Moustakas, 1996) state that man has lost his experience of neighbourliness and community life and thus experiences a feeling of alienation and estrangement from the human world about him. Other theorists also support the idea that feelings of loneliness have an earlier, more intrapsychic root; this can be described as follows:

The experience of loneliness has a significant developmental history that begins in infancy, when the infant's needs for contact and relatedness are not met. This experience of loneliness then emerges throughout crucial stages of development. Sullivan (1953) discusses various needs that occur in human development that relate to the experience of loneliness. The first is the need for tender contact and protective care in infancy and early childhood. When the child does not obtain the needed adult presence and participation, loneliness results. According to Sullivan (1953) the greater the intensity of

separation, the greater the development of the child's sense of isolation and parental rejection. This sense of isolation is especially threatening in children, due to their inability to care for themselves. The possibility of being abandoned is a matter of life and death (Fromm, 1941). This is supported by Moustakas (1996), who states that loneliness anxiety is:

> "an exceedingly unpleasant, driving experience, resulting from inadequate fulfilment of the need for human intimacy – beginning in the early years with the failure to establish rich contact with the living, extending to the frustration of the need for tenderness and protective care, and into adult years when there is a failure to meet others on a genuine, fundamental, loving basis" (p. 27).

Thus, loneliness that may have originated from unsatisfactory parental care in early childhood seems to be exacerbated by changes in society. The move away from community involvement and the break-up of the family unit may be contributing factors to fears of loneliness. Thus, the alienation and estrangement that seem to characterize substance-abusing lifestyles suggest that loneliness most likely has a significant role to play in the process of substance dependence and relapse.

2.6 HEROIN VERSUS COCAINE: THE DIFFERENCES

The psychodynamic developmental view of the etiology of substance use, which states that there are a variety of developmental problems that can lead to substance use, suggests that there are a number of different meanings for particular drugs and behaviours (Greenspan, in Frosch, 1985). Frosch (1985) states that different substances:

> "…produce not only distinctive changes in physiology, but also specific and distinct alterations of a variety of ego functions…The individual patterns of drug-induced alteration of ego functions are related to the drug ingested, the dose and social context, as well as to the individual's predrug ego structure.

> Having once experienced the particular drug-induced pattern of ego function, the user may seek it out again for either defensive purposes as a solution to conflict or as a substitute for defective ego structure or for primary delight. This may result in a preferential choice of drug" (p. 35).

Frosch (1985) suggests that the main groups of psychoactive substances produce different alterations in ego state, for example, satiation or arousal and that these ego alterations may recapitulate original experiences in specific phases of childhood development, providing a solution to a specific conflict. This results in certain drugs being preferentially chosen by a user because it matches or fits his internal conflicts. While opiate use seems to be associated with conflict arising from the earliest stages of development and seems to substitute for the lack of maternal containment, amphetamine use is generally linked to conflict in later stages. Feelings of control and mastery provided by these substances offer the solutions to these conflicts. With regards to systems theory, the use of a substance as a solution to an intrapsychic conflict, which could be viewed as an imbalance in the system, resembles a system striving toward homeostasis.

Milkman and Frosch (in Frosch, 1985) found that while opiates tend to aid in withdrawal and repression through decreased motor activity, reduction of perceptual intake and a reduction in the user's responsiveness to the environment, amphetamines increase a sense of autonomous functioning and self-confidence, result in feelings of heightened perceptual and motor abilities, and lead to an increased sense of potency and self-regard.

According to Lang (in Frosch, 1985) personality can be a contributor, a predisposing factor or a result of substance use and abuse, depending on the type, frequency, time, consequences, and stage of substance involvement. "Individual perceptions, attitudes and values and personal traits or styles can explain why given comparable environments people vary in their substance abuse" (Lang, in Frosch, 1985, p. 35). As well as highlighting the complexity of the 'drug of choice' phenomenon, the above quote also highlights the difficulty in establishing causal relationships. It is almost impossible to

decide whether users' personalities are contributing factors to substance use or the result of it.

With many users having experimented with a variety of substances, their preferred substance is not chosen by chance. The various natures of user's psychological vulnerabilities predispose them to finding the effects of certain types of substances welcome and this results in a self-selection or 'drug of choice' phenomenon. Some users who tend to use their drug of choice exclusively, tend to report the effects of other substances as dysphoric (Khantzian & Schneider, 1985). Glover (in Khantzian & Schneider, 1985) also emphasises the symbolic meaning of various substances to the users with regards to their choice of drug.

Khantzian and Schneider (1985) separated the typical street drugs into three major categories according to their effect on users. While cocaine and crack fall under the class named 'energizing drugs', heroin falls under the category 'controlling-stabilizing drugs'.

Crack and cocaine are known for their energizing properties as well as their mood elevating properties. They eliminate the depletion and fatigue states associated with depression and result in increased feelings of assertiveness, self-esteem and frustration tolerance (Khantzian & Schneider, 1985). Wurmser (in Khantzian & Schneider, 1985) states that these substances "help to ameliorate feelings of boredom and emptiness by producing a sense of aggression mastery, control, invincibility, and grandiosity" (p. 124). In people with depression, a great deal of energy is used up by denial, guilt and shame, thus the energizing effects of cocaine give a sense of relief as they feel they have overcome painful feelings of helplessness and passivity. Thus, crack and cocaine are used generally by users who have great difficulty managing boredom and depression. Despite the fact the use of these substances can result in users feeling agitated, it allows them to avoid overwhelming feelings of despair and hopelessness. However, their sensitivity to these feelings makes the 'crash' after using more intense, leaving them more depressed than they originally were (Khantzian & Schneider, 1985).

In contrast, opiates tend to have a muting and stabilizing action. Studies conducted into the deficiencies in the egos of heroin addicts revealed uncontrollable rage, impulse control problems, and dysphoria as a result of these violent feelings and impulses. The addicts in these studies described how heroin has a calming, relaxing and stabilizing effect on their feelings of restlessness, bodily tension, rage and anger and their feelings of depression (Khantzian & Schneider, 1985). According to Khantzian and Schneider (1985): "individuals were predisposed and became addicted to opiates because they discovered the ability of these drugs to supplement and strengthen their fragile egos. The specific and short-term action of narcotics was to reverse regressive states by attenuating, and making more bearable, painful drives and affects involving aggression, rage and related depression" (p. 127).

2.7 CONCLUSION

This literature study attempted to cover the four subsystems that constitute human beings: the biological subsystem, the intrapsychic subsystem, the ecological system and the metaphysical subsystem (Jordaan & Jordaan, 1985). However, these systems can also be conceptualised in Keeney's (1983) hierarchical manner, with the various subsystems making up the individual as a system, within a more-encompassing system – the family, which is also part of an even more-encompassing system – society.

As mentioned in the previous section on loneliness, the broader changes within society seem to be reflected in the changing nature of family structures, which, in turn, seem to be reflected in the intrapsychic systems of individuals. If one considers the object relations view that internal objects and their relationships to one another, that is, an individual's intrapsychic structure, are a reflection of the original family system, it is clear how these various systemic levels are interconnected. The fact that individuals and their behaviour constitute the essence of society then completes the recursive loop

between these various levels of systems. In other words, while patterns in society are reflected in the family system, and in turn, reflected in the individual; patterns in the individual systems, in turn, are reflected in society. This interconnectedness takes the form of feedback.

Each system attempts to self-regulate, for example, the individual as a system through self-control and coping techniques, which include defences like repression. Depending on the feedback, for example, alleviation of feelings of loneliness, the system will either continue to self-regulate in the same way or attempt new behaviour. However, the fact each system forms part of a greater system, which is also attempting to self-regulate, implies feedback from other systems also needs to be integrated, which may influence the current functioning of the system. The extent to which this happens seems to be influenced by the nature of the boundaries between the systems. As a child, when boundaries are not yet formalized, the individual as a system is extremely sensitive to feedback from the greater system – the family, which then seems to mould the identity and patterns of functioning of the subsystem – the child. On the other hand rigid boundaries seem to allow little feedback from higher order systems into the system. In terms of this notion, denial can then possibly be viewed as an attempt by the individual as a system to create more rigid, impermeable boundaries.

Thus, the various approaches to the problem of substance abuse that have emerged are all valid and can be viewed as merely explanations of a specific systemic level. Therefore, the more approaches that can be incorporated, the more systemic levels are included, and the better the understanding of the phenomenon of substance abuse.

Chapter Three

METHODOLOGY

But every man is not only himself;
he is also the unique, particular, always significant and remarkable point
where the phenomena of the world intersect once and for all and never again.
That is why every man's story is important, eternal, sacred;
and why every man while he lives and fulfils the will of nature
is a wonderful creature, deserving the utmost attention

Herman Hesse

3.1 INTRODUCTION

This chapter presents a description of the research process of this study. It provides information concerning the research method used and the various stages of the research process. The broad systemic framework applied in this study and the freedom it offers in terms of the integration of other approaches into a final understanding, has certain implications for research. These will be briefly discussed with the aim of providing a better understanding of the research process used in this study. A brief motivation and discussion of the use of qualitative research methods, and in particular, the semi-structured interview, is also given. The recruitment of participants and the data collection process is elaborated as well as an explanation of the data analysis process.

3.2 RESEARCH METHOD

3.2.1 Implications of a broad systemic approach for research

Systemic epistemology focuses on the inter-relationships between various systems. There is a shift from the more traditional approach to research where the goal is an objective, quantitative description of a static and measurable reality, to a subjective, qualitative description of constantly changing realities and truths (Hanson, 1995). Thus the aim of research within a broad systems perspective is to provide a description of a part of a whole, as the underlying assumption is that the researcher will never grasp the whole. This description is also then viewed as relative to a certain context and epistemology and is not meant to be generalized (Hanson, 1995).

Cybernetics describes the underlying principles of the processing, control and regulation of information. While first-order cybernetics focuses on the interactions within and between systems, which are described by an observer outside the observed system in an objective manner, second-order cybernetics is concerned with the cybernetics of cybernetics i.e. the interactions within and between the observer and the observed (Moore, 1997).

The influence the researcher exerts on the system is most noticeable in the way the observer draws distinctions and organises experience. According to Moore (1997) this is achieved through punctuation. The way in which a researcher punctuates the interactional patterns of his/her research determines which part of the system is looked at and therefore which realities will emerge.

Thus, within this approach, the researcher is not objective. Keeney's (1983) alternative to the traditional 'objectivity' is the idea of 'ethics', where the emphasis is on the researchers' responsibility to acknowledge the limitations of the distinctions or punctuations they make, and to take note of the fact they are thus only perceiving a part of a whole.

Thus the systemic perspective is concerned with second-order cybernetics. The influence of the researcher and the context must be taken into consideration. Unlike more traditional research approaches where the observer is seen as positioned outside the field of study, objectively observing without influencing the phenomenon (Hoffman, 1990), the systemic perspective acknowledges the influence of the researcher on the phenomenon. Merely by the act of observing, the researcher creates a new system, with its own homeostasis and equilibrium. Thus the influence of the researcher and his/her frame of reference on what is being observed must be taken into account as far as possible and acknowledged in the description (Hanson, 1995). The phenomenon being observed is also found within a larger context from which it cannot be separated. Thus the context or macro-systems within with the observed system is situated also need to be acknowledged (Hanson, 1995).

In summary, the systemic approach acknowledges the dynamic and recursive interactions that occur within and between systems and emphasises the complexity of systems (Hanson, 1995). It does not attempt to provide one 'truth' but rather a truth in the exploration of different realities. The researcher describes a co-created reality that is a

part of a whole, decided upon by the way the researcher and participants punctuated reality. Thus this epistemology supports a more qualitative approach to research.

3.2.2 Motivation for using a qualitative research approach

According to Punch (1998): "Qualitative research concentrates on the study of social life in natural settings. Its richness and complexity mean there are different ways of looking at and analysing social life, and therefore multiple practices in the analysis of social data" (p. 199). The aim of this study is to explore and describe the subjective experience of relapse in heroin and cocaine users and qualitative research methods are particularly relevant for studying the lived, everyday realities of people in their contexts (Kvale, 1996). The wider and less-structured format of qualitative research methods allows for fewer punctuations to be made before beginning the research and this fits the exploratory nature of this study. Qualitative research approaches allow the information gained from the study to guide the research process and this provides an opportunity for the individual 'meanings' ascribed by interviewees to emerge.

The influence of the researcher on the study and the way in which the researcher's punctuation impacted on the co-constructed reality is taken into account through a detailed description of the research methods employed.

3.2.3 Motivation for using semi-structured interviews

Qualitative research interviews attempt to tap into the 'experiential world' of the participants and to gain an understanding of their 'meanings'. According to Kvale (1996) qualitative research interviews obtain subjective descriptions of the interviewees' world in terms of their interpretations of meaning. Knowledge evolves through the conversation between two people.

Thus, qualitative, in-depth, semi-structured interviews were conducted to explore the concept of relapse from cocaine and heroin users' perspectives. The reason for this

choice is that qualitative interviews allow the interviewee more freedom to express his or her unique experiences in their totality. Where a structured interview with set questions might limit the study to previously decided-upon concepts in a certain manner of perceiving, to which meaning has already been prescribed, qualitative research allows the participant to be involved in this process. The majority of the researcher's questions emerge in the process as the interviewee's individual meanings become apparent. This style of data collection fits the exploratory nature and aims of the study.

The interviews consisted of open-ended questions to gain the participants' subjective experience of relapse, however certain themes were introduced during the interview by the interviewer, when necessary, to gain a fuller account of the experience – hence the term semi-structured interviews. These themes included:

- the conditions of life the participants experienced at the time of the relapse
- the triggering event/s
- the participants' feelings surrounding the relapse
- the participants' thoughts surrounding the relapse
- how the participants feel their choice of drug influences/d their experience of relapse

3.3 RECRUITING OF PARTICIPANTS

3.3.1 Phoenix House

Phoenix House is a semi-private rehabilitation clinic in Auckland Park that offers short and long-term in-patient care, as well as an aftercare service. Phoenix House was first approached telephonically and after an interview, where the nature and aims of the study were discussed, verbal and written permission to conduct the study was granted by the management of Phoenix House. When appropriate and willing candidates were admitted into the clinic, I was contacted telephonically by one of the resident psychologists. A convenient time for the interview was then arranged.

3.3.2 Selection criteria of participants

Due to the exploratory nature of the study, there were very few inclusion and exclusion criteria.

The first criterion was willingness. Only participants who agreed to participate in the study were used. Written informed consent was gained.

The participants of the study consisted of cocaine and heroin users who attended the in-patient rehabilitation programme at Phoenix House, who have been through a rehabilitation process before and who are currently at Phoenix House or in the aftercare programme due to a relapse.

The number of participants was determined by the number of interviews that it took to reach a satisfactory point of saturation – the point at which little new information was being gained from interviews and the research question was satisfactorily answered. Participants ranged in age from 20 – 35. Both males and females were used. The number of previous relapses was noted, but did not serve as an exclusion criterion.

Any cocaine or heroin users with an underlying organic condition that influences insight, judgement, impulsivity and behaviour inhibition, for example, mental retardation or epilepsy, were excluded from the study. Other underlying psychopathology was observed in some of the participants. This was noted but did not serve as exclusion criteria, due to the fact that most substance dependent individuals have other co-morbid psychological disorders. It was necessary for the researcher's discretion to be used and one interview was not included in the study due to the fact the underlying Axis II condition, borderline personality disorder, present in the interviewee seemed to distort the interview content and process.

3.4 THE DATA COLLECTION PROCESS

Once the researcher had been contacted with regards to an appropriate and willing candidate, which in the cases of recent admissions was at least two weeks after their admission to reduce the influence of physical withdrawal symptoms on the user's ability to be interviewed, and a time was arranged, the researcher personally interviewed each participant, one-to-one, at Phoenix House.

The nature and aims of the study as well as the method to be used were explained verbally to each interviewee by the researcher and a written copy of their rights with regard to their participation in the study was provided. The researcher's telephone number was also provided should any questions or discussion after the interview be required. Confidentiality was assured and then written consent was gained from each participant for the interview to be recorded on audiotape and for the information to be used.

In order to gain richer information, the researcher engaged in some informal discussion with each interviewee before the interview proper was begun. In this time limited but contextually important biographical information was gained and the interviewees had an opportunity to ask any questions and discuss any concerns they had. This helped to put interviewees at ease and aided in establishing rapport.

The data collection technique that was used was that of a semi-structured interview, consisting of open-ended questions. Certain questions were asked to all participants along various broad themes relevant to the topic (see paragraph 3.2.3), but some adhoc questioning at the interviewer's discretion was also used to explore various answers or 'meanings' more fully.

The interview style conformed to the characteristics of a qualitative research interview as described by Neuman (1997):

- the beginning and end of the interview are not clear

- the questions and the order in which they are asked are tailored to the participant and the situation
- the interviewer shows interest in responses and encourages elaboration
- it is like a friendly conversational exchange, but with slightly more direction from the interviewer
- it is interspersed with jokes, asides, stories, diversions and anecdotes, which are recorded
- open-ended questions are used and probes are frequent
- the interviewer and participant jointly control the pace and direction of the interview
- the social context of the interview is noted and seen as important for interpreting the meaning of responses
- the interviewer adjusts to the participant's norms and language usage

All in all, nine interviews were conducted over the course of approximately four months, and eight were eventually used. The interviews were on average about an hour long. After the interview, the researcher queried the participants' experience of the interview and any problems or difficulties were addressed. Some interviewees expressed the fact it was emotionally difficult for them to discuss these issues in length, but all experienced the interview as an overall positive experience. A few of the interviewees stated that they hoped their participation would assist others in the future and expressed appreciation for the researcher's interest in the subject.

The interviews were taped and later transcribed by the researcher. The benefits of the researcher transcribing the interviews was that it allowed the information to become familiar quicker. Also, subtle information contained in the interview, for example, the significance of a long pause, a sigh or quiet laugh, was not lost, as might have occurred if an independent person transcribed the information.

3.5 DATA ANALYSIS

Kvale (1996) states that in qualitative research, analysis and interpretation begin at the start of the research process and are not confined to the formal analysis stage of the process. Thus analysis was already occurring when the researcher began reading relevant literature, during the interviews themselves and during the process of transcribing the interviews. However, the formal analysis was conducted according to the seven steps outlined by Kvale (1996). Although this analysis entails a number of identifiable steps, they overlap and thus may not be carried out in a specific order.

Step 1: Orientation to the Interview Protocols

The interviews were each transcribed as soon as possible after the interview itself and then read through a few times. Each time a new interview was transcribed the others would be re-read. This allowed for the researcher to become familiar with the material and the information it contained. The time between readings allowed for new ideas and ways of thinking about the material to emerge.

Step 2: Meaning Units

Concurrent with conducting the interviews, the identification of meaning units began. These meaning units took the form of words, phrases or paragraphs. According to Krippendorf (1980) the units themselves and their meanings are not absolute as they emerge in the interaction between reality and the observer.

Step 3: Developing Experiential Categories

In this stage the meaning units are grouped into categories according to similarities and differences. According to Aronson (1994): "All of the talk that fits under the specific pattern is identified and placed with the corresponding pattern" (p. 2). Defining each theme or category aided in deciding whether a meaning unit belonged in the category or not.

The experiential categories that were common to most protocols were used and were eventually then combined or grouped together to form a set of broader categories or themes. Themes are identified by "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (Leininger, 1985, p. 60). Although the uniqueness of each participant's experience is acknowledged, there were shared experiences that formed themes that ran through most protocols. According to Aronson (1994) themes that emerge from the interviewees' stories are then pieced together to form a comprehensive picture of their collective experience. The "coherence of ideas rests with the analyst who has rigorously studied how different ideas or components fit together in a meaningful way when linked together" (Leininger, 1985, p. 60).

This stage is also referred to in qualitative research as induction, where concepts are inductively developed from the data and then raised to higher levels of abstraction where the inter-relationships between the concepts are ascertained (Kelle, in Punch, 1998).

Step 4: Establishing Stability

In quantitative research the concept of reliability is important. Stability is the equivalent of this concept in qualitative research. In this study, stability was established by repeating the grouping process described in Step Three after a period of time has lapsed. After the initial process of identifying meaning units and grouping them into categories there were forty categories. These were then grouped into twelve broader categories. After collaboration with a colleague, this was reduced further by combining a few of the themes into new categories of experience and by subsuming some of the themes into already existing categories. Eventually the process of analysis settled on eight overall themes. These eight themes are described in Chapter 5.

Step 5: Establishing Credibility

Internal validity is the term used in quantitative research to measure the extent to which a study studies what it set out to. Credibility is the term used for this in qualitative research and refers to the correspondence between the way in which the participants perceive certain issues and the way in which they are portrayed in the study (Mertens & McLaughlin, in Muir, 2000). Credibility is most often established by involving the participants in various stages of data collection and analysis to clarify their 'meanings' (Kvale, 1996). According to Aronson (1994):

> "When gathering sub-themes to obtain a comprehensive view of the information, it is easy to see a pattern emerging. When patterns emerge it is best to obtain feedback from the informants about them. This can be done as the interview is taking place or by asking the informants to give feedback from the transcribed conversations" (p. 2).

In this study the former method was used and the researcher used the interviewees' feedback, reflecting back in the course of the interview, to clarify their 'meanings' as well as establish the next questions in the interview.

According to Stiles (1993):

> "By revealing rather than avoiding the investigator's orientation and personal involvement in the research and by evaluating interpretations according to their impact on readers, investigators and participants, qualitative research shifts the goal of quality control from the objective truth of statements to understanding by people" (p. 593).

This statement highlights the issue of reflexivity, which can be maintained by the researcher by acknowledging the preconceptions he/she brings into the project with him/her and by looking at the data and its interpretation for competing conclusions (Malterud, 2001).

Step 6: Developing Descriptions within the Categories

Although this process began formerly at this stage, it had already informally begun with the development of definitions for the various categories of experience in step 3. However, once the eight categories were decided upon, the researcher went back to the original protocols repeatedly to ensure what was being described was still representative of what the interviewees had said. The meaning units and categories of experience that fell under each broader category were looked at separately and together and detailed descriptions of each category resulted.

Step 7: Discussion of Results

In this study, the results are written up in two stages. In Chapter 5 the themes and an integration of the themes are given with attaching as little as possible theory to them. Although some theory was used to provide definitions of the themes, the researcher felt writing up the results first, before attaching theory would aid in keeping them as true to the interviewees' experiences as possible. Chapter 6 provides an integrated discussion of the results including relevant theory. This also then retrospectively aids in building a valid argument for choosing the themes. According to Aronson (1994):

> "This is done by reading the related literature. By referring back to the literature, the interviewer gains information that allows him or her to make inferences from the interview or therapy session. Once the themes have been collected and the literature has been studied, the researcher is ready to formulate theme statements to develop a story line. When the literature is interwoven with the findings, the story that the interviewer constructs is one that stands with merit. A developed story line helps the reader to comprehend the process, understanding, and motivation of the interviewer" (p. 3).

In qualitative research, this process is also known as deduction. This is a necessary process as according to Kelle (in Punch, 1998): "theory generation involves theory verification as well" (p. 201). Thus, in conclusion, according to Kelle: "qualitative data analysis is a series of alternating inductive and deductive steps, whereby data-driven inductive hypothesis generation is followed by deductive hypothesis examination, for the purpose of verification" (Punch, 1998, p. 201).

3.6 CONFIDENTIALITY

In order to avoid breaking confidentiality and due to the length of the interview transcriptions, an example of an entire protocol is not provided. Using excerpts from the interviews is considered less exposing and effectively demonstrates the themes discussed.

3.7 CONCLUSION

This chapter provided a detailed explanation of the research method chosen for this study, the motivation for this and the theoretical approach within which this research method is embedded. The steps of analysis were also described at length. The following chapter presents the results of the study and descriptions of the various themes.

University of Pretoria etd – Bain, K A (2004)

Chapter Four

RESULTS OF THE STUDY

Forever and forever in our loneliness, shameful feelings of inferiority will rise up suddenly to overwhelm us in a poisonous flood of horror, disbelief, and desolation, to sicken and corrupt our health and confidence, to spread pollution at the very root of strong, exultant joy.

Thomas Wolfe

4.1 INTRODUCTION

In this chapter the results of the study are presented. They are discussed under eight themes, two of which integrate six other themes, but which occurred in the interviews as themes in their own right. Very little theory is integrated into the findings at this stage, in order for the reporting of the data to remain as true to the raw data as possible, however, due to the nature of qualitative analysis, some interpretation by the author was unavoidable.

4.2 THE PARTICIPANTS IN THE STUDY

There were eight interviews that were used in the study. All eight interviewees were either in the Phoenix House in-patient treatment programme or the aftercare programme after in-patient treatment at the time of the interview. All had been through a treatment programme previously and had relapsed. All participants were interviewed within a period of approximately four months. All the names have been changed to ensure confidentiality.

Anand

The first interviewee was Anand. He is a 29-year-old crack user who is married and has a two-year-old son. He was a successful businessman who had been using for about a year. After attending the Phoenix House in-patient treatment programme, he was clean for about three months when he relapsed. He then returned to Phoenix House. His father was an abusive alcoholic and Anand spent his high school and university career working part-time to support his mother. He paid for his younger brother to attend university. He was interviewed while in the Phoenix House in-patient programme.

Jason

The second interviewee was Jason, a 31-year-old crack user. He had been using for about three years. He attended an in-patient treatment programme in Cape Town and was clean for almost six months when he relapsed. He had tried to stop using twice before alone and relapsed both times. He was previously engaged and has a son who is almost one-year-old. He has been employed throughout his using, working part-time in sales. His parents divorced when he was very young and his mother remarried. He describes the relationship with his mother and stepfather as good. They live overseas. He describes his relationship with his biological father as a respectful friendship. He has one brother who he doesn't see often as he does not get along with his sister-in-law. He also has two half-brothers who are also overseas. He was interviewed while in the Phoenix House in-patient programme.

Daniel

Daniel was the third interviewee. He is a 30-year-old heroin user who is divorced. He used for about six years before attending the Phoenix House rehabilitation programme. He was clean for 18 months before relapsing. During the 18 months, he joined the family real estate business. He has a six-year-old child. After leaving rehab he lived with his brother until his brother also started using heroin. This he believes triggered his relapse. He was interviewed while in the Phoenix House in-patient programme.

Natalie

The fourth interviewee was Natalie, a 21-year-old heroin and cocaine user. She states however that heroin is her drug of choice. She had been using for about five years. She attended the Phoenix House in-patient treatment programme and relapsed about two weeks from the end of the programme. She left the programme and managed to stay clean for a few months before relapsing again. She then attended the in-patient treatment programme at Phoenix House again. She has been clean for almost 21 months and was interviewed while still in the aftercare programme.

Roger

Roger was the fifth interviewee. He is a 23-year-old production manager who has been using heroin and cocaine on and off for about five years. He also states that heroin is his drug of choice. He spent approximately a year in prison during this time, during which he did not use heroin. However, he returned to it weeks after being released from prison. After attending a treatment programme he went overseas and he did not use there for about a year. Upon returning home he relapsed. He was in the Phoenix House in-patient treatment programme when he was interviewed.

Mark

The sixth interviewee was Mark, a 29-year-old restaurant manager. He has been using cocaine and heroin for about seven years and has attended nine rehabilitation clinics. He tried to stop twice on his own and has thus relapsed 11 times. He started using cocaine and then began using heroin to bring him down so he could sleep. Heroin is his drug of choice. He has had one long-term relationship during this period with a woman who also uses. He felt forced into his second last rehab programme by his parents because the police were watching the restaurant from which he was organizing deals. He relapsed very soon after leaving. He was in the Phoenix House in-patient treatment programme during the interview.

Desiree

Desiree was the seventh interviewee. She is a 35-year-old black woman originally from Mozambique. She is married and has two children who live with her mother. She has been using cocaine and heroin with her husband for about 12 years. She worked as an accountant until 1996. She attended a previous rehabilitation clinic and has stopped in hospital before, relapsing each time soon after returning home. Her husband uses alcohol and becomes abusive at times. Her husband was in a different rehab, while Desiree was in the Phoenix House in-patient treatment programme at the time of the interview.

Anton

Anton was the last interviewee. He is a 32-year-old restaurant manager. He has been using for the past 17 years: crack for the past ten years and heroin for the past four years. He has never been married but has a twelve-year-old daughter. He attended the Phoenix House rehabilitation programme but relapsed about three months after leaving. He was once again in the in-patient treatment programme at Phoenix House at the time of the interview.

4.3 CONTEXT OF THE INTERVIEWS

The systems approach and qualitative research both emphasize the importance of context in the research process. Edwards (in Zinberg and Shaffer, 1985) states that it is impossible to understand substance abuse if it separated from the social matrix in which it occurs. Thus, it is necessary to acknowledge the impact of the interview setting, the approach of the rehabilitation clinic, the interviewer's experience of the research process, and the interviewees' life circumstances.

4.3.1 Phoenix House and the 12-Step approach

All the interviews were conducted at Phoenix House with seven individuals who were currently undergoing in-patient treatment after a relapse following previous treatment, and one individual who had completed the in-patient treatment programme after a relapse and was in aftercare. This allowed for clearer memories of the relapse, while the fact they had previously undergone treatment implied an increased amount of insight into the process of relapse.

The interviewees were all in treatment for at least two weeks before the interview occurred to prevent any physical withdrawal symptoms from interfering in the interviewees' ability to remember the process of their relapse and their ability to

participate in an interview. The fact that all the interviewees were undergoing treatment at the time of the interview also provided a therapeutic support system if any of the interviewees experienced negative consequences from the interview.

Although Phoenix House uses a variety of therapeutic techniques and perspectives in their treatment programme, the treatment is based predominantly on the 12-Step approach. This is most likely because traditional approaches to substance abuse treatment have tended to advocate working the 12 steps of programmes such as Alcoholic Anonymous or Narcotics Anonymous as the preferred method for all patients (Rotgers, Keller & Morgenstern, 1996).

Precise definitions of 12-Step theory are difficult to find as the literature does not lend itself to unambiguous interpretation and the various programmes based on this approach tend to vary in terms of how concepts are defined and applied (Wallace, 1985). However, it is possible to determine a few common characteristics.

4.3.2 The 12-Step approach, the disease model and the biopsychosocialspiritual model

Although the 12-Step approach subscribes to the disease concept of addiction, seemingly aligning itself with the medical model, its actual approach to the origin, maintenance and modification of substance dependence is that of a biopsychosocialspiritual model of addiction (Wallace, 1985).

Although the ideas of genetic determination or influence are included in some disease models of addiction, the focus in the 12-step models is usually more on the biomedical consequences of substance dependence. As Wallace (1985) states: “Whether or not one

believes in biological etiological factors is simply irrelevant in many practical treatment contexts" (p. 15).

The 12-Step approach focuses on the negative biological, psychological, social and spiritual consequences of substance use, which in turn leads to further distress and then further substance abuse. This model of treatment attempts to interrupt the vicious cycle associated with these consequences (Wallace, 1985).

Within the biological dimension, this vicious cycle consists of: positive reinforcement from initial drug use, chronic use then resulting in abnormal changes in brain chemistry, which then leads to negative changes in mood, and affective and cognitive states. Due to the fact that the users remember the initial positive reinforcement, they then resort back to the chemicals to change the negative affective and cognitive states (Wallace, 1985).

The psychological dimension can be seen with regard to the negative affective and cognitive states induced by the substances. Although depression and anxiety are usually the result of substance abuse, they could also have preceded the use of substances. According to Wallace (1985), other negative psychological consequences of substance abuse and dependence include:

> "…low self-esteem; anger; grandiosity; resentments towards others; repressive defences including denial, rationalization, assimilative projection, minimization of difficulties, avoidance of feelings, and resistance to feedback from others about self; hostility; excessive self-pity and sensitivity; lack of self-confidence; low frustration tolerance; and fears of various kinds" (p. 17).

These negative psychological consequences also enter the vicious cycle, maintaining the very behaviour that gave rise to them (Wallace, 1985).

The social dimension consists of a variety of social problems that develop due to heavy use. Intimate interpersonal relationships deteriorate as well as the skills these people have to address relationship problems. The families and loved ones usually also become tangled in the web of addiction, developing patterns of interaction that serve only to worsen interpersonal conflict. For this reason, the 12-step method encourages the involvement of families in the treatment process. Users also experience career difficulties, problems with the law, decline in social status and role identity confusion (Wallace, 1985).

According to Wallace (1985), the spiritual dimension of users is also negatively impacted by substance use and tends to: "…culminate in intense feelings of alienation, apartness, emptiness, meaninglessness, and lack of purpose in living" (p. 19). Moral values are also compromised, a lack of goals results in directionlessness, and a sense of despair is experienced (Wallace, 1985).

4.3.3 The influence of the 12-Step approach on this study

The issue of powerlessness is prominent in this treatment method and can be seen frequently in the interviews. The first step in the programme is for the users to acknowledge their powerlessness over the substance. Although concerns may be raised about the influence of this step on the users' general sense of powerlessness in their lives, which was a theme that emerged from the interviews, the 12-Step approach addresses this, stating there is a difference between powerlessness and helplessness. Admitting that they are unable to control their substance use and that they have a disease does not render them helpless or no longer responsible for their actions, but assists them in taking responsibility for the management of their illness. This can be empowering as it also allows for the process of recognition, identification and acceptance to occur. Due to denial, rationalization and minimization most users cannot acknowledge that they have a problem, which prevents them from receiving the correct help (Wallace, 1985). Thus feeling generally powerless is different to being powerless over a substance.

This issue of powerlessness is also associated with the spiritual dimension of the 12-Step approach. The second and third steps encourage users to give their will and lives over to a power greater than themselves. Although the religious element in this has been widely criticised, according to Wallace (1985):

> "Twelve-Step fellowship programs neatly dodge thorny problems here simply by defining the AA group as a power greater than self. There is a certain cunning in this position because the problem is not that addicted people need to find a conventional god but that they need to give another approach a try. In AA terms, they need to 'get out of the driver's seat'. Left to their own devices, many addicted people fail again and again but still keep returning to the belief in their own willpower as the means to conquer their addictions" (p. 27).

Whether these steps encourage users to partly give up their responsibility for their lives and actions is debatable on many levels.

Awareness, self-examination and self-criticism are also encouraged in the 12-Step approach. Although self-criticism could be viewed as exacerbating an already existing problem, it is coupled in this approach with techniques for making amends, thus decreasing guilt and shame and allowing for reparation. Increased awareness about themselves and their relapses is fostered in these programmes, which was beneficial for the study as it allowed richer information to emerge.

Although this model brings attention to the factors involved in changing the behaviour of substance dependent people by addressing the multiple factors that maintain this behaviour once it has begun, it does not address the important but complex question of etiology (Wallace, 1985). However, as a treatment programme it has shown reliability and effectiveness.

4.4 CONTEXTUAL FACTORS IN RELAPSE

4.4.1 The family situations of the interviewees

Although the family situations of each interviewee were unique, some similarities were noted. Firstly, a history of alcohol abuse and physical abuse was common in many of the families. Anand states: "Uh…there was my dad…he was an alcoholic. He drank a bottle of cane and then beat my mom up every Saturday and Sunday. Needless to say he brought in no income or very little. My mom had to go and work when I was probably five years old…it was when I started school and uh…that's my life. I started working at the age of 12. I used to get home from school, go to work, come home. That was my life…" Roger's father is also an alcoholic: "Ja…sure…big time…everyone is like…okay, my father himself is an addict…well, he's an alcoholic, so…and he's still like in the denial thing…so, I suppose he really wants it bad for me as well because, um…he probably knows that it…what addictions do…I mean he's been an addict for what…30 years or something, you know…".

Secondly, as a result of substance abuse in the family a few of the families had been broken through divorce and death. Desiree explained about the death of her brother: "…you see…so it's a big problem…my brother he was also a drug addict…he killed himself…" Jason mentioned his parents divorce when he was very young: "I mean, my father was divorced…my father was an alcoholic, ok, and he left my mother when I was very young…about one…and she remarried and…to my stepfather who is now…I consider my father…" Jason currently reports that his relationship with his biological father is not very close.

Thirdly, all the interviewees reported a difficult relationship with at least one parent. Anton states: "you know my last few sessions in therapy we kind of scratched on the issue of my mother…and what happened to me growing up…and my relationship with her…but…ja, actually, I know it has something to do with this…but I don't know what it was that happened to me that caused it…I don't know…". Mark also explained his poor relationship with his parents: "I'm angry with my parents, my ex-girlfriend, my friend for killing himself…but what's underneath that I don't know…maybe I was angry with my parents for not giving me enough attention as a child or…I'm not sure…"

These circumstances imply that during childhood the participants in the study experienced at least one parent as being either physically or emotionally unavailable. For Anand this resulted in a feeling of being detached from his family:

> "I go to counseling and the issue has come up…that I felt severed, you know…I had a really sh…terrible life as a child…um…right up to the time when I finished university I worked, you know…it's almost like I took on responsibility at the age of 12 years old…for my family at home. I came home from school, went to work, came home. There was no time for friends at that time and this happened throughout my life. You know when I was at university I was staying at home… my whole life was just hectic, you know."

Feelings of rejection and abandonment also appear to be common for users in relation to their families. This can be seen in a statement made by Anton: "…the woman who is paying for me now…is my ex-stepmom…her and my dad got divorced when I was 16, but I kind of kept in contact with her…even though things between me and her weren't good in the beginning…I think at one stage my dad even kicked me out of the house…but I saw her a few times since then and I still see my brother".

Feelings of distance and loneliness also seem to characterize family relationships. Jason states: "My brother, my parents are overseas, they live over there…my brother stays not

too far from here in Joburg North…um, I don't know, I don't see him often…I don't really get on with his wife…a clash of personalities…call it that".

Roger explains the way substance use helped him to escape the pain associated with his childhood: "…I mean I'm the only child and my mother and father are divorced and you get these abandoned feelings and all that comes with it…like some serious, serious shit, you know…and many others come with it …especially if your father's an alcoholic…now these friends of mine in the old playground that I used to live in…half of them…their parents…both…they lost both their parents…ja, um…or their parents are divorced…the majority of the people's parents are divorced and they had a shit childhood…so they like take anything to take it away…drugs, pills…you know, at least if I take my heroin then everything's alright…I don't need nothing…don't need nobody to talk to about what my problems are and all that bullshit…I feel fine…"

However, the interviewees are not merely victims of traumatic childhoods. Their substance abuse also plays a role in the abandonment they perceive from their families and seems to perpetuate their own rejection. As Daniel states: "Ja, definitely…the people who love you…those are the ones taking the real strain. And you keep throwing it up in their face 'cos you go back and you steal from them and you lying to them…its one vicious terrible circle. They start rejecting you and you get angry and you go use more…put more into the needle…you smoke more…that's how these people land up killing themselves. Probably a lot of them from rejection from their families…no one caring about them anymore…no-one to fall back on…so they land up killing themselves."

The users' substance dependency also plays a role in their feelings of distance from their families. Desiree explains: "Yes…because we…you see, our lives for the past years…they were not great…'cos drug users…have no friends…they don't read newspapers…they never know nothing…so we are just alone together all the time…old friends were not a part of our lives…and family…we were never able to be with them, so…me and him…always…all the time…it is hard not having my family around…and

you know my mother says I can come back to the family but I must leave my husband…I don't know…"

Anton also explains the way his substance use contributes to poor relationships with his family: "…but like the last ten years I have been drugging purely on guilt…and that of course is like a cycle…the more you drug the more guilt you feel…it's a dangerous place for me…going to my family and their sympathy for me…'cos they just want to help me and then I steal from them…and you don't feel too good about yourself…and then of course you use more…" This comment also highlights the intense guilt users end up feeling in relation to their families. Jason also mentioned feelings of guilt and explained how it exacerbates his substance use: "That you've let yourself down, my family down…I put my family through hell through all the years that I've been using and…that I've let them down, I've let myself down…it's um…it's so, so overriding…that's what makes…that's the difference between a slip and a relapse." Anand also explained his feelings of guilt after he relapsed: "Uh…basically that my wife…I don't deserve my wife. I don't deserve my child. I don't deserve the life that I've got, you know…"

Although most participants stated that it was futile blaming their childhoods for their substance abuse problem, a few of the interviewees expressed a wish that their childhoods could have been different. Anand states: "But in saying this you know, I can't blame that on my youth, it's not…there again I wish my life was more normal, sure ja…but I'm trying to change my behaviour…you know I used to have a huge problem saying what I just said to you now. I would never say it to anyone. I would never feel comfortable saying that my dad came home and beat my mom up. I was always too ashamed of it." Roger expressed a similar notion: "You know I'm not responsible for my childhood but I had to learn to deal with it…I mean…people made you feel like this but you have got to forgive them…but you got to forgive yourself first…and just like live on…"

In conclusion, the family situations of the participants seemed to be characterized by difficult relationships with at least one parent, a family history of substance abuse,

physical abuse, divorce and distance. The result of this seems to be that on the whole the users experience their families as emotionally and sometimes even physically unavailable. Feelings of rejection, abandonment and loneliness were common in relation to their families. However, their substance abuse seems to perpetuate this pattern of relating, often exacerbating it with intense feelings of guilt they experience with regard to their families.

4.4.2 Social situations of the interviewees

While using, the alienation users experience from family seems to extend to relationships with friends. Often avoiding friends who do not use, for reasons ranging from guilt and fear of interference to feeling misunderstood and a sense of not belonging, the relationships they have with other users tend to revolve around seeking, attaining and using substances. Jason explains this in more detail:

> "I can be with a bunch of friends and still be lonely, um…it's not…just because I've got people around me means that I'm happy, entertaining, uh…it's…no-one else can understand what I'm going through, they don't unders…they just don't really have any idea of what my life is like. They…you can speak to them and tell them things and they…they can't quite relate. A lot of it's my own… I am lonely sometimes because I do tend to isolate myself and push people away…people who I feel are getting too close to discovering that I, you know, use drugs or that they will get in the way of me using drugs or that they will just compromise my lifestyle in some sort of a way…and that does…um, I'm selective, I mean I will want that person to be my friend, you know while I'm using there, there, there, but after that, you know, there's it…just be on your way, you know and then I'll phone them up and say 'listen, let's go out, do this, that, that, fine…kind of…for my own selfish…it's a very selfish thing this…this whole disease."

Despite the fact some of the interviewees report feeling a sense of belonging amongst other users, due to the fact they feel they have the same types of problems in common, the quality of these relationships can be questioned in terms of emotional support and genuine relatedness. Thus, this leaves users living a largely isolated lifestyle in which feelings of abandonment and loneliness predominate. Mark also commented on the isolation of substance abuse: "…you know there was originally a big group of us…now most of them are dead…so it…starts off quite socially but then degenerates into a very solitary kind of thing…"

In terms of intimate relationships, the participants also related problematic patterns of interaction. These relationships seem to be characterized by physical and emotional abuse as well as substance abuse. Desiree has been in a marriage, during twelve years of which substance abuse has played a role. Her husband is a physically abusive alcoholic, but when he uses heroin he doesn't drink. She feels she cannot leave him. She commented on the abuse: "…and it confused me 'cos he is such a nice guy…so nice and so gentle and it confused me…and the next day after he hit me or cut my finger with the knife or something…he will cry like a children…when he drinks something happens to him…he is so angry…with the heroin it was not like this…" Mark was involved in a long-term relationship which broke up due to his heroin use, about which he reports he is still extremely angry: "…and it was weird we started using together and then broke up over it… I was doing very well…I was confident in myself…it was just a lot of anger towards her…it was just the situation 'cos I still have big hang-ups with this woman and uh, she came back and …I was just really angry. I know I have a lot of anger inside me and I don't like people seeing that part of me and heroin flat lines me, so I don't snap…"

In both these relationships, substances seemed to mask a great deal of the emotional pain and anger and actually seemed to help maintain the relationship for a while. However, ultimately the substance use seems to contribute to the problems in the relationships, making worse problems than the ones it was originally masking.

For other interviewees, intimate relationships play a similar role to substances in their lives. Sex and relationships are used in an attempt to compensate for feelings of inadequacy and to distract from their own pain. They seem to play out original trauma over and over. Anton states:

> "…I definitely need affirmation from women…it's a major thing for me…I don't know where that came from…sex and relationships are my primary addiction…I don't know if I use drugs to get away from that or what…because especially when I am not using…I will gravitate toward women who are addicts…and I try and rescue them or I don't know what…"

Mark also reports a similarity in the way he perceives relationships and substances, in that he reports attempting to remove a feeling of emptiness with a relationship or heroin:

> "…it was because I didn't have a relationship at that stage…and that was the hook, the heroin took away the pain…maybe I'm craving a relationship or something because when I did break up…there was a huge gap that I had to fill…and heroin filled it…so there is some aspect where I think I need a relationship or loving from someone else…um, I struggle to be by myself and encourage myself…I struggle to tell myself I am a good person…"

Some of the other interviewees reported ending intimate relationships due to the expectations and responsibility they entail. Jason explains why he left his fiancé: "I walked out when she was two weeks pregnant and I left her…I walked out because of my using. I just didn't really find time to have a relationship and I just felt I had all these expectations on me…where do I fit in?" It seems as if the substance abuse allowed some of the participants to avoid responsibilities they felt they could not handle. Anton also mentioned this: "You know what I really miss about the drugs…or what I really loved about the lifestyle was the irresponsibility of it…not having to get up in the

morning…you can go buy rocks at five o'clock in the morning and smoke them till 12…not having a place to be…"

Thus, while alienation and a sense of superficiality seem to characterize the majority of the participants' friendships, their intimate relationships seem to contain a borderline-type of relating, which consists of confused boundaries and a desire to 'fuse' to remove feelings of emptiness and loneliness on the one hand, and a great deal of anger and fear of being overwhelmed by the expectations and responsibilities that relationships entail on the other hand. This fear manifests as distance in their experience of themselves and others.

4.5 THEMES AND SUBTHEMES IN RELAPSE

4.5.1 Introduction

There were a vast number of topics that repeated throughout the interviews, but the following discussion focuses on the themes relating to the experience of relapse and the context within which it occurs. This discussion attempts to report the data as accurately as possible as it presented during the interviews, however, due to the author's psychology background it was unavoidable that some interpretation would occur while reporting. In order to keep the data as close to the participants' own experiences as possible, these themes are only attached to theory in the next chapter.

Also it is important to note that all of the interviewees have been through various therapeutic processes prior to the interview and thus many of them display a great deal of insight into their own emotional processes and into the process of relapse. Using participants with insight into their own relapse process has helped to gain richer and more detailed information, however, it has resulted in what at times appear to be contradictory statements. Through various therapeutic processes much more of their experience has become conscious. A consequence of this is that it can appear that certain aspects of the experience of relapse are more conscious than they actually were at an earlier stage and

prior to their relapse and readmission to Phoenix House. Also, some of the data illustrate a number of the themes, thus some repetition is inevitable.

4.5.2 Control and Powerlessness

Definitions of control include: "to have power to direct or regulate; exercise authority over" and "to hold in check, curb, restrain" (Halsey, 1979, p. 220). Powerlessness is defined as "lacking the ability or authority to do or effect something" (Halsey, 1979, p. 786). Although more formal definitions of control state that control is experienced when the outcomes of various situations are determined by one's own actions, for the purposes of this study this definition is extended to include a subjective feeling of 'manageability', which is a feeling of coping or 'not being overwhelmed'.

Most of the interviewees describe a sense of powerlessness or 'trappedness' in their lives. They seem to experience their emotions as overwhelming and they describe feeling 'out of control'. The use of substances initially seems to offer them the promise of control, but eventually also becomes 'out of control', leaving the users more powerless than ever.

Anand explains how overwhelmed and confused he felt in the three months he was clean before his relapse:

> "Uh…it started becoming hectic. I would have mood swings…I would go home and be terribly upset about nothing. I would be upset with my wife. I'd be upset with my son. And uh…just trying not to talk as much as I used to talk…and I'd try and avoid them…a lot of confusion in my head…"

For most of the interviewees, emotions are extremely uncomfortable and daunting. They threaten to overwhelm and become out of control – a situation the users seem to fear, because the 'out of control' emotions tend to lead to 'out of control' behaviour. Mark explains: "…like I've trashed a whole house before when I've lost my temper and when I had it under control again I was actually shocked what I did to this house…every

room…and I'm really scared of that. The drugs control it…but then it also makes it worse."

There also seems to be a distinction between internal and external control. Although the interviewees seem to experience being 'out of control' within themselves and also the external world as uncontrollable, they seem to place a great deal of their 'control' outside of themselves i.e. externally, in order to gain control internally. Although 'The Addict' within (see paragraph 4.5.4) is experienced as having control, this is an aspect of the self from which they are separated. Externally, firstly, the substances are perceived as having the ability to control them, influencing the presence or lack of emotions and thereby their behaviour. Sadly, this process eventually leaves them feeling less 'in control'. Also, the users attempt to place control in others, for example, parents and a higher power (see below), in an attempt to gain a feeling of control within themselves. Again however, it seems due to unresolved feelings of perceived abandonment and mistrust as well as at times an actual inability on the part of others to provide this sense of control, the interviewees feelings of powerlessness, helplessness and lack of control can be exacerbated.

This process of placing 'control' in the hands of others external to themselves highlights the important balance 'sponsors' from Narcotics Anonymous need to achieve. The concept of choosing a sponsor – someone who has been through the process him/herself, to check in with and to phone when necessary – is an excellent method for creating support structures for recovering addicts, but one that needs to be carried out with care. Attempts to externalize all control seem to exacerbate the interviewees' experiences of powerlessness.

The method of externalizing control through the use of substances initially seems to offer some degree of control over unbearable and frightening feelings. Mark states: "…I was always just comfortable when I was on heroin…no-one could piss me off…I was just very quiet. I could deal with my emotions." Roger agrees: "I'm angry…I think that's why I was…I went and I was drinking 'cos I just wanted to like kill those things…'cos

alcohol also just like helps you to manage your daily life…to deal with that problem, you know."

It seems as if the use of substances offers an escape from a situation that feels intolerable and so the use of substances appears to be a means of control over their emotions. By 'removing' their emotions, which they experience as chaotic, they experience a degree of control over themselves. Anand explains:

> "Just the high that it put me on. And…ja. I can't even tell you that it was the company I was with because I wasn't with anyone…you know. I just smoked on my own. But it was just that high…that feeling of…of freeness. You know I felt trapped at home…like the walls were caving in on me…uh...ja it's…uh…it's a confusion…but very unpleasant confusion…"

For a while the users feel they can control their use of the substances. Mark states "…I mean I knew heroin was the bitch of all substances but at the time 'I was stronger'." However, this feeling of control over the use of substances, as well as the control offered by the substances seems to be an illusion and the use turns into abuse and then begins to exacerbate the very emotions they were intended to remove. Mark explains how his substance abuse started becoming a problem:

> "…ja, but I have used lots of excuses, emotional upsets, just that I have the money and lying to myself that I can have just one shot, using coke to go up and then needing the heroin to come down…and you really do think you can control it…you really do honestly believe your own bullshit lies…thinking you can control it, but you can't…it just gets out of control. For me now the psychological withdrawal from cocaine and the physical symptoms from heroin are so daunting I have to book myself into treatment…it's just like the withdrawal symptoms are terrible…and emotionally…'cos it suppresses all your emotions and when you stop it all starts bubbling up…all the things you've done…all the people you've hurt…so like the more times you

> relapse, the more rubbish you have to deal with…and it just gets more and more and more."

Once caught in the cycle of abuse, the theme of control seems to become even more complicated. Once the user realizes the substance abuse has become a problem and another aspect of their lives they need to control, feeling 'in control' becomes another reason to use. As Jason explains: "…on the one hand things are not going my way…that's an excuse to use…playing the victim or whatever the case may be…then on the other hand, things are going so well, I've got this thing waxed…it's under control, so let me go and use." So either way, the user is again trapped and powerless.

What initially starts out as something the users feel they can control becomes frightening. They begin to feel controlled by the substances and again fear being overwhelmed. Roger states "…'cos the stuff we were using was getting stronger and a couple of times I felt myself slipping, you know, where I don't want to go…and every time I would like come back again…like you feel yourself falling into a place where you haven't been and getting scared, you know…"

The substances begin to render the users completely helpless to the point their lives feel completely out of control and unmanageable. Anton states "…so as I said I have been using for 17 years and the first time I walked into a rehab was January this year because things had gotten to a point where they were unmanageable…because with the heroin I can't get up in the morning…previously, for years and years I smoked crack and I would get up and go to work…heroin changed all of that."

The substance abuse leaves them with feelings even more overwhelming than before that directly threaten their lives. Anand states "The down side to it is that you fall into a serious depression, you get suicidal…I get suicidal. I didn't want to go home and face my wife and kid. I couldn't. Rather kill myself…"

The substances become more and more powerful and leave the users more powerless than before. Daniel states "And you can't really help yourself…once you're a heroin addict there's no way you can help yourself. If you don't get help from somebody you're going to land up dead. There's no doubt about it. I've seen it happen too many times." Anand agrees: "It's just too strong. You can't fight it. It's like fighting with a knife against a machine gun, you know. It's powerful…it's really powerful. I was powerless over my addiction. I am still powerless over my addiction." And ultimately, the belief that they cannot control themselves is reinforced by the substance abuse. Each relapse seems to confirm to them that they cannot control themselves.

After relapsing, users are then faced with the daunting task of returning to where they were before the relapse to face the feelings they initially tried to escape, feeling more powerless than ever. Mark states: "…I don't know…maybe I am afraid of my emotions…I just don't know how to deal with them…which is maybe why I am here…to learn who I am…accept myself for what I am…" However, while on the one hand there is a sense of powerlessness that the users experience after relapsing, going into a treatment process seems to provide a sense of direction and empower the users. Roger also explains his process of learning to allow his emotions, instead of escape them: "…you know, I've got to learn that when something pisses me off I don't have to go and pick up…sit with that feeling…just understand that feeling and even if you just hold onto your chair or something, phone up somebody, speak to somebody, you know…you got to learn to like handle that feeling."

However this process seems to be extremely difficult, with users trying a variety of other means to control themselves and how they feel. A common theme was that of intellectualization. Many references were made throughout the interviews to the fact that 'if only they understood what was happening' or 'had more knowledge' they would cope better. Anand explains:

> "I didn't know how to cope with feeling this. I didn't know there were things I could do…because basically I didn't have any…any knowledge of

> what this drug actually does to a person…and that's it. And now I know a bit so maybe I'll be able to handle it a bit better. There's a lot of people out there who…uh…who if they had the right tools would know how to cope with the situation. I wasn't one of them because I wasn't in rehab for long enough the first time. I stopped cold turkey…you know, that's it, just stopped… and I didn't know how to manage…and I still don't even know if I do know how to manage…I know what to do now…that…you know…the advice is that you join NA…and uh…get a sponsor…and …things like that...but… I don't know if I get the feeling again…then, would I actually call my sponsor…you know? That's the question I'm asking myself now. Will I actually phone if I want to use?"

However, this cognitive process still seems to leave them feeling uncertain. Roger states "…but you know you have to be consciously aware of yourself all the time in everything you do 'cos the mind is so poisoned by the addict that lives inside of you…" This seems to be due to a lack of trust in themselves, their own minds and their capacity to cope with their own emotions. (The theme of trust will be discussed in more depth later in the chapter).

Others believe instituting rigid structure in their lives will help them to feel more in control. Roger says "…I've got to put structure and programmes in place to deal with all these things…" Another method of regaining control that emerged from the interviews was that of giving up control to a higher power. Roger says:

> "…because you have God in your life and he…he's going to control you because God is…God's great…God is amazing…I mean I saw myself a few times sitting and using and stuff and like praying and saying 'I don't want to go to jail again, please help me 'cos I don't know how to get out of it…show me little signs and things'. And He would but then the very next day I'm doing the wrong things again and praying…and then He would like show me again…some signs…show me like this is the way, you know."

The last and perhaps most desperate attempt to gain control is through suicide. This was a topic that also repeated often throughout the interviews, with many of the interviewees expressing the opinion that if they don't manage to stay clean this time, they will choose to overdose as a last attempt at regaining some form of control over their lives. Mark explains:

> "…it's gone too far…I figure if I relapse again…it's pretty much death…I can't afford another relapse…it just gets worse every time and the things you do…
>
> *Do you think your death will be accidental if you relapse again?*
>
> No…I think I'll probably choose…I know I'm going to be an addict for the rest of my life but I don't want to be a user…I won't allow myself to do that…"

Most 12-Step programmes for addiction involve acknowledging that you are powerless against your addiction and they encourage giving up control to a higher power. Although this is an effective method to interrupt the process of denial that the users are trapped in, assisting them to realize they have a problem, it has the potential to exacerbate the users' feelings of powerlessness and their tendency to locate their locus of control externally. This is a situation that would have to be carefully managed and balanced.

To conclude, the interviewees describe feeling overwhelmed and a sense of powerlessness or 'trappedness' in their lives. They seem to experience their emotions as overwhelming and they describe feeling 'out of control'. Some of them attempt to use defences like intellectualisation in an attempt to gain cognitive control of themselves, but this appears to result in more confusion. Thus experiencing themselves as unable to control themselves, there is a tendency for them to attempt to place this control externally, in others e.g. family and also in substances. The use of substances initially seems to offer them the promise of control, as it offers an escape from a situation that

feels intolerable. By using substances they initially appear to gain control over their emotions, which they experience as chaotic, i.e. by 'removing' their emotions. However, this process seems to compound their emotions, which inevitably return, more overwhelming than before. Thus the substance abuse eventually also becomes 'out of control', leaving the users more powerless than ever.

Thus, paradoxically, although relapse is experienced as a 'loss of control', the return to substance use seems to be an attempt to gain a degree of control over emotions that threaten to overwhelm. Although temporary relief is found, the longer-term result is greater feelings of powerlessness.

4.5.3 Trust

Trust is an exceptionally difficult term to define. Most formal definitions of trust tend to include the idea of predictability, however this needs to be accompanied by a sense of security. Halsey (1979) states trust is a "firm belief in or reliance on the integrity, honesty, ability or reliability, or justice of someone or something" (p. 1068) or "that which is believed, believed in, or assumed: confident expectation" (p. 1068). However, Halsey (1979) also states that trust, confidence and reliance are all characterized by a certainty that something will meet one's expectations but that "trust implies an absolute emotional security based on intuition and personal relationship rather than rational considerations" (p. 1068). Erikson (1968) also emphasised a sense of safety in his definition of trust, stating: "Trust is the expectation that one's needs will be taken care of and that the world and outer caretakers can be relied on" (p. 18). Thus, trust implies being able to rely or depend on someone.

The theme of trust recurred throughout all the interviews in terms of trust in themselves, their trust in others, other's trust in them and trust in God. Being able to rely on others and on themselves seems to be extremely difficult. Ironically though, it is only through dependence on a substance that many of these individuals realize the problems they have with the idea of dependence, on substances as well as on others, and trust. Daniel states:

> "…I felt scared…I felt really scared that I've got to go through this whole…lucky I knew I could rely on Phoenix House…well not rely…I knew I could come to Phoenix House for some help…otherwise I wouldn't have been able to handle it. It's a real scary feeling…really…it is…that you have to depend on something to get you through the day. It's a really scary thought."

It seems to be extremely difficult for many of the interviewees to trust themselves or to trust other people to help them, thus the idea of being dependent on someone else is frightening. Even the trust the users have in the substances to alter their mood and remove their emotional discomfort eventually fades and their fear of dependency becomes confirmed, as it becomes more and more uncomfortable in between use of the substance and ultimately almost impossible for them to survive without it.

Most interviewees expressed a lack of trust in themselves, on both cognitive and emotional levels. Anand states: "I strongly believe that …my mind…I cannot trust my mind anymore. I've been in treatment and you don't think it will happen…but I cannot trust my mind…"

This lack of trust in themselves was often related to the theme of 'The Addict' (see paragraph 4.5.4), where it is 'The Addict' inside that they cannot trust. Roger explained this with regard to the fact he feels when he leaves the Rehab he should not get a cell phone: "I can hear the addict inside telling me something about this cell phone… 'Hey you can do something with this, blah, blah, blah, blah' and then off I go again and all the lies start all over again…so I'm not going to give myself any more rope…no more slack, that's it…'cos I'm like on a tightrope…no slack. That's fine…just so I can start trusting myself and you know…have that confident feeling again."

With regards to emotions Anton states: "…it's kind of like I don't trust myself emotionally to see things through…like carrying on with the job and stuff…" Mark also

discussed his distrust of his emotions due to his inability to control them. He spoke about the problems he experiences with his aggression.

Roger also spoke about a sense of distrust in his bodily feelings. This is illustrated by his reaction to his body feeling healthy. After having been in hospital for four days with a lung infection, being treated for withdrawal at the same time he reports: "…the very same day I came out of the hospital I asked myself why am I feeling so lekker…and I looked at the tablets and then I knew…that's why I'm feeling so lekker so the only thing that was missing basically was that habit of smoking…so the very same day I went back to the stuff." He did not seem to trust that it was his own body feeling healthy and therefore good, demonstrating his belief that only substances or tablets can make you feel good.

Although, psychodynamically, trust is an issue from the earliest stages of life and is associated with the opinion that substance abuse is a problem of orality, most of the interviewees relate their lack of trust in themselves to their experience of relapsing over and over, proving to themselves over and over that they cannot be trusted. However Anton did express the opinion that each time he goes into rehab he feels he can trust himself a little more. This may relate to users' tendencies to repress a large part of their emotional life, resulting in it 'bubbling over', making their experience of themselves largely unpredictable and frightening. Uncovering this emotional life in rehab may assist the users to become more comfortable with various aspects of themselves. Thus, it appears that while repeated relapses give rise to a distrust of the self, rehabilitation programmes seem to offer users a chance to change this and once again gain self-trust.

With regard to others' trust in them and their trust in others, the interviewees describe a sense of having betrayed their families and friends, which impacts on the sense of trust between them. Daniel states: "We do terrible things to our families…we put them through hell…it's the ones closest to you that get hurt the most…" However, the importance of having family to support them through the process was also emphasized. Daniel stated later in the interview: "It's hard if you haven't got family behind you, you know, I've realized that…if you haven't got family behind you, you're gonna die in the

gutter, I'll guarantee it…I've seen it happen too many times." However there also appear to be problems with this in that sometimes the addicts feel they cannot trust their families to support them in the ways that they need. Mark explains:

> "…so I'm trying to kind of educate my whole support structure…they also see certain signs and symptoms before I relapse but usually only afterwards because they also don't want to see that…denying it…so I'm trying to teach my parents to see the signs and symptoms before I relapse…kind of a defense mechanism against relapse…but it's not easy…'cos the closer someone is to you the harder it is for them to see it 'cos they don't want to see it…they only really accept I'm using again once it's out…but I'm trying to tell them I am an addict…because I really don't want to use again…"

Mark's comment highlights their need to relegate control outside of themselves because they can't trust themselves, however, this does not seem successful either. With regards to trust in others and others' trust in them there is an interesting paradox. As much as they feel they need to have family on whom they can rely, they don't seem to be able to rely on them. This is as a result of actual unavailability of family members and due to fear and distrust on the part of the users. Sometimes even a family who is supportive can perpetuate the cycle. Anton explains: "…it's a dangerous place for me…going to my family and their sympathy for me…'cos they just want to help me and then I steal from them…and you don't feel too good about yourself…and then of course you use more…"

Although there is always a fear of disappointing their families, the users tend to exploit their families' denial of the issue through stealing and lying, which at times can force the family to reject them entirely, which is their worst fear and leads to even more of an inability to trust their families to contain their problems. Speaking about his relationship with his wife after his first treatment, Anand states: "She felt better…she started building up her trust again. I must tell you, I had no access to a car in those two months. I had no access to a car…my wife wouldn't let me drive…uh …she took me to work, she brought

me back…um…and then in two months I built back the trust and started taking my own car to work and coming back…and that's when I started planning this whole relapse." This shows how often the user's behaviour maintains others' distrust in them, which then reinforces their perceptions of themselves as untrustworthy. The situation families face when a member is abusing cocaine or heroin seems to create a situation where support becomes conditional to the user abstaining. Although this is necessary for the families, it plays into the essential distrust the users already experience.

Although many of the interviewees seemed to find relationships with user friends easier, expressing that they felt more of a sense of belonging amongst their user friends, there still seem to be difficulties in these relationships with regard to trust. Jason explains how he kept his relationships superficial for fear that they would interfere in his drugging:

> "A lot of it's my own… I am lonely sometimes because I do tend to isolate myself and push people away…people who I feel are getting too close to discovering that I, you know, use drugs or that they will get in the way of me using drugs or that they will just compromise my lifestyle in some sort of a way …and that does…um, I'm selective, I mean I will want that person to be my friend, you know while I'm using there, there, there, but after that, you know, there's it…just be on your way, you know and then I'll phone them up and say 'listen, let's go out, do this, that, that, fine…kind of…for my own selfish…it's a very selfish thing this…this whole disease…I don't know, maybe it's to do with fear of rejection or something like that, you know…or a whole host of things… it's anything that gonna get in the way of me using, if it's going to expose it, put a stop to it, uh…my basic purpose in life during my days of heavy using was my disease…my drugs…that's what my life revolved around…and…nothing at the time could come between that, so…"

As well as not trusting others not to interfere with the need he has for substances and the lifestyle it entails, Jason's comment contains a deeper fear: he cannot trust others not to reject his substance abuse and along with that – him. Besides for an unwillingness to

become closer to others and rely on them for fear of rejection, there is also a fear of abandonment. This seems to occur often, as it was mentioned by many of the interviewees that what started out as social using in a big group deteriorated into a very solitary activity, mainly through the death of most their friends due to overdose. Through death, their friends ultimately abandon them. Daniel states: "Every one of my friends are dead, everyone around me are falling down dead. Since I started using six years ago all my friends have died from heroin." This process reinforces their belief that others are not able to be there for them and support them and thus it continues the cycle of distrust and distance.

Ironically, mistrust in certain relationships is necessary after rehabilitation, as a return to previous relationships where using substances together was an integral part, or where certain patterns of relating result in emotional triggers to use again, can cause a relapse. Narcotics anonymous (NA) encourages users to avoid previous user friends after joining the programme. As Roger says "…and so in some sense I feel we have got to be careful of relationships 'cos that's also a hell of a setback and can cause you to relapse…"

The issue of trust also involved God. There seems to be a belief amongst users that if only they could trust in a higher power completely, they will be able to stay clean. The 12-Step approach's emphasis on a belief in a higher power may encourage this. Roger states:

> "I mean, if you really, really want to come clean then there's 50% chance that you'll make it, but I think if you've got some kind of higher power, God, something that exists that you can trust in 100% and you know what it's about, you'll never relapse…there's a 99.9% chance that you won't relapse…"

However trust in God also seems to be difficult. There is a need to 'understand' God before they can trust completely and the idea is expressed that trust in God is not enough. Later in his interview Roger said:

> "I'm a Christian…this time I need to work for God…I think this time I really have to give myself 100%…I need to understand it…and I think if I have that it's 50% already of the way…the other 50% is to be motivated enough to put those little things in place…don't carry money…don't go back to my friends, dangerous places and people, avoid it completely."

Again the idea of 'conditional support' can be seen. Here, the opinion is expressed that one needs to 'work' for God in order for Him to help you and again reflects the 'conditionality' of love and support that these people experience.

The theme of trust appeared with regards to trust in themselves, their trust in others, other's trust in them and trust in God. Overall, being able to rely on others and on themselves seems to be extremely difficult for the interviewees. The theme of trust seems to revolve around the idea that the users know they have a need to trust, but they cannot. They wish to be able to trust themselves and their families, but their behaviour seems to elicit feelings of rejection and abandonment from their families, which confirms their belief that they themselves as well as their families are essentially untrustworthy and leaves them feeling more unsafe and even less trusting. The initial lack of trust they have in themselves to be able to cope with their emotions and the lack of trust they feel in their families, seem to contribute to the decision to use substances. Then, despite the self-trust regained in rehab, for many each relapse reinforces their belief that they cannot be trusted and devastates their families, resulting in immense feelings of guilt and eventually real rejection from their families, leaving them with less trust in themselves and their families, thus perpetuating the relapse process.

4.5.4 Splitting

According to Kaplan and Sadock (1998), splitting is the defence used when a person cannot hold his/her ambivalent feelings towards someone or something else and so divides aspects of his/her world and the people in it into either of two categories: good and bad. It involves an active compartmentalization and separation of mental contents

and is used most often to ward off the unpleasant affects associated with the integration of contradictory parts of the self. When the defence of splitting is used anxiety tolerance and impulse control are usually also impaired. When used in conjunction with repression, the picture can look similar to dissociation. In specifically psychodynamic terms, splitting involves "mental cleavages that produce self-representation connected with internal object representations" (Kaplan & Sadock, 1998, p. 660). In terms of systems theory, similar to denial, splitting in combination with repression, can possibly be viewed as the system's way of maintaining rigid boundaries between subsystems, in order to attempt to avoid feedback loops which they experience as painful.

The tendency to split their experience of the world was evident amongst the interviewees with many of their opinions, decisions and behaviours demonstrating an 'all or nothing' or 'good versus bad' approach to life in general. The most predominant splitting was evident in many of the interviewees' concepts of self. A clear distinction seemed to be made between 'The Addict' inside and 'Me'. 'Me' is described as 'weak', 'the hurt aspect of the self', and 'the one left behind to deal with the consequences after using'.

Throughout the interviews the theme of 'The Addict' recurred, where interviewees described this as being an aspect separate from the self. Many names were given to this part e.g. 'my addict personality', 'my addiction', 'the disease' and 'the addict in me'. 'The Addict' is described as being 'cunning', 'deceptive', 'strong' and 'selfish', with fulfilling its own needs i.e. using drugs, being its primary aim. To achieve this aim 'The Addict' can also be encouraging, supportive and reassuring. Anand explains this process: "…so what my addiction was actually telling me was 'it's cool man, you can go on, have a good time, get out…uh…when you go home you can deal with that at that time". Personified, 'The Addict' engages in conversation with the 'Me' part of the self. This is described as an ongoing battle and symbolically represents the internal psychological conflict the user experiences prior to a relapse. Anand describes this process:

Before using:

> "Even on a thinking level…that addict inside was saying 'it's not so bad' because you can use and two months later it's going to be alright…after two months…all you need is two months gap…"

And then after using:

> "…now it is the real mind stuff. It's things playing up in my head. Now that I've used, my addiction has taken care of itself on that level…now it's me against the world, you know, not the addiction. It's me. I'm going home and the addiction plays its part by telling me I'm tricking these people, I'm fooling them into believing that it's my last time…you know…I cry genuine tears…I'm really crying, but its like…it's saying to me 'it's good you're crying, you know, it's good…it's like you're showing remorse'. But there's a part of me that's genuinely crying."

On the process:

> "*So the addiction criticizes you?*
> Ja, all the time.
> *Okay, but why do you think it does that?*
> Because it wants what it wants…it wants to use…it will do whatever to get you to.
> *So how does criticizing you get you to use?*
> That I'm weak and also the whole thing it plays on…that this is going to be the last time…it's okay…you can use and then we'll worry about the consequences afterwards…"

'The Addict' is viewed as powerful and as taking the choice away from 'Me'. It seems to embody the 'badness' associated with substance abuse and holds the responsibility for the lying, stealing and betrayal that occurs. Interviewees describe their behaviour while under the influence of 'The Addict' as 'completely out of character for me' and as if 'it was a whole different person that came out in me'. Although this may be an effective

method in the short-term for easing guilt, it seems to leave users disempowered. It seems to be extremely difficult for users to integrate these two parts of themselves, but the process of rehabilitation seems to foster the beginnings of integration. Daniel states: "…ja, I'm an addict and the quicker you realize that the quicker you are going to come right…ja, but the word, hey, it offends me…it offends me. But I'm getting used to it…'cos I mean I am…I have to face up to reality…I'm an addict."

An 'all good' versus an 'all bad' view of the substances themselves was also evident in the interviews. It appears as if the interviewees also split the drug. Mark refers to the use of his drug of choice as a form of self mutilation, while discussing what he feels is the 'heroin personality': "You know they talk about a heroin personality…like a form of self-mutilation, especially with people who use intravenously…", but then two minutes later in the interview he is referring to heroin as 'love' and the one thing that contains him emotionally: "… 'I really need some love' and that was like our code word…and eventually the joke progressed to 'love in vein'…so, um…it did…it became like my emotional…it was where I grounded my emotions…to keep my emotions in check…I was always just comfortable when I was on heroin…no-one could piss be off…I was just very quiet. I could deal with my emotions." This is an example of how the users 'split' the drug. On the one hand it is bad because it is killing them, but on the other hand it is good because it allows them to escape a lot of their emotions and makes them feel temporarily better. Although for most users these two different experiences of the drug are kept separate, Mark manages to integrate this idea later in the interview when he says: "Ja, I suppose somewhere along the way it got screwed up…when a heroin addict feels pain he feels love…"

The process of splitting also seems to occur in the perceptions of the interviewees concerning the 'drug lifestyle'. On the one hand it is described as glamorous where Mark states: "…and there's kind of a whole subculture around it as well…literature…the E Generation; Irvin Walsh, the author of Trainspotting; Al Ginsberg; the fashion industry with the heroin look models; and then the whole music industry, Kurt Cobain, Courtney Love, Janis Joplin, Jimmy Hendrix, the Doors with Jim Morrison…and so I suppose I

also glamorized it in my head…um, and that's what got me interested in it…". Anton also describes how the lifestyle was 'glamorous' for him: "You know what I really miss about the drugs…or what I really loved about the lifestyle was the irresponsibility of it…not having to get up in the morning…you can go buy rocks at 5 o'clock in the morning and smoke them till 12…not having a place to be…yes, but then there are also a lot of things I lose that are important to me…". However, the beginnings of integration can be seen with him admitting that there is also a lot that this lifestyle denies him. Mark also explains how the lifestyle was exciting for him, but his last sentence highlights the other side of the lifestyle that they consider 'bad': "…it's a very punishing habit and there's that flirtation with death all the time…overdosing or shooting up something that isn't heroin…the whole thrill of going to score…putting yourself in that dangerous position. I enjoyed that a lot…I remember especially that I enjoyed scoring the drug more than using it…it was a rush carrying it in my pocket or going through a roadblock…but it's terrible…definitely an ugly neediness." The 'neediness' or 'dependence' that the lifestyle entails is something the users seems to consider as 'bad'. Daniel also states: "It's a real scary feeling…really…it is…that you have to depend on some thing to get you through the day. It's a really scary thought."

Splitting other people was also evident in the interviews. In order to continue a relationship that is clearly unhealthy and abusive, for fear of being left alone or abandoned, it is necessary for Desiree to split her perceptions of her husband. She states: "Yes…and it confused me 'cos he is such a nice guy…so nice and so gentle and it confused me…and the next day after he hit me or cut my finger with the knife or something…he will cry like a children…when he drinks something happens to him…he is so angry…with the heroin it was not like this…"

Also, in order to avoid the pain and anger associated with acknowledging how abandoned she feels by her mother, Desiree splits her perception of her mother. When speaking about her emotionally distant and rejecting mother she states:

> "Even though she is not an emotional person…she suffers…

> *Can you explain 'not emotional'?*
>
> Ja, like for example when the camera people went to talk with her…they say sorry to ask you to talk about this…it must be very emotional for you and she says, no, the emotions are over…she is too much hard.
>
> *It sounds like it is hard for you that your mom is like that…*
>
> It is…but I can't put the guilt on her…I am the only one to blame…"

Another significant person who is split is the dealer. Roger states: "I don't know, but maybe I'm like one of the lucky ones, but I had this dealer that like was such a gentleman and he always used to give me credit and always use to give me whatever I need." In this comment it is clear that the 'bad' side of the dealer is split off and suppressed. However, later in the interview Roger was able to integrate his perception of his dealer more and comment on how the dealer made money off his addiction, and expresses his anger in this regard:

> "…and I calculated that it was like close to like a million Rand in that five years only off me and there was a group of about 16 of us white guys and girls who bought from him, so you can imagine how much money he made…he was like a friend…he would treat you like a friend…like you his friend…when you talk to him he's like…motivating you…it's almost like he wants to help you…and I mean he's like a Christian and he goes to church and he does all these things which I can't believe. I mean he destroys people's lives and then goes to church and prays…"

Splitting is also evident in the interviewees' 'all or nothing' approach to life, where it seems they experience difficulty living in the grey areas of life. Anand states: "My life was turning out ok. I had a fancy house and snazzy cars but then, just something inside that said it's enough, the time for work is finished…it's over…it's time for rest." This 'all or nothing' approach features in the relapse process, where it seems at a point in the lead-up process of the relapse, something just 'clicks', a decision is made and the process

snowballs toward the use of the substance. This process is clear in Anand's comment: "Well eventually you come to a decision that you can't do anymore. You can't go on like that…and you go out and use. And that's when I started planning this whole thing…uh…relapse. Uh…I say I planned it but… it's more like my addiction planned it." It is significant that the idea of 'The Addict' is mentioned here as it supports the notion of this process as splitting. 'The Addict' takes the responsibility for the decision and is now in control, leaving the 'Me' part of the personality split off and inaccessible.

It appears as if splitting is a defense that is used in many facets of these users' lives and that it has a specific role to play in the process of relapse. The interviewees seem to experience a period of immense emotional turmoil and cognitive conflict before a relapse. The ambivalence they experience with regard to using becomes overwhelming and then in order to cope with this ambivalence splitting occurs. Firstly, the splitting of the drugs themselves and the using lifestyle allows them to perceive them as 'all good' i.e. the drugs as containing and comforting; and the lifestyle as exciting, glamorous and in which they feel they belong. The 'bad' side of the substances and the lifestyle is suppressed and not available to consciousness. The splitting of other people is also an important aspect in the process of relapse. Splitting their perceptions of family after a fight, where they can view them as 'all bad', allows them to be angry, eliminating feelings of ambivalence, which enables them not to care about how they are hurting their families by using, and make the decision to go out and use. The splitting of the dealer allows them to see him as a friend, thereby eliminating ambivalence about using. Lastly, the splitting that occurs within themselves provides relief from the constant internal conflict they have been experiencing while craving. Once the decision to use is made, the internal "Addict" is now in control and the 'weak me', who was against using, is suppressed.

All in all, splitting aids in the relapse process by removing unbearable feelings of ambivalence. However the suppression and repression that accompanies splitting entails the loss of various aspects of self, others and their experiential world, which leaves the

users feeling fragmented, lonely and with a sense of meaninglessness. Thus, by allowing users to avoid painful feedback, splitting seems to prevent change in the system.

4.5.5 Denial

Considered one of the narcissistic or most primitive defences, denial is commonly used in both normal and pathological states. It is formally defined as: "Avoiding the awareness of some painful aspects of reality by negating sensory data." (Kaplan & Sadock, 1998, p. 220). A concept often confused with denial is that of repression. However, repression is defined as "expelling or withholding from consciousness an idea or feeling. Thus, while repression refers to the avoidance or 'denial' of affect or drive states, denial "abolishes external reality" (Kaplan & Sadock, 1998, p. 220). As mentioned previously, in terms of systems theory, denial can be viewed as a part of the boundaries around the individual as a system, which prevent feedback from higher order systems form entering the system.

For the purposes of this study the above definition of denial is used, but in a slightly wider sense, as it seems that in most cases external reality is not entirely 'abolished' – it is merely not given priority in conscious awareness. Many interviewees describe a vague sense of knowing, but disregarding this knowledge anyway.

The denial of external reality can be clearly seen in a comment made by Mark. Although obvious to everyone in his environment that he was using substances, he did not believe anyone knew: "…like my boss who when I went to her to tell her I thought I should go into rehab, wasn't surprised. I didn't think she knew, but she did…but you lie to yourself and think what you want, but…ja…"

Roger explains a vague sense of knowing, but disregarding this knowledge, in terms of the use of denial between relapses and how it contributes to the relapse process:

> "I went abroad for two years and I couldn't touch the heroin or the cocaine…just having the occasional drink and having a joint now and

> then…nothing like major like having it everyday…I was like living like other people who live normally. I would just put it out of my mind…forget about it and find something that will challenge me this time…and when I came back here I met up with the same people again and they were still busy with the same things and I thought 'this is cool, this is nice, you know, this is where I belong' and for some stupid reason…you know where its going to lead to…but you become instantly powerless, instantly, instantly…as you see this guy you become powerless and just pick the stuff up."

This process of knowing but not acknowledging the reality of a situation is also explained by Natalie: "If I have to think about what led to it [her relapse]…like complete denial and not working through stuff. It's like looking at a situation and thinking 'okay, well that affects me, but not actually asking how does it affect me'. Um, I still believe that no addict after a relapse, unless they go into it in great detail can fully understand what it was that led to it…and most addicts…like when I relapsed, well that's it, I used."

Natalie also states: "…and then there's the denial…like the whole time I was smoking dope it was like 'no, I won't use heroin, I'll be okay, I'll just smoke dope'…but it was kind of inevitable that I was going to relapse on the heroin too." An important aspect of the denial, in addition to disregarding the current reality, seems to be ignoring the past. Previous negative outcomes of similar situations are ignored and the user believes something different will happen. This was explained by Jason: "…you know they say that's the definition of stupidity – doing the same thing and expecting a different result…" Jason's experience of relapse also included denying the reality that his past experience dictated. He states:

> "…I think even knowing full well the consequences of me having that beer could lead to a sort of full-scale relapse where I could spend months, maybe even years in active addiction…didn't cross my mind…I think the loneliness, frustration…um, was about the biggest factor because for months it had been building up. It just got to a situation now where it was becoming

> a little bit unbearable and that was ultimately what led to the… Then again, as well…also in denial…having been through a treatment center before…knowing the disease and the concept of the disease…yet still going ahead and using…it clouds your…any sort of logical or rational thought pattern and that was it…back into it."

This process of denial even extends to the denial itself. The user is not even aware of the denial process occurring. As Natalie states: "I think that relapse is a mystery…it is a mystery to the addict 'cos they tend to disregard things that happen to them in the months leading up to a relapse…which is really a part of the whole process…you know this disease is cunning…the addict in you doesn't allow you to realize the process of denial which is so involved in relapse."

The denial experienced by many of the users appears to be extremely strong and seems to be one of the key elements in the process of addiction. It is obvious to see why addiction is so often called the 'disease of denial'. It plays a crucial role in the process of relapse as Jason states: "…but denial's so easy to kick in, you know…'you can do it just this time'…ja."

Denial seems to enable the user to ignore the negative realities that substance abuse inevitably entails and is an aspect of the process of addiction that so often frustrates the families of users as well as mental health professionals. Roger's mother attempted to free him from his process of denial through confrontation. She attempted to confront him with the physical reality that heroin was killing his body:

> "…but my mother was actually the one who said to me like 'look at yourself in the mirror'…she said 'go, come in front of the mirror' she put me in front of the mirror and said 'take off your shirt and take off your trousers and look at yourself just for 10 minutes…look at yourself'…so I stood there and looked at myself and she like pointed out on my body… 'What do you look like? Can you imagine what you look like on the inside?'…then she started

> telling me about this guy who is like 30 years old and his kidneys and his liver are like a 70 year-old man's…"

However, the process of denial was so strong, even this did not work. When asked what happened after this confrontation with the mirror Roger explained that he just continued using.

Sometimes the denial process is so strong it affects the families of users too. It is another way that denial helps to maintain the process of addiction and encourage relapse – through the families of the users. The denial the family uses to avoid the painful realities of their family member's addiction manifests as missing signs that a relapse is coming, thus maintaining the way that the family functions. Mark explains: "…so I'm trying to kind of educate my whole support structure…they also see certain signs and symptoms before I relapse but usually only afterwards because they also don't want to see that…denying it… but it's not easy…'cos the closer someone is to you the harder it is for them to see it 'cos they don't want to see it…they only really accept I'm using again once it's out…"

Denial also seemed to be common in many of the users' relationships. To avoid the painful reality that their relationship is dangerous or unhealthy, much like splitting, denial is also used, in order for them to continue the relationship. As Natalie states: "…ja, then the whole thing was around the fact I started dating somebody who used socially…and I went into denial…I completely disregarded the fact that it would affect me. I disregarded the fact that drinking a lot would affect me. And then I got home one day and he was smoking dope…and, ja…I don't know if it was a split-moment decision…but with my self-destructive nature it was like 'ja, lets do it'."

A large part of overcoming addiction and preventing relapse seems to be tied to acknowledging and accepting external realities – a process whereby a state of denial becomes harder to maintain and opportunities are created for new information to enter the system. Mark states: "…and you realize it's really quite a selfish thing…you don't

realize what you are doing to the people around you…but now I've realized the damage I am doing to my life…". Anand explains how the denial maintains the process of addiction: "…you know that I always denied being a drug addict. I never wanted to be and I never thought of myself like that…but the more I deny it, the more I am, because it says there's nothing wrong." This statement emphasizes how important it is to interrupt the denial in order to break the cycle of addiction and prevent relapse.

In conclusion, denial is a defense used by all the interviewees to avoid painful realities in their lives. Acknowledging these realities would involve being confronted with a number of emotions by which users fear they would be overwhelmed. Denying the reality of an unhealthy relationship allows them to avoid the pain they perceive being alone would bring. Denying the reality that their substance use is destroying their health and their relationships allows them to continue using in order to avoid other intolerable emotions. Denial results in users missing vital aspects in the beginning of their process of relapse. They deny the influence triggers will have on them e.g. being around other people using, to avoid being alone and feeling abandoned by old friends; and using other substances like alcohol to numb uncomfortable emotions. Lastly, denial prohibits them from becoming aware of the process of denial itself, ultimately enabling the cycle of addiction to continue. It thus serves the function of maintaining the way in which the system functions.

4.5.6 Detachment

Detachment was a theme that recurred throughout all the interviews in a variety of contexts. Definitions of the term detachment, which implies a detaching from something else, range from "not being interested or connected", "not being emotionally involved", a "separation" to a "standing apart or aloofness" (Halsey, 1979, p. 276). However all imply a sense of distance.

The theme of detachment was evident in a physical sense in relation to other people. Jason explains the nature of his relationships with friends while using, stating that he kept

relationships with his friends very superficial when he was using. He liked having them around, to go to places with and to use with, but he also did not wish to get too close to them for fear that they would interfere with his substance use.

When using, Anand also describes being completely detached from his family: "I didn't think once about my wife or my son." However, detachment also seems to characterise the nature of many of the users' relationships with others even when not using. Anand experienced a process of detaching from his wife and child in the month before his relapse. He was experiencing a great deal of emotional distress and began detaching from others in an attempt to control this:

> "Uh…it was again the situation where I was at home and I was like…I couldn't concentrate at home because I was like thinking too much… about the crack and…uh…I couldn't concentrate in any atmosphere…um…at home I would just switch off… and that was it…and uh…just trying not to talk as much as I used to talk…and I'd try and avoid them…I didn't function at home. I didn't…I couldn't do a thing because I avoided everyone. I sat in my room…you know…I just watched TV the whole day. I watched TV without watching TV."

When asked about the relationship he had with his wife at that stage, Anand explained his feelings of detachment as follows: "Uh…it wasn't very good…it was terrible…uh…I tried to put on a façade and tried to act like the perfect husband…you know." This comment highlights the important idea that something of themselves is missing from their interactions with others. In order to avoid various unpleasant feelings and to continue their using they seem to detach the 'caring' aspect of themselves from their families and loved ones. Roger states: "…you don't give a damn about anybody, you know…your family…everything just goes and nothing is important anymore…just when you going to get that next fix…that's what's important…you don't care who you hurt…" Mark agrees: "…but I suppose it's just that I don't care enough about myself and the people around me…so it's like a death wish kind of thing…" This 'caring' aspect is most likely

a part of themselves they experience as being vulnerable, thus they perceive detaching from it as a way of avoiding the pain of caring. As Anton states: "…and I suppose I just got to a point when it was all enough…you know…I suppose you don't care anymore…"

Ironically though, recovery also entails a detaching from former relationships. Discussing the situation with former friends, Roger states: "…I mean you going to see those people and you are going to turn your back on them and you are going to walk away…". The recommendation by Narcotics Anonymous that users avoid former friends who still use is obviously essential to avoid risky situations where environmental triggers may be present, but the awareness that this is repeating former patterns of 'detached' relating is important.

This detachment from others seems to mirror their inner worlds, as the above comment made by Mark indicates. He makes a link between the feelings he has for others and the feelings he has for himself. So as much as detachment from others was evident, the theme of detachment from the self was also prevalent. There seems to be a detachment from their thoughts and emotions that occurs, especially around the process of relapse. When remembering his last relapse, Jason states: "I can't remember the thoughts that were going through my mind, but generally speaking the thoughts that I try and sort of suppress…". This detachment from their thoughts and emotions seems to entail a detachment from the self. Jason states:

> "I try not to think about myself…I…that is one of reason why I use drugs as well is not to feel, not to think, not to feel the guilt, not to feel the shame, although it always comes back…uh, when I use I don't think of how I'm feeling…that I do…I block out because I know full well what it's doing to me, what it's going to lead to. I can't…I don't want to feel…I mean that's the last thing I want to feel…um, I think about everything else but that and I never deal with it."

This detachment from their emotions is more classically referred to as repression, which is defined as expelling or withholding from consciousness an idea or feeling (Kaplan & Sadock, 1998). This repression or detachment from emotion also seems to lead to an inability to recognise and differentiate feelings, and in this sense serves a similar function to denial – that of preventing new information from entering the system and thus maintaining the way in which the system functions. Anton describes being vaguely aware of feeling something but not being able to identify the emotion: "…so I became aware of a lot of things…I felt the emotion but I couldn't really put a name to it…".

Detachment from their own emotions seems to create further problems. As Natalie states: "…ja, I needed the companionship, so I told myself it just didn't matter…I just couldn't face up to my feelings. You know I don't think like up until…ja, until I cleaned up the last time that I had actually given myself the space to allow myself to…accept the fact that I was unhappy, so I just kept on beating myself up about the fact I'm pathetic and I'm useless." In this statement Natalie explains how her detachment from her emotions created a vicious cycle, which did not allow her the opportunity to acknowledge her true feelings and seek help. This ultimately contributed to the destruction of her self-esteem and exacerbated her perception of her inability to cope with her emotions, thus resulting in the need for her to detach further.

Naturally, the substances themselves also contribute to and exacerbate detachment. Anand explains the almost complete detachment the substances offer: "I don't know how to explain it to you in words…it's like a total freedom from everything…you don't care about anything…nothing." The substances offer a method of reliable detachment from uncomfortable emotional states, when the users feel overwhelmed and unable to cope with their own emotions. Roger explains how just before his last relapse his use of alcohol kept him detached from his thoughts and feelings as well as his process of relapse: "…I mean I had to adapt and change some of my ways but the addict inside of me was still haywire…it was going mad and I didn't realize…I mean I was using alcohol and stuff to keep that pain away…" Natalie also explains how the substances helped her to detach from her emotions: "…God knows what it is…but there's a combination of

feelings that most addicts run from…and heroin is the one way we know of to do that…you know 'things aren't going well, I may as well use to make it better for a while.'" Daniel also states:

> "Yes, well, most of the people who are in Phoenix House…it's from emotional reasons…you know…they've been sexually abused as kids, physically abused, whatever, they've all, all given their story here…and that's why they are using drugs…trying to like bury that feeling inside of them somewhere…and they keep running to drugs to just like block it out…block the feeling out. They don't want to face their reality of what happened to them in life."

This process of using the drugs in order to detach does not seem to be a conscious decision initially. What begins as casual substance use results in substance abuse and then dependency due to the fact the substance use fits the pattern of detached relating these people already have. The substances allow them even more effective detachment from their emotions and so, like their other defenses of repression, splitting and denial, the substances are used regularly in order to detach from various painful emotional states. These emotional states seem to be experienced as a vague emotional discomfort and the users appear to be so detached already that they are not even aware of what they are detaching from. However, the users become consciously aware of this process through therapy and rehabilitation, which is why they are able to discuss it. As Anton states: "…and you don't feel too good about yourself…and then of course you use more…knowing that the drug is…I never really realized, I don't think…it wasn't really a conscious decision…ok, right, the drugs are going to make me forget…".

The role of substances in detachment is obvious during the period of active using, however the substances seem to continue to play a detaching role during withdrawal. Roger states: "…when I'm using in active addiction and I don't do for 10 hours or so I feel a little bit sick and a bit lost, you know…". This includes detachment from emotions. Roger explained:

> "Now the thing is with this heroin and stuff…it takes you a long time to get your feelings back after you stop…I can like walk round for 16 days and still not be like 100% with it…I'm only now slowly but surely starting to get my feelings back…ja…so you're actually a bloody walking corpse after using this stuff…"

The role of substances in the process of detachment also seems to extend to the using lifestyle itself. The lifestyle also seems to promote detachment from the self, as Anton explains: "…I didn't have to look at myself 'cos I was so busy like…it's actually quite weird because I put myself in a position where I'm stealing and lying…also taking away from looking at where I am…"

The role that detachment and the repression of emotions play in the process of addiction is integral. Much like denial and splitting, the distance that detachment entails, enables the users to avoid the reality of their lives and their painful emotions, which in turn perpetuates the illusion that there is no problem and that they do not need help from others. Detachment also has an integral part to play in the process of relapse. There seems to be a detachment that occurs right before the relapse, which Roger explains: "…and for some funny reason…it just came out of nowhere… 'Let's go and score', you know…so it was like 'okay, why not?' and I don't know what I was thinking, I don't know what I was feeling…". This detachment in the form of repression of thoughts and feelings aids in the relapse process by not allowing the users conscious awareness of their own internal processes. Daniel states:

> "You see, when you relapse, you don't know you're relapsing…little things are just triggering in your mind, making it worse and worse until you do relapse…but you don't realize that this has triggered it…just little mechanisms in your mind push you closer and closer and closer to a relapse…things that you don't…you don't pick up straight away but sitting here and thinking then you can think back and say, 'ja, these little

> triggers…during that year were going off in my head…that led me to relapse."

Being detached from themselves and their own emotions, thoughts and needs, and from others enables the users to detach from the pain associated with these things. However, 'being detached' then also means they lose the positive aspects of being connected to the self and others. Thus, detachment, which implies a sense of distance, seems to heighten their feelings of emptiness, meaninglessness, loneliness and isolation. This in turn, leaves them feeling more emotionally overwhelmed and vulnerable to relapsing. The sense of distance that detachment implies also relates to maintaining a rigid boundary around a system, which prevents new information from entering the system, thus maintaining the way the system functions.

4.5.7 Loneliness

Common definitions of loneliness include being "without friendship or companionship" and the feeling of being "depressed from lack of friendship or companionship" or "lonesome" (Halsey, 1979, p. 601). These definitions imply that loneliness entails a lack of close relationships, whilst such relationships are desired. Other definitions include "lacking people", "unfrequented" or "deserted" (Halsey, 1979, p. 601). The idea of being 'deserted' is important as it implies a sense of abandonment. Although strictly speaking abandonment is a different feeling to loneliness, the result of abandonment is often loneliness. The same applies to the concept of rejection. Thus feelings of abandonment and rejection are included under this theme.

The theme of loneliness occurred in almost all the interviews and it was often cited as being one of the main contributing factors in relapse. Loneliness often occurred in conjunction with the concept of isolation – a physical sense of loneliness. Jason commented on how he was feeling in the weeks before his relapse and a sense is gained that he is wishing to be close with someone, but that he is not experiencing that closeness:

> "Lonely…feeling…you know…struggling through this on my own…um… loneliness was the biggest thing…I didn't have…I came home to pretty much an empty house, I made my own supper every night…I…the problems I had, I had no-one to share them with…I was dealing with everything on my own. I had no sort of support base whatsoever…probably just loneliness…I was quite lonely…I was withdrawing."

Loneliness seems to be a fairly constant feeling that the interviewees carry with them. Even when around people they struggle to connect. Jason explains: "…speaking for myself here, um…the worst thing is loneliness and I mean I can be with a bunch of friends and still be lonely, um…it's not…just because I've got people around me means that I'm happy…" It seems as if most of the interviewees have felt lonely for most of their lives. Mark states: "…loneliness was actually a really big part of my relapse…I never really actually thought about it until someone brought it up in group yesterday…and I've always actually been quite a lonely sort of character in my life…" Anton explained his sense of loneliness as a child and how this has carried through to his adult life:

> "I don't know…I just don't like to feel it [loneliness]…I'm not used to feeling…but I mean, I grew up as an only child…it's not being alone that worries me…I don't mind being alone…it's just the companionship…the sharing…I just want somebody to share with… someone to tell me how I feel and stuff…and you can do that with friends but it's not the same…but really, I don't think I know what to do with the feeling…really, I would rather run away from it than going through the loneliness…"

Abandonment is defined as "the desertion or forsaking of something or someone completely" (Halsey, 1979, p. 1). To be abandoned implies a sense of aloneness and like loneliness, the feeling of having been abandoned suggests a wishing for someone to be

with you, but they have gone. However, more so than loneliness, the term abandonment relates to people the users once felt were there, but who now have left them either physically or emotionally. Both feelings of loneliness and feelings of abandonment seem to be interrelated with the detachment these people experience in their lives. The theme of abandonment runs quite strongly through all the interviews, ranging from abandoned feelings as children through to feelings of abandonment after break-ups and feeling abandoned by their families.

Roger explains his feelings of abandonment as a child: "…absolutely…I mean I'm the only child and my mother and father are divorced and you get these abandoned feelings and all that comes with it…like some serious, serious shit, you know…and many others come with it …especially if your father's an alcoholic…" As discussed earlier, many of the interviewees came from families where at least one parent was 'unavailable'. Mark states: "…but what's underneath that I don't know…maybe I was angry with my parents for not giving me enough attention as a child or…I'm not sure…" Having the experience of their parents as 'unavailable' most likely left them with a sensitivity toward feelings of abandonment. Daniel's comment: "…people getting thrown away by their families…their family giving them so many chances…but the family not understanding what the person is going through…" shows how even feeling misunderstood by their families can be construed as abandonment. Two of the interviewees, Daniel and Mark, also describe break-ups as being the cause for them to use more heavily, citing their feelings of abandonment as being overwhelming. Daniel said: "…when my wife left me and I lost care in the world…that's when I really became an addict…I didn't care if I died…I went completely overboard…living in Hillbrow…living with the Nigerians."

These feelings of abandonment are possibly so prevalent due to the immense need these people seem to have for love and nurturance. This need presents itself in a number of different ways. Anton describes his need for attention and affirmation from women, going so far as to say his primary addiction is sex and women. Daniel emphasizes the importance of family who love and support you. Natalie describes her relapse as occurring due to her dating a user. She said she knew she shouldn't but that at that stage

of her life her need for a relationship was greater and so she denied the reality of the situation. Desiree's reluctance to leave her husband even though the relationship is unhealthy can also be viewed as a fear of losing what love and nurturance she gets from him, possibly due to the lack of emotional containment she receives from her mother.

Feelings of love, nurturance and belonging are also mentioned frequently and are referred to with regard to family, partners and the substances themselves, but seem to be split off from feelings of loneliness and abandonment. With regards to family members and partners these feelings were spoken about in a wishful and hypothetical sense. Whereas many of the interviewees emphasised the importance of feeling loved and supported by family, there was no direct mention of this occurring and no incidents were discussed.

The theme of belonging was mentioned frequently in various forms. It was referred to as feeling understood, being able to relate or connect, and as a feeling of being accepted. Many of the interviewees spoke about a sense of belonging that they experience amongst other users. They describe being able to relate to other users and describe a feeling of being truly understood. When discussing his old circle of friends Roger states: "Well you see these people as people that are like hurting…people that have the same attitude as you have, you know…their approach to life…even if you're using or not…so basically, you can um…relate to these people…" Anand describes the same sense of belonging and being understood in the context of the group at Phoenix House: "…a good thing I get here with the group, because we're all drug addicts, I can't bullshit anyone (laughs), they're just too sharp for me these guys."

Later in his interview, Roger also mentioned this theme in connection with Narcotics Anonymous: "I think that's why NA is like so important, 'cos whenever you want to talk to somebody or anything…or even if you are a person who can't talk to anybody you just go and sit in those rooms and listen to people share and that gives you that…'cos they are addicts…they have the same problem, you know."

They feel they belong amongst other users and believe because these people have had similar experiences, they are not likely to reject them. However, as discussed in a previous theme, despite this feeling of belonging, there does not seem to be a great deal of trust in even these relationships. This is most likely due to the fact that other users are unlikely to be able to offer the emotional support needed to stop using, while they are using themselves, and in all probability may die, ultimately abandoning them.

In addition, a sense of 'not belonging' also emerged from the interviews. Often referring to themselves as 'different' some of the interviewees stated that they felt awkward amongst non-using people. Jason said: "…but if I do look, I mean, I'm not an extrovert, you know…I've never been the life of the party, you know…I feel more comfortable in…at parties or functions where there are a lot of people using alcohol or drugs, most definitely, it gives me a bit more confidence…" Also when discussing being around other friends of his who do not use, Jason stated: "…no-one else can understand what I'm going through, they don't unders…they just don't really have any idea of what my life is like. They…you can speak to them and tell them things and they…they can't quite relate."

This feeling of 'not belonging' is also associated with the idea of detachment. However, while detachment implies an element of choice, that is, the users choose to detach, the feeling of 'not belonging' seems to be out of the users' control. This feeling of 'not belonging' even seems to go so far as to become rejection. When describing his personality and tendency to have mood swings, Mark explained how he often feels rejected by others: "…but it's basically where you have these ups and downs…I don't enjoy it at all…the one minute I'm all chirpy and the next minute I want to tear them apart…and people struggle with that…and I just get ostracized…but obviously addiction does the same but I didn't realize that at the time…" Mark's comment again highlights the way the substance abuse exacerbates an existing problem in a circular manner. Although fearing rejection, the very use of substances results in society rejecting and ostracizing them, which, in turn, leads to a greater need for the substances. This tendency

for users to gravitate toward groups on the periphery of society, who are often rejected by mainstream society, was also evident in his comment on his experience of high school:

> "Actually that whole theme goes back a long way…because originally I was from Cape Town and then my parents drove me up to Joburg…and the whole new kid at school thing…where my slang was different…the way I dressed was different…and I just felt so out of place…and I was immediately kind of put to one side…so I found friends who were like different subcultures, so I was Goth for a while, Rasta for a while…I even went vegetarian for a while too, but mainly I just hated the labels…I didn't like to be boxed into something…when someone asked me what I was, I would say 'just a teenager who wants to have fun'…even though I did go through a whole bunch of phases…"

As well as feeling rejected by society, feelings of abandonment also seem to characterise the way in which users experience society in general. Roger states: "The only problem out there is that if you are an addict there aren't many places you can turn to…because it comes like this…ok, you want to stop, but then the question comes, how do you stop?" Although this may be an attempt by Roger to externalize his control (see paragraph 4.5.2) and place the responsibility for his substance abuse at society's door, he experiences the fact that society is not responding to his needs as abandonment.

The pattern of eliciting rejection and then using more substances to escape it was also evident in their relationships. Feelings of rejection were common after break-ups, with this being cited as a reason to use more heavily. Daniel states:

> "It was just that feeling of being rejected…I couldn't understand it and then I could understand it because of the things I was doing. She…also…she gave me many chances and I just kept going back and back…not knowing the addiction…heroin is something that you don't play with. It's really a terrible addiction…but I didn't know that at that time and I started blaming

> her and…then she left me and I thought 'oh, I've been rejected now – let me just carry on…use and kill myself'. I just lost every care in the world."

As discussed previously under the theme of Trust, feelings of rejection are also common within the context of their families. Obviously it is difficult to say which came first – the substance abuse or the rejection from their families, but either way the two are undeniably related.

Loneliness, abandonment and rejection are emotions that most of the interviewees experience as unbearably painful, which they need to escape. Substance abuse seems to be a way to do this. Anton said: "…and when you use crack or heroin or any drug I feel, then you are out of it…you are not thinking about things like loneliness…"

Loneliness within the self can also be conceptualised as a sense of emptiness. As mentioned previously under the section on the social relationships of the interviewees, Mark speaks of an 'emptiness' or 'gap' that the substance removes, often in relation to relationships as well as to the self:

> "…maybe I'm craving a relationship or something because when I did break up…there was a huge gap that I had to fill…and heroin filled it…so there is some aspect where I think I need a relationship or loving from someone else…um, I struggle to be by myself and encourage myself…I struggle to tell myself I am a good person…"

However, substance abuse increases their tendency to isolate themselves and seems to exacerbate their feelings of loneliness. Jason states "…when I was on crack I just completely isolated myself…it was my own thing…I would get back from work…I was working at the time…and just use, use, use…" Jason also explained under the theme of detachment the role he plays in his own isolation, avoiding his friends and family for fear they will discover he is using and avoiding his user friends except for if he wants to go out. He explained how they all then use together, but have little contact between outings.

Mark explained under the section on the social situations of users, how the substances substitute for intimate relationships in his life, however, in explaining this he also explains how his desire to escape his loneliness contributed to his relapse and then how using heroin isolated him further: "…it was because I didn't have a relationship at that stage…and that was the hook, the heroin took away the pain…I don't know…and it was weird we started using together and then broke up over it…you know there was originally a big group of us…now most of them are dead…so it…starts off quite socially but then degenerates into a very solitary kind of thing…"

Love and nurturance are also described in relation to the drugs themselves. The drugs seem to offer the containment of emotion these people are unable to experience in relationships. Mark explained previously how his code word for heroin was 'love', which then progressed to 'love in vein' and how heroin was where he felt he could ground his emotions. When he was using, he felt comfortable and his anger never felt 'out of control'.

Although the drugs seem to be able to offer freedom from anxiety and pain, the drugs also, in a sense, abandon the user too. Many of the interviewees describe a 'crash' – a terrible depression – after having used. Daniel describes the feeling the morning after: "Well, everything you…you drained, you can't get out of bed without…you have to have [heroin] just to get out of bed to go brush your teeth and wash your face. Without it you just gonna lay in that bed and suffer. You can't …you can't function as a human being without it." Jason also said: "It [crack] made me feel good…while I was using…but when I wasn't using…the crash…it was terrible…"

Considering how unbearable most interviewees consider feelings of rejection and abandonment to be, it was interesting to note how often it is their own behaviour that elicits the rejection and abandonment they fear, leaving them isolated and lonely. Many of the interviewees seem to be trapped in the vicious cycle that Daniel described of 'using – being rejected – using more'. Speaking about his experience of being 'kicked out' of a

halfway house and later out of home, Anton said: "…but there is a very good possibility that I do elicit rejection…and I don't like it…"

Loneliness is also present in certain aspects of recovery. A part of the process of rehabilitation is cutting ties with friends who use, to prevent recovering substance users from being confronted with situations where environmental triggers may be present. However, this often leaves recovering addicts feeling very lonely and seems to evoke feelings of abandonment. Roger states:

> "…come to think of it…I knew I couldn't see old friends…I couldn't go to the old playground because of the previous time I went back to the hard stuff when I came back from overseas…and I knew it was all going to go back in the same circle…so it was again loneliness, definitely and a sense of abandonment…you don't see anybody…you don't talk to anybody…you got to make yourself new friends and move in a different environment…I think that's the whole reason I went to the pub…"

Another significant aspect of the 12-Step programme that was mentioned previously under the theme of detachment, is that it is recommended recovering addicts avoid beginning a relationship for at least a year, to avoid patterns of relationship where feelings of abandonment, rejection and loneliness might be elicited. However, this is something Anton found extremely difficult: "…'cos you know they tell us no relationship for a year…but I just couldn't…I just decided…'cos I mean the boredom and the loneliness was just too much…". Obviously the emotional impact these recommendations make on recovering addicts' lives needs to be closely monitored.

Thus, the role loneliness plays in relapse seems to be extremely significant. It seems as if feelings of abandonment, rejection and loneliness are common in the lives of users and for this reason they seem to be exceptionally sensitive to them. There seems to be a theme of circular causality related to these feelings, as the users tend to behave in such a way so as to lend continuity to these feelings. Loneliness, abandonment and rejection are

experienced as intolerable and this seems to predispose users to a relapse. The substance abuse is one of the ways the users attempt to cope, as the substances allow them to detach from these feelings, temporarily relieving their pain. However, this temporary detachment seems to intensify their experience of these emotions afterwards and the very nature of detachment, which implies a distance, leaves them more lonely and abandoned than before.

4.6 INTEGRATION OF THEMES

In the theme of trust it was suggested that the interviewees experience a great deal of difficulty trusting others as well as trusting themselves and that a lack of trust implies distance. Due to feelings of powerlessness in almost every aspect of their lives and the resulting lack of trust in themselves, they employ defence mechanisms like splitting, denial and repression to try to gain some degree of control over their inner experience, all of which entail a separating or pushing away, again implying distance. The theme of detachment encompasses an entire style of living and being in the world in a separate or disconnected way, distant from others and themselves. Thus, all the themes seem to centre around the idea of distance and a lack of integrated wholeness. The next two themes can be considered superordinate experiential categories in that, as well as occurring throughout the interviews in their own right, they allow for the integration of the above themes.

4.6.1 Lack of an integrated identity

Having a healthy relationship with the self implies an integrated sense of identity. In terms of the interviewees' relationships with themselves, the concept of distance is significant. Due to the defence of splitting, they experience aspects of themselves as separate i.e. 'The Addict'; and other parts of themselves as essentially weak and powerless. As a consequence of denial and detachment other aspects of their experience and themselves become consciously inaccessible. Ultimately, their detached way of relating to themselves leaves the various parts of themselves isolated, lonely and far from close, whole and integrated. The detachment, repression and suppression that occur

before relapse make identity or the lack thereof an integral aspect in the process of relapse.

In terms of systems theory, Freeman (1993) states that problems develop in the boundaries between systems. Boundaries can either be too permeable or too rigid, which influences the regulation of information flow within and between systems. The struggle users seem to experience forming a separate identity seems to revolve around the issue of boundaries. It appears as if the feedback they receive from all systemic levels, in the form of feelings of rejection, abandonment and loneliness from themselves as systems, their family systems, and society as a whole, is extremely intense and threatens to overwhelm, thus, their defensive attempts to block and avoid this feedback through repression, suppression, denial and detachment. This, however, results in boundaries that are too rigid, which prevents new information from entering the system, leaving them trapped within a certain way of functioning. The rigid boundaries between the subsystems within themselves, a situation to which splitting contributes, leaves these parts disconnected and the users' identities unintegrated. Very little of this process is consciously available to the users. They merely experience the loneliness and feeling of being trapped in this situation.

The theme of identity recurred throughout the interviews with many references being made to the fact that the interviewees felt they needed to 'find out who they are and accept themselves for who they are'. Knowing who they really are is something that is difficult for many of the interviewees. Anand explains: "Look I … I don't know…because I always thought of myself as a logical person, you know…uh…geez…uh…I don't even know why I even started all this…but only once you're there…it's very impossible to…almost impossible to come clean." This difficulty they experience connecting with themselves seems to be largely due to the fact they have used various defences to avoid reality. This is then exacerbated by substance abuse.

The acceptance into and sense of belonging afforded to substance users within the subculture of heroin and crack users also relates to the issue of identity. Affiliation with

a group forms a large part of an individual's identity; thus a large part of a users' identity is invested in the using group. Society has provided various images for this group over the past decades. Alongside the view of users as criminal, immoral junkies is an image of a dangerous, exciting and 'free' lifestyle. This is a phenomenon that was described by Mark as 'glamorisation' of the drug culture. It is obvious to see how a person with a low self-esteem coupled with feelings of lostness in the world and a fragmented sense of self, could see the drug subculture as inviting. As well as the anticipation of feeling understood by people with similar worldviews and problems, the danger and risk associated with this subculture could be construed as exciting and glamorous. Being a part of this seems to promise to supply the user with a sense of identity and a more positive self-esteem.

As stated above, other themes that are associated with a lack of an integrated identity are those of denial and detachment, where users attempt to escape various external realities, feeling states, and the more needy, angry and vulnerable parts of their personalities. Whilst disowning these parts of their personalities and denying various external realities and the impact these may have on them, they tend to experience themselves as disjointed and distant from themselves i.e. not knowing who they are – a situation that seems to foster feelings of self-doubt and a lack of trust in themselves. Their subsequent feelings of being distant and disconnected from others then tend to perpetuate their feelings of loneliness. These feelings then also relate back to the theme of trust in themselves and others, as distance tends to foster mistrust, as does the disconnectedness they feel in relationships with others.

The pattern of relating that most of the users display within relationships was discussed previously in paragraph 4.4.2, but highlights the difficulty many of the addicts experience feeling whole or 'enough' in the absence of another. This inability to feel whole suggests a fragmented identity. The themes of rejection, abandonment and loneliness are also related in terms of the intense 'hunger for love and belonging' that users experience, which leaves them feeling incomplete. Their wish for connectedness to others seems never to be realized due to a greater fear of the pain associated with rejection,

abandonment and the resulting loneliness that relationships can entail. Thus, while searching for connectedness, their lack of identity and associated detached style of relating to the world, seem to result in repeated experiences of rejection and abandonment, ultimately leaving them isolated and lonely.

On the whole, the users' sense of a lack of identity leaves them feeling extremely vulnerable and distrustful – a situation in which detached relating is the only kind that feels safe enough. However, it is this style of relating that then keeps them distant, disconnected and lonely within themselves, discouraging integration and wholeness.

4.6.2 The game without end

The game without end has a circular nature and thus the explanation of it requires some degree of repetition.

i) The users' perception of their problem

From the users' subjective perspective, their problems appear to be their feelings. They are extremely sensitive to negative emotions and tend to experience feelings like loneliness, abandonment and rejection as intolerable. Whenever these feelings arise within themselves they experience substantial amounts of emotional turmoil, conflict and ambivalence, which threatens to overwhelm them and with which they cannot trust themselves to be able to cope. On the one hand, relationships carry the risk of evoking feelings of abandonment and rejection, but on the other hand, isolation carries the risk of loneliness. This catch-22 then gives rise to further feelings of powerlessness and fear. These are also experienced as threatening. In essence their experience seems to be a fear of these emotions, which leads to feelings of distrust in the self and the world; in a reciprocal manner various aspects of the self that experience these emotions and 'uncontrollable' external realities maintain their fear.

Their substance abuse is experienced as a problem when it eventually becomes one of the most significant 'uncontrollable' realities in their lives.

ii) Their solutions to these problems

Their solutions to their problems with emotions include attempts to regain a sense of control through distancing or detaching themselves from their thoughts and emotions, the parts of themselves who experience these emotions; and the external world in which they are embedded.

Physically, they detach from family and loved ones to avoid the pain of rejection and abandonment – feelings which may be maintained by their families' reaction to their substance abuse and which are exacerbated by the users' hypersensitivity to them. To avoid feelings of isolation and loneliness they appear to surround themselves with relationships that have substance abuse as the common 'joining' factor, in which only the substance using aspect of the self appears to engage.

Psychologically, they use intellectualisation and rationalization to detach from their thoughts, repression and suppression to detach from their emotions and splitting to avoid the intense feelings of discomfort that ambivalence causes. Splitting aspects of themselves, others and the substances allows them to feel in control as it separates the 'all-good', exciting and glamorous, comforting and containing, from the bad side, which they suppress. Suppressing the 'bad' allows the users to avoid the painful feelings associated with it. This process is most apparent in the relapse process just prior to using where the ambivalence created by internal conflict becomes unbearable. Splitting gives them relief from the internal conflict related to the decision to use. Just before relapsing the dangers and consequences related to using are suppressed and thus not available to consciousness.

Denial is also prevalent as a means of detachment from the external world. They deny various aspects of external reality in order to avoid the painful emotions associated with

them. They deny the realities of unhealthy relationships to avoid feeling alone or abandoned. Denial and splitting are often used in conjunction with one another, in that certain realities are split and then only the negative aspect is denied, for example, they split substance abuse into positive and negative aspects and then deny the negative – the fact that their substance use is destroying their health and their relationships to avoid the pain of guilt and shame.

Due to their intense distrust in themselves and their abilities to cope, they tend to place a large degree of their control as well as their responsibility externally. While splitting the self and assigning responsibility for their substance use to 'The Addict', an entity they experience as separate to the self, is an example of this process, it also occurs on a more concrete level. Control and responsibility are also placed in other people. Family members and loved ones are blamed for relapses as well as expected to watch for warning signs of relapse. Again, detaching from the problem appears to provide a solution because if their use is someone else's responsibility – then using does not entail guilt and further self-recrimination.

Another attempt to gain control from external sources is the use of substances themselves. This process of detaching from their emotions and thus from themselves, and from potentially painful external realities is maintained through the use of substances. They describe the use of drugs as giving them a feeling of complete freedom. Thus the use of substances can be viewed as almost the ultimate means of detachment, second to death. Death was a theme that was frequently mentioned, often in the context of being the final escape from pain.

When the substance abuse begins to be experienced as a problem, the same solutions are applied. The ambivalent feelings that are experienced due to the substance use now causing further problems are dealt with through splitting. The substance, its consequences and the accompanying using lifestyle are split. The 'positive' aspects of using are focused on, while the 'negative' are suppressed and denied.

In the short-term these defences and methods of detachment seem to be successful. They allow for temporary relief and seem to lessen the anxiety and fear that is evoked by experiencing overwhelming emotions.

In terms of relapse, short-term relief is the aim. Despite knowing the consequences and the inevitable emotional turmoil that will follow, the decision to use again is made to escape the inner conflict recovering entails. In a split-second the same solutions are applied: the consequences are denied; the substance use is split – the user can only think of the substance and the use of it as a solution, not a problem; aspects of the self that don't want to use are split off and suppressed; and any emotions that conflict with the decision to use are suppressed. Ambivalence over, the decision is made.

iii) How their solutions become the problem

The solutions that the users apply all seem to revolve around creating distance or boundaries between themselves and the problem. Most of their behaviour seems to be directed toward the avoidance of and escape from emotions, due to their distrust in their own abilities to cope with them and the uncomfortable feelings of powerlessness this entails. The array of defences they use to avoid these emotions, including substance use, all appear to entail detaching and distancing themselves from the pain itself or the people and situations that they perceive to be potentially painful. As discussed above, this is successful in the short-term. However, in the long-term, these solutions tend to exacerbate the very problem they were intended to solve.

When they experience feelings of loneliness, abandonment or rejection, their first instinct seems to be to suppress them in order to avoid having to feel them. However this appears to result in the emotions compounding and returning at a later stage and then being experienced as more overwhelming than ever. This leaves the users feeling more powerless and less able to cope, which in turn, leads them to attempt to suppress these emotions even further.

The denial and detachment they use to distance themselves from external realities that are potentially painful, leaves them feeling more disconnected from the world around them and thus more lonely. To deal with these feelings they then apply the same solution, which is attempting to disconnect further. This distance and disconnectedness then also create feelings of distrust between the users and other people and the users and the world in general. As stated earlier, trust implies a connection. This distrust then exacerbates the users' feelings of powerlessness, as they cannot trust others and the world to reliably attend to their needs. To cope with the ambivalence that is created by wanting to trust but not being able to, they split others and the world. Keeping the various aspects separate allows them a feeling of greater control, but implies a condition in which they can now only relate to 'parts' of 'wholes'. This superficial relating then exacerbates the disconnectedness they feel from others and their feelings of loneliness.

To avoid the emotional turmoil that is associated with inner conflict they also split themselves. By keeping these various aspects of themselves separate, they keep their 'self' fragmented. A fragmented identity implies a sense of estrangement from the self. Again, the idea of distance fostering distrust emerges. Without a solid sense of self, they feel less able to cope with their emotions and more vulnerable to being overwhelmed, and thus, the sense that they cannot trust themselves to cope is heightened. This distance from the self also maintains their constant feelings of loneliness.

This loneliness is exacerbated by feelings of rejection and abandonment from family and loved ones, which sadly, is often maintained by their own detachment from these people and their substance use, which drains the family's empathy. The lying and stealing that accompanies the using lifestyle also contributes to this circular process. Thus, their behaviour allows the users to confirm their view of themselves as untrustworthy.

This view of themselves as untrustworthy then also perpetuates the problem they have with feeling powerless. In order to gain control of their lives and themselves, they feel they have to place their control externally as they cannot trust themselves to take control. This then robs them further of control and leaves the 'self' more powerless. Thus, their

anticipated fears of being overwhelmed increase and they begin to detach, deny and repress more in futile attempts to avoid situations and feelings that might overwhelm.

In summary, the distance they foster in their lives through the creation of rigid boundaries within and around themselves, in an attempt to avoid events and feelings with which they feel they would not be able to cope, maintains their sense of disconnectedness and detachment. This detachment then exacerbates the very feelings they are attempting to escape – loneliness, abandonment and rejection. These are then experienced as unbearably painful and 'out of control'. The users' beliefs that they are unable to control these feelings or cope with them maintains their attempts to escape them, which leads them into another cycle of detachment. This detachment also perpetuates their feelings of distrust in themselves and others, which then keeps them trapped in this cycle. Unable to exert any control over their chaotic lives and emotions they feel they are left no choice but to try to escape. Their escape from the outside world and from aspects of themselves then inevitably leaves them more lonely, more disconnected and more powerless – ultimately perpetuating the cycle. Thus, users seem to live in a circular process that constantly maintains itself.

It is easy to see how this cycle contributes to the process of relapse. Rehabilitation is an extremely difficult emotional ordeal. Users describe how all the emotional pain 'bubbles' up – unresolved pain from the past that was repressed as well as pain caused through their substance use. Without the substances to escape this pain, the users fear being overwhelmed by it. However, resorting to their primary coping style, that of detaching, which has developed throughout their lives, just perpetuates the problem. While the 12-Step programme does discourage some types of attachments, for example, with former using friends, the 12-Step and group processes used in rehabilitation clinics also discourage detached styles of relating, however, when alone, outside of rehab months later, and emotions threaten to overwhelm, the default mode of defence is detachment. Without negating the extremely strong role that the physical dependence plays, the substances provide the ultimate form of detachment from psychological pain – and so the craving begins. The inner conflict created by this craving and the ambivalence

it entails becomes unbearable and to solve this problem, other forms of detachment come into play. Splitting, repression and denial create the perfect conditions of powerlessness and intolerable loneliness – to the point relapse becomes the only way to escape and thus, their only solution. Repression, denial and detachment result in a loss of aspects of self and others and of the experiential world, which leaves users fragmented and lonely and with an overwhelming sense of meaninglessness. Denial causes the users to miss vital warning signs in the beginning of the process of relapse and increases the possibility of them encountering environmental triggers. This process is discussed is more detail in Chapter Two. Their unawareness of the process of denial means they can't see it so they can't address it. In terms of the self, detachment creates mistrust and an overwhelming feeling of powerlessness, which in turn, perpetuates their need to split further, thereby exacerbating their fragmented identities. This fragmentation then maintains the users' feelings of loneliness and isolation, and exacerbates their feelings of being overwhelmed, which leaves them feeling less able to exert control over themselves and their lives. Detachment also means they lose out on the positive aspects of being connected to self and others, which heightens their feelings of emptiness and meaninglessness, loneliness and isolation. Eventually they are so emotionally overwhelmed, the only escape appears to be relapse.

Thus their solutions become the problem. The constant cycle of detachment and isolation leaves them vulnerable to relapsing. Even after relapse the cycle continues. Without treatment, the relapse confirms their lack of trust in themselves and their lack of control. The guilt they feel added to the original emotions they were trying to escape feels more overwhelming than before. To escape this they detach, split, deny and repress more, which leaves them less connected and intensifies their experience of loneliness. And the cycle continues.

4.6.3 A process of self-destruction

The theme of self-destruction emerged strongly throughout the interviews with mention being made of how many of their user friends have died, of how the substances are

'killing them', of choosing suicide through overdose, of 'death wishes' and of their own 'self-destructive natures'. The fact the entire cycle is destructive in nature suggests that underlying this entire way of being in the world is a self-destructive process. This self-destructive way of relating to the self seems to be associated with early patterns of interaction, where pain and love became confused, while the 'death wish' they seem to have could be viewed as a desire to escape indefinitely.

The cycle discussed above represents a system that is constantly striving for homeostasis, but in a symmetrical manner. The reactions of the system to feedback seem to escalate the situation. The protective boundaries around the user as a system prevent new information from entering the system, which maintains the symmetrical behaviour occurring within the system. The only feedback that seems to be allowed into the system is feedback that maintains the current manner in which the system functions. Thus, the cycle is spiralling toward eventual self-destruction of the system. Users either break the cycle, allowing new information into the system, and begin the process of recovery, where complementary behaviours occur, or they die, which represents the final disintegration of the system.

4.7 HEROIN VS. COCAINE: THE DIFFERENCES IN RELAPSE EXPERIENCES

Although one of the aims of the study was to note any differences between relapse on cocaine or relapse on heroin, the data did not reveal significant differences. The literature supports theories that different personality styles are attracted to different drugs i.e. the 'drug of choice' phenomenon. However, in this study, although interviewees admitted to having a preferred substance, most of the users reported substituting one drug for the another, depending on what was available, and no significant differences were noted in the actual experience of relapse on crack or heroin.

The experience of relapse, before relapsing, did not differ at all except for heroin users feeling more 'sick' due to more severe physical withdrawal symptoms, but even this differed from person to person. While some reported terrible physical withdrawal, others described merely feeling a little lost. While Daniel describes an intense withdrawal experience: "…you drained, you can't get out of bed without…you have to have just to get out of bed to go brush your teeth and wash your face. Without it you just gonna lay in that bed and suffer", Roger states: "Ja, in a way, but for me withdrawals have never really been that bad…I don't know how, I don't know why…it's strange, I don't know…when I'm using in active addiction and I don't do for 10 hours or so I feel a little bit sick and a bit lost, you know, but I don't feel like I'm dying…"

After relapsing, again they differed only in terms of the actual physical withdrawal – heroin being worse physically and cocaine worse psychologically. Mark states: "For me now the psychological withdrawal from cocaine and the physical symptoms from heroin are so daunting I have to book myself into treatment…it's just like the withdrawal symptoms are terrible…and emotionally…'cos it suppresses all your emotions and when you stop it all starts bubbling up…all the things you've done…all the people you've hurt…" Depression seemed to be common to withdrawal from both substances.

A gender difference in the experience of relapse was also mentioned. The psychological and physical withdrawal seems to be worse for women. Daniel stated:

> "Well I find women are…they are a lot more addictive than men and the physical withdrawal is a lot worse for women…from what I've seen women go through hell…it's a horrible sight, but they do…they suffer a lot more than men…I don't know why, but they do. It's not that they are weaker but they just suffer more…physically their bodies…they get cramps for months and months after…and then their bodies…they are still not normal. So for a woman I think it's a lot harder then for a man to kick this habit. I don't know if that's true but from what I've seen."

While the defence mechanisms involved in relapse appeared to be common to both substances, emphasis was placed on the illusion of control crack users experience, which contributes towards relapse. The feeling that everything is under control plays into the process of denial and aids in the decision to use. Jason, a crack user, explains: "…then on the other hand, things are going so well, I've got this thing waxed…it's under control, so let me go and use".

Due to the fact these issues were only enquired about incidentally during the interviews, only a limited amount of information emerged. A more in-depth exploration of this issue will reveal more support for the literature.

4.8 CONCLUSION

This chapter introduced the interviewees, included a brief contextual discussion and presented the results of this study. Six earlier categories, consisting of control and powerlessness, trust, splitting, denial, detachment and loneliness, were identified and were integrated into two superordinate experiential categories: lack of an integrated identity and the game without end, including a brief discussion on the self-destructive elements therein. The following chapter discusses these results and explains them in terms of relevant theory.

University of Pretoria etd – Bain, K A (2004)

Chapter Five

DISCUSSION OF RESULTS

Sweet are the uses of adversity,
Which like the toad, ugly and venomous,
Wears yet a precious jewel in his head.

William Shakespeare

5.1 INTRODUCTION

As discussed in the integration section of the previous chapter, the cycle in which the users are trapped contributes to relapse and the solutions they apply to their problems seem to exacerbate them. This chapter presents a discussion of the findings from the previous chapter integrated with relevant literature in order to provide an understanding of relapse within its context of substance abuse.

5.2 RELAPSE AS AN ESCAPE FROM EMOTION

After reviewing all the themes, at first glance it appears as if the primary problem these people experience is with their emotions. They seem to be so sensitive to negative emotions because they experience them as overwhelmingly painful and 'out of control', so much so they are forced to self-medicate with substances. However, as the themes have shown over and over, all the users' attempts to remove these emotions only succeed in exacerbating them. Thus it appears as if a circular process is occurring, in which the solutions to the problem the users are applying have become the problem. The reality is that these emotions are not going anywhere – they cannot be removed, prevented or controlled. They can only be felt, acknowledged and managed. Thus, without negating the significance of physiological factors in relapse, it can also be viewed as an unsuccessful attempt by users to manage their emotions.

Empirical research supports the idea that negative emotional states frequently trigger relapses (Marlatt & Gordon, 1985). According to Keller (1996) an intolerance of negative affects and an inability to verbalise emotions are the core of most contemporary psychodynamic views on substance abuse. A study by Keller and Wilson (in Keller, 1996) found that heroin and cocaine addicts were significantly less able to tolerate negative affects than a matched control group. Substance users were also found to have greater rates of alexithymia and to experience their emotions as 'blended together' and thus as global, diffuse and overwhelming (Krystal, in Keller, 1996). Krystal and Raskin (in Frosch, 1985) also describe, in terms of psychodynamic theory, a developmental

problem in substance users in the differentiation of affect. This dedifferentiation results in resomatization and deverbalization and feelings become out of control and overwhelming, making it impossible to differentiate anxiety from anger or other affects. This experience of emotions as dedifferentiated is similar to Kernberg's (1975) description of the way infants experience emotions. When a baby feels frustrated the emotion appears to radiate through its entire body, from head to toe, but as the infant gets older, it learns to manage and differentiate these emotions better through interaction with the primary caregiver. By learning to differentiate these emotions verbally, the radiating effect of emotions seems to wane. Thus substance users need to learn to differentiate the various emotions in order to not experience them as entirely overwhelming.

This dedifferentiation or 'blending together' of emotions is reminiscent of the concept of enmeshment, once again highlighting the issue of boundaries. In this case, a lack of boundaries between emotions makes identifying them from each other difficult and appears to maintain the users' experience of their emotions as overwhelming. This situation seems to run parallel to the users' experiences in their families, where blurred boundaries seem to maintain the users' difficulty in establishing separate identities. Their defences like denial and detachment appear to be attempts at enforcing boundaries between themselves and the external world, while defences like splitting, repression and suppression seem to be attempts to place boundaries between themselves and their emotions. It was mentioned previously that these defences can be viewed as feedback in their own right, in the sense that these defences are feedback that seeks to maintain the homeostasis of the system, through excluding higher order feedback which may allow change to occur within the system. Substance use is thus another attempt at creating boundaries. This, however, creates distance and a sense of fragmentation within the user's experience of the self, maintaining their lack of identity.

Wurmser (in Frosch, 1985) noted defects in the affect defence of heroin addicts, resulting in the use of external 'things', such as substances and behaviours, to manage feeling states. These 'things' are invested with magical power and control. Thus, at times when emotions threaten to overwhelm, relapse is the ideal way to avoid having to confront

them. Due to the fact that the users seem to experience the feedback from their 'emotional subsystem' as overwhelming, the use of substances functions in much the same way as repression and suppression, to create a boundary to limit this feedback and thereby maintain the way their 'self' system functions.

5.3 THE ROLE OF A LACK OF AN INTEGRATED IDENTITY IN SUBSTANCE ABUSE AND RELAPSE

The problems with identity that users seem to experience appear to be related to the concept of boundaries. Boundaries between themselves and others, as well as boundaries between various parts of themselves, are either too rigid and impermeable, or non-existent. According to Luzzatto (1987) the majority of substance users in her study had a 'self-image' that fell into either the 'objectless self' or the 'divided self'. The 'objectless self' tends to reject or deny a relationship with the outside world and a 'barrier' against the outside world is mentioned, often in relation to the substance abuse itself. The 'divided self' is where good and bad are split, and the self is threatened by either a 'bad object outside' and the world is perceived as 'explosive', 'aggressive' or 'meaningless'; or a 'bad object inside', which is described as 'cold', 'indifferent', 'irresponsible', 'aggressive' and is usually associated with substance abuse. Both these descriptions apply to the users in this study, with denial of external realities and splitting being prevalent.

Having a fragmented sense of self implies problematic boundaries between subsystems and thus a sense of distance between elements of the self, and distance contributes to a lack of trust. Erikson (1968) felt that the conflict of basic trust versus mistrust is the first with which a child must grapple and that the outcome of this first crisis in the infant's first year of experience is an enduring attitude toward oneself and the world. It is

significant that many of the interviewees reported broken and disconnected families, often from a very young age, and difficult relationships with at least one parent.

As has been noted previously, substance dependence does not have a single etiology. From a developmental perspective, Greenspan (in Frosch, 1985) identified a number of periods during development where problems occur that can possibly contribute to later substance dependency. The first of these, according to Greenspan (in Frosch, 1985) is that:

> "The infant's failure to achieve beginning regulation of internal experience in a context of maternal attachment can result from environmental trauma, unusual constitutional sensitivity of the infant, absence of a pleasurable maternal object, or problems in the mother-infant interaction. Drugs may facilitate homeostatic regulation or later substitute for human attachment" (p. 34).

This statement seems to relate to the users' extreme sensitivity toward emotions and their lack of trust in themselves or others to cope with these overwhelming emotions.

The second scenario is that the infant who fails to achieve a separate image of self from the mother towards the end of the first year of life may as an adult use substance abuse as a way to do so (Greenspan, in Frosch, 1985). However, it is not a healthy individuation that is achieved because in essence all that takes place is a substitution. The enmeshed relationship is swapped for dependence on a substance and the homeostasis of the internal structure is maintained. In this instance, it can be clearly seen how the user's solution to the problem becomes the problem. Substance use, instead of allowing the user to develop a sense of identity, exacerbates this situation by trapping the user in another relationship where the emergence of his/her own identity is disallowed. Through relapsing, the system perpetuates itself and the way it functions is maintained.

The third period during development where problems can occur is in the second year during the phase of separation-individuation where experimentation in the presence of a protective figure is necessary to achieve a sense of mastery. Failure to achieve this may result in a lessened capacity to experience and channel aggression. Drugs are then used later to achieve a sense of safe merging with an omnipotent object (Greenspan, in Frosch, 1985). Piaget (1954) states that from 12 to 18 months of age the infant repeats and reworks earlier conflicts and that if support from a nurturing figure is not available, the resultant anxiety can lead to a fragmented self, a low self-esteem, impulsivity, depression and other masochistic-like characterological problems. Although these theories also relate to the users' inability to differentiate and express emotions and the self-destructive element common amongst the interviewees, they highlight developmental problems that may have maintained a lack of an integrated identity. The self-perpetuating nature of systems is also evident in these theories.

Another important developmental stage is that of adolescence and the fact that most cocaine and heroin users began their substance abuse in adolescence is significant. According to Erikson (1968) adolescence is the stage of Identity vs. Role Diffusion. The main task of this stage is to develop a sense of identity and often it rests on having successfully attained trust, autonomy, initiative and industry in the previous stages. Identifying with healthy parents facilitates this process. Here again, it is significant that most of the interviewees in this study report troubled relationships with parents, divorced parents or having a substance-abusing parent. The fact that it was unlikely any of the users successfully developed trust contributes to their inability to develop a stable, healthy identity.

At the end of this stage, Erikson (1968) describes a normative identity crisis that occurs. Failure to negotiate this crisis leaves adolescents without a solid identity. This identity diffusion is characterized by the adolescent not having a secure sense of self and experiencing confusion about their place in the world. The role diffusion that Erikson describes again highlights the issue of boundaries. The self as a separate system does not seem to be differentiated from the more-encompassing systems within which it is

embedded, thus their lack of a sense of self and a feeling of confusion about where they fit in. Erikson (1968) stated that a way of defending against this role diffusion is to join cults or by identifying with folk heroes. The 'glamorisation' of the drug culture plays a role in attracting vulnerable youths into the substance-using lifestyle.

According to Kaplan and Sadock (1998) identity problems are multidimensional and include the predominantly negative experiences related with a highly dysfunctional family of origin as well as the traumatic influences of co-existing mental disorders. Thus, their lack of an integrated sense of self and the associated role diffusion seems to leave users feeling alienated and constantly lonely.

According to Kaplan and Sadock (1998) the essential question posed in an identity problem is 'Who am I?'. "Conflicts are experienced as irreconcilable aspects of the self that the adolescent is unable to integrate into a coherent identity" (Kaplan & Sadock, 1998, p. 1263). This statement highlights the role that splitting plays in users' fragmented sense of identities. By separating the negative and positive aspects of themselves, others and the external world, including substances, they avoid the ambivalence associated with conflict, but leave themselves fragmented without an integrated, coherent sense of self, thus maintaining the way the system functions.

As discussed in Chapter Two, splitting is not always detrimental. By keeping aspects of the self separate, space is created for creative 'generativity', allowing new perspectives to surface in psychological experience (Schneider, 2003). However, the aim is for these parts to be integrated eventually. According to Bion (1962) the process of integration toward experiencing oneself as a whole and separate person is never straightforward and tends to move in a backward-forward fashion. The goal is for a balance to be achieved between mature ambivalence and healthy but primitive splitting. These two then balance and preserve each other and 'wholeness' is prevented from becoming static. However, in the cycle of addiction it has been shown that 'pathological splitting' is used and that this becomes a problematic solution and integration is never achieved. Thus, splitting aids in keeping the self fragmented.

Thus, a recursive process can be seen. Their fragmented identity state, which seems to leave users vulnerable to becoming trapped in a cycle of substance abuse, is in turn exacerbated by the process of substance abuse. Constantly disengaging with reality through defences like denial, repression and splitting and then substance use, in an attempt to create boundaries, leaves them living a detached life. This detachment from their own experience makes connection with 'the self' virtually impossible, thus maintaining their fragmented identities.

From the data that was gathered it appears as if this lack of identity plays an integral role in the process of relapse itself. The users split the self into two main parts: 'The Addict' and the weak, powerless 'Me'. Winnicott (in Malcolm, 1995) describes the formulation of the 'false self' to protect the 'true self' which could not develop due to maternal failure. In the earliest stages of development, the child is unintegrated, but then due to the primary caregiver not providing sufficient containment for the child's emotions, a process of disintegration, due to destructive and defensive factors, begins, and complicates the unintegrated states, resulting in fragmentation (Bion, in Malcolm, 1995). This fragmentation is enclosed in a 'false self' structure which is based on a falsely idealized object (Malcolm, 1995). This 'false self' is reminiscent of 'The Addict', which is a self that is created in defence.

The 'divided self' identity (Luzzatto, 1987) seems to play a significant role in the process of relapse. At various stages in the process of relapse, the users function from either 'The Addict' or 'Weak Me'. This demonstrates how the lack of integration in their identities contributes to relapse. While the 'Weak Me', who is against using, is repressed before relapse, the interviewees described how 'The Addict' 'speaks' to them – reassuring and encouraging them before relapse, for example, 'just have one and then you can stop'; and is then condemning and punitive after the relapse. Anand explained (see Chapter Four) how the criticizing 'voice' after relapse adds to the guilt and the feelings of worthlessness, thus making further relapse more likely. Anton also stated how he felt he

had been drugging purely on guilt for the past ten years. The significance of this derogatory internal voice is discussed by Firestone (1985):

> "…the 'voice' plays an important role in supporting addictive tendencies: first, by seducing the person into indulging the 'habit', then by punishing him or her…These self-accusations in turn lead to more self-hatred. In attempting to alleviate these secondary reactions of guilt and pain, a person invariably resorts to more 'painkillers', and the vicious cycle continues" (p. 166).

Firestone (1985) attributes this voice to the internalised parent, stating that due to unsatisfactory care in early infancy the child learns to self-parent, but in a punitive, rejecting manner. Thus, the system into which the child is born seems to perpetuate itself through the child, who maintains the way the system functions by continuing to parent themselves as an adult in a manner similar to their original experience.

Thus, a fragmented identity encourages relapse in that when the decision to use is made the user seems to be functioning from only a 'part' of themselves which is rageful, impulsive and self-destructive in nature, much like the descriptions of the 'trickster' archetype. Due to repression of other parts of the self, a decision is then made that is not for the good of the 'whole' being.

The concept of 'The Addict' inside seems to be encouraged by the 12-Step programme's emphasis on the disease model of addiction, where addiction is seen as a disease like any other, for example, cancer or heart disease. It is viewed as incurable and something the user must learn about and manage. An advantage to this is that it removes the stigma attached to the self as 'addict' or 'junkie', and aids in breaking the cycle of using to relieve feelings of guilt. However, a possible disadvantage is that it may encourage splitting and detachment from aspects of the self thereby hampering integration of the personality.

5.4 THE ROLE OF CONTROL AND COPING IN SUBSTANCE ABUSE AND RELAPSE

Carver *et al*. (1989) state that:

> "coping should be thought of as a dynamic process that shifts in nature from stage to stage of a stressful transaction. Such a view suggests that the development of a coping style would at best be counterproductive, because it locks the person into one mode of responding rather than allowing the person the freedom and flexibility to change responses with changing circumstances" (p 270).

Unfortunately, the interviewees seem to have fairly stable coping styles – that of avoiding potentially painful feelings and situations by using a variety of defence mechanisms. The fact that this style of coping is used over and over, even though it seems to exacerbate the original problem in the longer-term, is why they are trapped in a "game without an end" (Segal, 1991). This coping style allows the users to repeatedly detach from certain aspects of themselves by limiting the feedback from various subsystems, for example, feelings of loneliness and anxiety that frequently arise from the emotional subsystem. This coping style maintains stability within the user as a system, in that it allows the self-system to maintain its way of functioning. However, this does not imply that the user as a system is stable in a more general sense. The instability of the user as a system will be discussed later in this chapter.

Carver *et al*. (1989) distinguished two types of coping: problem-focused coping and emotion-focused coping. Problem-focused coping seems to predominate when people feel that something constructive can be done, while emotion-focused coping is used more when people feel that the stressor they face must just be endured. Emotion-focused coping is a coping tendency aimed at managing distress emotions rather than at dealing with the stressor. The fact the interviewees describe feeling powerless and lack self-

efficacy or a sense of trust in their ability to cope with most of life's stressors and the associated emotions, suggests they will tend to use emotion-focused coping techniques. However, only maladaptive emotion-coping techniques seem to be used, such as suppression and repression. While temporarily distracting oneself from an emotion can be adaptive, users seem to attempt to postpone their emotions indefinitely.

Carver *et al*. (1989) state that denial can be useful in that it aids in minimizing distress and thereby facilitates coping. However, denial also creates additional problems unless the stressor can be successfully ignored. "That is, denying the reality of the event allows the event to become more serious, thereby making more difficult the coping that must eventually occur" (Carver *et al*., 1989, p. 270).

According to Carver *et al*. (1989) another emotion-focused coping technique that can be problematic is the 'focusing on and venting of emotions', which is the tendency to focus on whatever distress or upset one is experiencing and to ventilate those feelings. This is a phenomenon described by some of the interviewees in which they experience the emotion as entirely overwhelming. As indicated in Chapter Four, Mark described 'rage attacks' that he experienced which terrified him. Their hypersensitivity to feelings of anger, rejection and loneliness may be maintained by their tendency to focus on these feelings. This experience of their emotions being 'out of control' then leads them to attempt other methods of coping with their emotions, which aim to avoid the experience of them altogether.

This tendency to focus on their emotions can be explained in terms of systems theory as follows: As was previously discussed in this chapter, users emotions are not differentiated, a situation maintained by a lack of boundaries. This lack of boundaries seems to make it extremely difficult for users to not feel overwhelmed by their emotions and to not focus on them. Hence their attempts to create boundaries through detachment, repression and suppression. According to Antonovsky's (1979) theory of salutogenesis, in order to feel in control individuals establish boundaries and cut off the things that it is

not necessary for them to deal with immediately. Although this can be useful in moderation, users' tendency to over-use this technique is maladaptive.

Carver *et al*. (1989) describe a process of 'behavioural disengagement', which is "reducing one's efforts to deal with the stressor, even giving up the attempt to attain goals with which the stressor is interfering" (p 269). This can be seen in the recovery process where substance abuse can be seen as the stressor and goals can be seen as positive relationships and a stable career. Within this context, it appears as if behavioural disengagement occurs before relapse, when the interviewees in this study describe a sense of not caring about the consequences of their using. Carver *et al*. (1989) state that behavioural disengagement is associated with phenomena such as helplessness and is most likely to occur when people expect poor coping outcomes. Before relapsing, the users describe a sense of being overwhelmed and powerless, in addition to a fear of being overwhelmed by their emotions, which implies feelings of helplessness and expectations that they will not be able to cope without the substance. Carver *et al*. (1989) also place alcohol and substance use in the cluster of coping tendencies that tend to be maladaptive.

Carver *et al*. (1989) state that "the tendency to seek out social support may have both good and bad overtones, and whether it is primarily good or bad may depend on what other coping processes are occurring along with it" (p. 269). The users' tendency to associate with other users in order to distract from their feelings of loneliness and isolation, as well as their tendency to engage in intimate relationships in which emotions such as anger and abandonment are vented, repeating early childhood patterns of relating, highlights the maladaptive aspect of social support in their lives. This is something that Narcotics Anonymous addresses by discouraging users from socializing with former using friends and by creating more healthy and structured support structures for users.

Another method the interviewees seemed to use in an attempt to cope is that of externalising their control. According to Horney (1952) the tendency to externalise or to experience internal processes as occurring on the outside is a defence against the feeling that one is succumbing to chaos. However, having an external locus of control seems to

exacerbate their feelings of powerlessness and seems to decrease their trust in themselves and others. Once again, a circular process is evident.

One of the ways users externalise their control is through attributing it to a 'part' of the self, for example, 'The Addict', and to others, for example, blaming significant others for their use and giving others responsibility for checking for signs of relapse. This could be seen to be viewing 'powerful' others as in control of their lives, which is one of the external locus of control orientations (Levenson, 1973). Studies show that a difference found between the two external locus of control orientations is that individuals with a 'powerful others' orientation are more likely to have less social interest (Ashby *et al*., 2002). This finding is significant with regards to this study as the theme of loneliness and disconnectedness was found to be prevalent throughout the interviews. According to Eckstein and Baruth (1996), Adler describes social interest as a "lifelong process characterized by a feeling of brotherly love or close kinship with other human beings in the present, as well as a strong affinity for the human race as a whole, past and present" (p. 5). Ferguson (1984) states that a person who feels his/her life is controlled by powerful others would tend to have limited feelings of connectedness to others. The fact that powerful others are perceived to have the control would mean that other human beings could constitute a threat to a person's existence and this would prevent any feelings of connectedness to others (Ferguson, 1984). This highlights the interrelatedness of the themes and shows how the users' attempts at coping tend to exacerbate the very problem they were trying to escape. Their tendency to externalise their control leaves them with less interest in connecting with others. This may be due to fear that the 'powerful other' will reject or abandon them, but essentially reflects on their difficulty trusting others. Hence, their attempts to remain detached and disconnected from others, despite a desire to feel close to someone.

In conclusion, whenever users are faced with a problem, they tend to focus on the emotion associated with it. The emotion-focused coping techniques that they then use tend to be maladaptive, because they are based on a desire to remove the emotions indefinitely, which is impossible. Emotions can be postponed but not avoided altogether.

These techniques only succeed in exacerbating the original problem and thereby maintaining the system's way of functioning. Thus, their solutions to the problem become the problem.

5.5 THE ROLE OF LONELINESS IN SUBSTANCE ABUSE AND RELAPSE

Moustakas (1996) believes that fears of loneliness are related to a set of values and standards that centre on acquisition and control. He states:

> "The search for safety, order and lack of anxiety through prediction and mastery eventually arouses inward feelings of despair and fears of loneliness. Unable to experience life in a genuine way, unable to relate authentically to his own nature and to other selves, the individual in Western culture often suffers from a dread of nothingness" (p. 25).

Once again, the interrelatedness between the themes is highlighted. Through their unsuccessful attempts to control themselves and their world, the users only manage to isolate and detach themselves further, leaving them feeling an overwhelming sense of loneliness. Johnson (1997) relates attempts to control others and the feeling of being controlled by others to an ultimate fear of loss.

When discussing his concept of loneliness anxiety, which he believes is different from existential loneliness, Moustakas (1996) states that the separation of self from others and from nature is what constitutes the primary condition of loneliness anxiety in modern societies. Users' unhappiness, misery, pretence, their superficial relating and their failure to find genuine human contact often results in a fear and dread of loneliness. Users' detached way of life leaves them disconnected from others and lonely. Moustakas (1996) states that lonely individuals feel cut-off, isolated and abandoned. They see no hope for restoring relatedness and feel a complete absence of concern and love in the world. However, they still long to be with others and find love, but they are held back by their

own fears. This is the case with the interviewees, who express feelings of loneliness, but then seem to sabotage any chance of closeness in the relationships in their lives.

The users' relationships with other users, although offering a sense of belonging, tend to also lack true connectedness, due to their inability to trust others, including other users. Moustakas (1996) states: "He [the lonely man] seeks group adjustment rather than group solidarity and enters into relations on the basis of formal agreements and contracts rather than trust" (p. 26). Thus, their relationships with other users seem to be based more on the shared experience of seeking the substances and using them, rather than on a sense of trust or connectedness.

> "Modern man is plagued with the vague, diffuse fear of loneliness. He goes to endless measures, takes devious and circuitous pathways to avoid facing the experience of being lonely. Perhaps the loneliness of a meaningless existence, the absence of values, convictions, beliefs, and the fear of isolation are the most terrible kind of loneliness anxiety" (Moustakas, 1996, p. 27).

Moustakas (1996) also states that people with loneliness anxiety are suffering the consequences of an impersonal world of self-denial and alienation and that they will go to great lengths to avoid or escape this fear of loneliness "to avoid any direct or genuine facing of their own inner experience" (Moustakas, 1996, p. 31). This seems to be the case with the interviewees as their entire system of coping seems to be one of avoidance of their own thoughts and feelings as well as avoidance of potentially emotionally painful situations through detachment and denial. The substance abuse seems to be another length they will go to avoid the pain of loneliness. "In attempting to overcome loneliness anxiety, the individual sometimes gives up his individuality and submerges himself in dependency relations" (Moustakas, 1996, p. 31). Hence, even the user's identity is sacrificed in the attempt to avoid painful inner experience, thus contributing to the vicious cycle in which these people are trapped. Moustakas (1996) states that loneliness debilitates an individual and "stifles any emergence of self or realization of capacities and

talents" (p. 27). The loneliness they exacerbate in their own lives through detachment from the self and others disallows further integration of their identities. Feelings of inferiority are also experienced along with loneliness anxiety. A great deal of pain and suffering is associated with a feeling of being unloved and neglected (Moustakas, 1996). Thus, their feelings of loneliness also contribute to the maintenance of their negative identities and low self-esteem. As stated previously in the section on the social situations of the interviewees, Mark explained how difficult he finds it to be alone and retain a positive self-image and that he needs others to do this. Anton also stated that he needs constant positive affirmation from women to maintain his self-esteem.

In conclusion, Moustakas (1996) explains how the user's solutions become the problem and how any attempts to avoid loneliness, including relapsing, can only succeed in exacerbating it:

> "Loneliness is as much organic to human existence as the blood is to the heart. It is a dimension of human life whether existential, sociological, or psychological, whatever its derivatives or forms, whatever its history, it is a reality of life. Its fear, evasion, denial, and the accompanying attempts to escape the experience of being lonely will forever isolate the person from his own existence, will afflict and separate him from his own resources so that there is no development, no creative emergence, no growth in awareness, perceptiveness and sensitivity. If the individual does not exercise his loneliness, one significant capacity and dimension of being human remains underdeveloped, denied. A fear of despair, an agony of aloneness replaces the real experience but strategies of escape and alienation can never substitute for the growth-inducing, deepening values of a genuine, vital, lonely experience" (p. 35).

Thus, the users' coping styles consisting of defences like denial, detachment, repression and suppression, which are all aimed at creating boundaries between subsystems and around themselves as systems, seem to isolate them further from themselves and others.

The boundaries which are an attempt at protecting their fragile identities only serve to detach them further from others and fragment their identities further, creating more disconnectedness within the self as a system, which leaves the users with a constant sense of loneliness.

5.6 THE SELF DESTRUCTIVE GAME WITHOUT END

It can be seen that substance use for the purpose of detaching from unacceptable emotions and thus, parts of the self, results in further isolation and a cycle is created in which the two intensify each other. Interestingly, this process seems to occur on both an intra- and an interpersonal level, as if reflections of each other. While the users' relationships in the external world become more and more detached, their relationships with themselves do the same and their identities become increasingly fragmented and vice versa. Thus, from a theoretical perspective it seems as if the intrapsychic or psychodynamic process and the interpsychic or systems processes mirror each other.

According to Firestone and Catlett (in Firestone, 1985) substance abuse temporarily satisfies emotional hunger and primitive longings left over from childhood, creating in users the feeling of some measure of control over their internal state, supporting the illusion of self-sufficiency. This illusion is the fantasy that they can take care of themselves without a need for others. The entire process is primarily defensive and self-protective and allows the substance user to shut off their personal feelings.

Substance use can be seen to be fulfilling the function of parenting oneself and thereby establishing a pseudoindependence. It also allows users to cut off painful feelings and reduces users' anxiety, which allows them to feel better temporarily. However, this process involves denying oneself fulfilment and satisfaction from objects in the outside world, which results in users having to rely on substance use as a substitute. In order to ease their suffering, users learn to block out painful episodes and emotions, but in doing this they simultaneously limit their experience of feelings of joy and exhilaration as well. Due to the fact that substance use is closely associated with the destructive process of

self-denial, users become increasingly crippled in their ability to function and find satisfaction in personal relationships. They begin to limit their pursuit of actual goals and become progressively more involved in an inward life style of fantasy and substance dependency (Firestone, 1985).

According to Firestone (1985) this cycle of substance abuse and isolation lends itself to self-destruction: "Eventually, well-established self-nourishing habits usually become self-destructive because they progressively limit the person's capacity to cope with everyday experiences. They tend to foster an inward, isolated life style" (Firestone, 1985).

This self-destructive element seems to be contained in the users' tendency to use the same coping style and defences repeatedly, despite the fact that these attempts at control seem to exacerbate the situation. Horney (1952) saw this tendency as similar to resistance that is found in therapy, which she saw as being due to the patient's tendency to maintain the status quo. In other words, she suggests that the patient wishes to maintain his neurosis but without the difficulties and disturbances arising from it and thus experiences the need to defend parts of his neurosis. The parts the patient feels he needs to defend are those he feels have subjective value i.e. they protect him from something he fears more. This tendency to hold onto aspects of their neurosis, like certain defences, can be seen as a process of continual self-destruction, in which these people keep themselves trapped and unable to experience difference. This process can be viewed as a system caught in a cycle of symmetrical behaviour that is constantly escalating in an attempt to reach homeostasis (Bateson, in Keeney, 1983). The system's tendency to perpetuate itself then maintains this dysfunctional way of functioning.

This self-destructive process is a part of the vicious cycle the interviewees describe and can also be looked at in terms of the Freudian concept of repetition compulsion, which states that infantile trauma is repeatedly experienced in disguised forms throughout life (Ingram, 1987). This concept can be considered parallel to a system's tendency to perpetuate itself through recursive feedback. According to Horney (1952), these self-destructive repetitive cycles can be viewed as a continuing process along a deviant path

that requires more and more self-deception and unconscious defensiveness. This statement captures the essence of symmetrical behaviour within a system.

The self-destructiveness associated with substance abuse is often linked to repressed rage misdirected at the self. As previously discussed in this chapter, the problems that occur in early childhood that contribute to the difficulties these people experience in establishing trust, and during adolescence, where difficulties establishing a stable sense of identity continue, seem to interfere with the process of individuation. According to Fromm (1941) these problems with individuation contribute to the immense rage these people feel:

> "Just as a child can never return to the womb physically, so it can never reverse, psychically, the process of individuation. Attempts to do so necessarily assume the character of submission, in which the basic contradiction between the authority and the child who submits to it is never eliminated. Consciously the child may feel secure and satisfied, but unconsciously it realizes that the price it pays is giving up strength and the integrity of the self. Thus the result of submission is the very opposite of what it was to be: submission increases the child's insecurity and at the same time creates hostility and rebelliousness, which is the more frightening because it is directed against the very persons on whom the child has remained or become dependent" (p 29).

Thus, feelings of rage and anxiety at a sense of losing the self seem to be associated with a lack of completed individuation. In other words, the lack of clear boundaries within and around the user as a system maintains feelings of rage, anxiety and a feeling of being overwhelmed. Hence, the users' attempts to establish boundaries through repression, suppression, denial, detachment and substance use. However, these then exacerbate their feelings of loneliness and alienation, which according to Moustakas (1996) fuels their rage: "Often accompanying this feeling of loneliness anxiety is a smouldering but

helpless rage and a desire for revenge for being 'left out' of life" (p. 29). The circular process in which the users seem to be trapped is once again evident.

This rage also seems to contribute to the deep sense of guilt these people experience. Zinberg and Shaffer (1985) state that a great deal of guilt arises within users due to the raw and uncontrolled quality of their impulses. This sense of guilt is often a maintaining factor and not merely the consequence of their self-destructiveness and their difficulty with self-care. Thus it appears as if these feelings of rage are directed toward the self. Their substance abusing lifestyles then allow this process of guilt, self-hate and self-destruction to continue.

Freeman (1993) states that all problems develop in the boundaries within and between systems. The two main problems that users seem to experience subjectively are emotions that threaten to overwhelm and a lack of an integrated identity, both of which seem to be associated with a lack of clear boundaries. Thus, the user as a system is characterised by a lack of clear boundaries, or too rigid boundaries, and thus undifferentiated, overwhelming emotions and a lack of an integrated identity; and a tendency to apply solutions to these problems that then exacerbate the original problem.

This cycle or circular process can be viewed as the way in which the user as a system functions, and the system's tendency to perpetuate itself or maintain the status quo (Freeman, 1993) is what maintains this cycle. Although the user as a system is attempting to strive toward balance or homeostasis like all systems, their constant use of maladaptive coping techniques is maintaining a downward spiral toward ultimate self-destruction. The users' tendency to keep applying the same solutions can be viewed in terms of Bateson's (in Keeney, 1983) theory. The users are using symmetrical behaviour, which is when the inputs into the system or behaviours are equal (or the same) and thus escalate, which in turn results in disruption or destruction of the relationship or the system (Guttman, 1991). An example of the symmetrical behaviour evident in the process of substance abuse is that users feel lonely and angry, so they detach, which leaves them feeling more lonely and angry, so they detach further. An example of

complementary behaviour would be connecting with someone to relieve feelings of loneliness. Thus, relapse as a method of detachment can be viewed as an example of symmetrical behaviour, or feedback into the system, which keeps the system in a constant self-destructive process. The users' tendency to keep returning to substances in an attempt to escape realities with which they feel they cannot cope is a recursive loop in a system that is heading for self-destruction. Hence, their constant feelings of being 'out of control' and powerless.

The maladaptive coping techniques that the users apply and the way they perpetuate the self-destructive cycle can be viewed in terms of the MRI model, where the users' tendency to use more and more of the same solution in an attempt to solve the problem becomes the problem (Segal, 1991). The problem these users face now is the vicious cycle they speak of or the process of self-destruction that is occurring.

The MRI model identified three ways in which the solution can become the problem. Within this self-destructive process users seem to make all three errors. The first of these is that no solution is applied and action is not taken when necessary. The process of denial that occurs throughout the process is an example of this. The next way their solution becomes a problem is when action is taken when it should not be. The users' attempts to remove their emotions indefinitely, which is not possible, is an example in this regard. The last way the solution becomes the problem is when they commit an error in logical typing and a game without end is established. This is when a solution from the wrong level is attempted. Users constantly attempt first-order change, which is change from within the system, when second order change is what is needed. An example of this is relapse. They return again and again to substance use in an attempt to change the way they feel, but because the substance abuse is a part of the system and thus first order change, the situation merely escalates. The game without end refers to the fact that problems tend to increase or escalate when no solution or the wrong solution is repeatedly applied (Segal, 1991).

Bateson (in Keeney, 1983) provides another example of how a first order solution becomes the problem, suggesting that dependency problems originate from "a dissociated epistemological premise, usually some variation of self versus environment or body versus mind" (p. 163), in which the substance dependent person is engaged in a battle arising from a separation between mind and body. The person's 'will' to resist the substance, which arises from the conscious mind, is used in an attempt to control the body's 'hunger' for the substance, which creates a symmetrical battle.

Bateson (in Keeney, 1983) views the idea of self-control, or the idea that one part of a system can have unilateral control over other parts, as an erroneous epistemological premise. The challenge to attain abstinence provides the motivation to do so, however, as soon as abstinence is achieved, the challenge that generated it is destroyed. Thus, the more the user attempts to stay clean, the more likely he/she is to use and a vicious oscillatory pattern is set in motion. With each oscillation, the intensity steps up and eventually the user is merely trying to stay alive. As soon as the notion of self-control is acknowledged as an illusion, it becomes clear that the user is part of a more-encompassing self-corrective system, in which symptoms can be viewed as communication regarding higher order cybernetic processes. This realisation is often achieved by users when they hit 'rock bottom' and then realise they do not have control over the situation, which in turn leads to self-corrective behaviour due to reconnection of the dissociated dualism between symptom and self (Keeney, 1983).

Keeney (1983) identified two ways in which a system may be out of balance: a cybernetic system may be amplifying deviation in one direction or amplifying deviation in an ever-widening range of oscillations. Both of these seem to occur within substance using systems. Before entering any form of treatment programme or deciding to stop of their own accord, these systems seem to be running away in one direction – towards self-destruction. This form of imbalance is usually triggered by efforts to maximise or minimise one variable, which in this case could be the minimisation of emotion. Wild range oscillations are the second way in which a system can be out of balance. This seems to occur once the user has begun the process of recovery, which usually entails a

number of relapses. While oscillations still entail an imbalance, viewed from a meta perspective, they represent the beginnings of change toward stability.

According to Keeney (1983), both these types of imbalance are usually the result of uncoordinated feedback, which is a result of boundaries between the systems that are too rigid or impermeable or boundaries that are too permeable. In these instances, the feedback is inadequately structured (Keeney, 1983) and inadequate feedback between systems is associated with various types of escalation. The users attempts at establishing boundaries through denial, detachment, repression and suppression seem to result in boundaries between and around the self as a system that only allow feedback that maintains the system's way of functioning to enter.

However, this process occurring between systems is recursive. The systems that the user is embedded in also have a role to play in the escalation of the user as a system. The lack of adequate higher order feedback also seems to maintain the problematic boundaries around the user. Thus, this self-destructive process of escalation of the user as a system can also be viewed within the recursive cybernetics perspective as merely part of a larger system attempting to self-correct. Thus, a system that is in the process of self-destructing due to unchecked escalation, can be viewed as a system that lacked feedback of feedback. In other words, symmetrical behaviour occurring within a system may be due to lack of feedback from a higher system. By the same notion then, in order for the subsystem to cease escalating, feedback from a higher order is necessary.

Thus what it seems is needed is second order change or in other words, a new response from outside the system. This response would take the form of complementary behaviour, which is behaviour or inputs into the system that are opposite to each other, which allows the system to stabilise (Guttman, 1991). Thus, where the user's reaction to pain is to attempt to escape, the complementary behaviour would be to risk connection with the self and others and surrender to the pain or according to Jung's (in Sharp, 1988) notion: risk the fight with the dragon.

According to Sharp (1988) few people choose the Hero's Journey, for who would want to face the dragon? But sometimes something deep inside demands that the journey is lived out. Nature has ordained it and the cripple is offered the opportunity to become the hero. Sharp explains the symbolic meaning of the dragon:

> "Psychologically, the whale-dragon-monster is the unconscious, and in particular the parental complexes. The battles and suffering that take place during the night sea journey symbolize the heroic attempt to assimilate unconscious contents instead of being overwhelmed by them. Symbolically, the vital organ that must be severed is the umbilical cord, the regressive tie to the past…The hero is the one who conquers the dragon, not the one devoured by it" (p. 109).

Thus, in order to conquer the dragon, which represents the old ways of functioning that keep them trapped in process of self-destruction, the users have to face their pain and individuate fully in order to begin the process of integrating a separate identity for themselves.

According to Waddell (2002) many theorists have speculated about a baby's experience of the world, with Freud suggesting that the child's primary conflict centres around the death versus the life instinct and Melanie Klein emphasizing the conflict between states of love and hate. Bion in (Waddell, 2002) had a different conceptualisation and saw the conflict as "the predicament of having the desire to know and understand the truth about one's own experience on the one hand, and the aversion to that knowing and understanding on the other" (p. 62). According to Horney (1952) alienating oneself by walling off inner experiences results in feelings of despair and hopelessness. To avoid this, Bion (in Waddell, 2002) maintained that the success of this quest for knowledge about the truth of one's experience is found in the capacity to actually have the experience, in the sense of really going through it and suffering it, rather than seeking to avoid or dismiss it. According to Allport (in Jordaan & Jordaan, 1985):

> "Man finds himself 'thrown' into an incomprehensible world…He lives in a whirlpool of instability, aloneness, suffering, and is haunted by the ultimate spectre of death and nothingness. He would like to escape from the burden of anxiety, but he would also like to know its meaning" (p. 769).

The Hero's Journey offers the user the opportunity to face his/her dragon and find this meaning. According to Campbell (1972) in his Hero's Journey, Separation is

> "the 'awakening' of the self no matter what the stage or grade of life, the call that rings up the curtain, always on a mystery of transfiguration – a rite or moment, of spiritual passage, which when complete, amounts to a dying and a birth. The familiar life horizon has been outgrown; the old concepts, ideals and emotional patterns no longer fit; the time for the passing of a threshold is at hand" (p. 51).

In the users' experience this is the time they first realize their substance abuse is a problem. For many of them it closely resembles a death, in the form of a near overdose, but for all it signifies the beginning of the death of an illusion of control. This 'call' signifies the lessening of denial. The crossing of the threshold is symbolically linked to dying and it is significant that many references to death were made by the interviewees. However, this death is associated with a process of rebirth or individuation.

The psychic 'death' experienced during the Hero's Journey, spoken of by Campbell (1972) is a theme explored by many theorists. Freud first spoke of it as the 'death instinct'. Since then it has been implicated in pathology as well as in the process of individuation, where its motivating role is vital. Jung (in Mudd, 1990) touched on the fear of death as an interfering factor in the process of individuation: "The neurotic who cannot leave his mother has good reasons for not doing so: ultimately, it is the fear of death that holds him there" (p. 24). However, it has also been considered an essential motivating factor in the individuation process. In Campbell's Hero's Journey, the protagonist must face the ultimate fear in order to transform. Perhaps it is significant that

so many of the interviewees who are in the process of recovering and facing their 'dragons' spoke of the theme of death and related their substance using to this. Mudd (1990) explains the process in which death is a transforming factor:

> "Our commonplace, everyday anxieties concerning any form of risk, failure, need or limitation, all of which inhabit the darker reaches of the self, can be traced ultimately to the ego's most dreaded fantasy: its own extinction…Despite the ego's horror in the face of its own mortality, death has tremendous psychological utility. It is in reality the primary catalyst for individuation and offers us the opportunity to enter our own destinies by passing through the ego's illusions into the ineffable essence of human life…" (p. 25).

Users' inability to form a solid, healthy identity can also be viewed in relation to the ego's struggle with death. Mudd (1990) suggests that Jung's persona, and its fraternal twin, the shadow, and Freud's constructed conscience, the superego, are all symbolic of the ego's struggle with the paradoxical nature of the self and the light and dark of life and death. Mudd (1990) suggests that balance of the psyche, or Jung's transcendent function is based on the archetypal experience of living through the threat of physical death. Thus, in order to achieve homeostasis of the system an ongoing series of conscious voluntary psychological deaths are necessary. "It is human relationship which provides the sacred space within which we learn to die and which enables the transcendent function to evolve into operational psychological reality" (Mudd, 1990, p. 127).

Thus, in terms of Campbell's (1972) Hero's Journey, death, represented by a crossing of the threshold, symbolizes facing all that is feared in order to live again. For the users this is facing the pain of loneliness, abandonment, rejection, rage, self-hate, guilt and fear. The next phase of the journey is Initiation, which is described by Campbell (1972) as follows:

> "Once having traversed the threshold, the hero moves in a dream landscape of curiously fluid, ambiguous forms, where he must survive a succession of trials. This is a favourite phase of the myth-adventure. It has produced a world of literature of miraculous tests and ordeals. The hero is covertly aided by the advice, amulets, and secret agents of the supernatural helper whom he met before his entrance into this region" (p. 97).

For users, this stage represents the beginnings of recovery. This is the stage where they encounter the dragon and instead of running like before, stay and fight. This fight includes the physical pain of withdrawal, the psychological pain associated with facing the various parts of themselves and how they feel and think, facing relatives and friends and being honest about these relationships, and ultimately letting go of their illusions and protective defences. The helpers they find along the way represent external relationships in which they begin to learn to connect as well as aspects of themselves they discover.

Relapses also occur in this stage and can be viewed as 'slips', a momentary overwhelming fear of the dragon that caused the user to stumble backwards, but not altogether leave the fight. They are merely a part of the battle. This process of dusting oneself off time and time again can be viewed in terms of Keeney's (1983) process of oscillation, which appears to be a necessary step toward increased stability. Some users lose the battle with the dragon and decide to run forever, returning to substance abuse until the system self-destructs. However, for most users this battle is life-long. Although they reach the final stage of the 'Hero's Journey', they must often return to face the dragon again. Campbell (1972) describes the stage of Return:

> "When the hero-quest has been accomplished, through penetration to the source, or through the grace of some male or female, human or animal, personification, the adventurer must still return with his life-transmuting trophy. The full round, the norm of the mono-myth, requires that the hero shall now begin the labour of bringing the runes of wisdom, the Golden

> Fleece, or his sleeping princess, back into the kingdom of humanity, where the boon may rebound to the renewing of the community, the nation, the planet, or the ten thousand words" (p. 193).

This stage symbolically represents the integration of new information into the system. It represents the process of integration of the self and others, the emergence of a new identity and essentially a new way of being in the world that is more aware and more connected.

For substance users, relapse appears to be an integral part of the process of recovery, which is intertwined with a process of individuation in order to achieve an integrated sense of self. According to Campbell (in Johnson, 1997):

> "One of the first functions of the puberty rites of primitive societies, and indeed education everywhere, has always been that of switching the response systems of adolescents from dependency to responsibility – which is no easy transformation to achieve. And with the extension of dependency in our own civilisations into the middle or even late twenties, the challenge is today even more threatening than ever, and our failures are increasingly apparent. A neurotic may be defined, in this light as one who has failed to come altogether across the critical threshold of his adult 'second birth'. Stimuli that should evoke in him thoughts and acts of responsibility evoke those, instead, of flight to protection, fear of punishment, need for advice and so on" (p. 82).

The process of individuation can be seen as a re-negotiating of boundaries between the user as a system and their more-encompassing family system, as well as a re-negotiation of the boundaries between the subsystems of the self, in order to maintain boundaries that are neither too diffuse nor too rigid.

To achieve wholeness, the conscious decision to cross the threshold needs to be made (Johnson, 1997). This process of recovery, which entails facing the dragon and thus allowing new information into the system, seems to send the system into a process of oscillation. However, this can be viewed as a step toward an eventual balancing of the system.

Complete balance is never achieved, due to the fact that systems maintain a dynamic form of homeostasis, which implies that recovery is never entirely complete and is, in essence, a process which users choose to maintain.

5.7 CONCLUSION

This chapter provided a discussion of the results of this study and an integration with literature from various theoretical perspectives. An overall integration of these perspectives within systems theory was also presented. The final chapter provides some broad conclusions gained from this study and a brief discussion of the limitations of the study.

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Chapter Six

CONCLUSION AND RECOMMENDATIONS

Learn to sit still and hurt

AA Saying

6.1 INTRODUCTION

This chapter presents the broad conclusions that can be drawn from this study. A brief discussion on the limitations of the study is also provided. Finally, a few recommendations can be made to substance users and professionals in the field of substance abuse rehabilitation, in addition to avenues for further study.

6.2 CONCLUSIONS DRAWN FROM THIS STUDY

- Relapse is a maladaptive coping technique.

By maintaining the way in which the users as systems are accustomed to functioning, it allows them a sense of security in familiarity. Whenever users are faced with a problem, they tend to focus on the emotion associated with it (Carver *et al*., 1989). This contributes to their experience of these emotions as overwhelming. Thus, the emotion-focused coping techniques that they then use tend to be maladaptive, because they are based on a desire to detach from or remove the emotions indefinitely, which is impossible. Emotions can be postponed but not avoided altogether. The use of a substance to remove negative affect states is temporarily effective, but in the longer-term compounds these painful emotions. Thus, these techniques only succeed in exacerbating the original problem, thereby maintaining the system's way of functioning. Thus, their solutions to the problem become the problem (Segal, 1991).

- Relapse is a dysfunctional way of strengthening boundaries within and around a sense of self that threatens to fragment.

A recursive process can be seen in the relationship between substance use and identity. Their fragmented identity state (Luzzato, 1987), which seems to leave users vulnerable to becoming trapped in a cycle of substance abuse, is in turn exacerbated by the process of substance abuse. Constantly disengaging with reality through defences like denial, repression and splitting and then substance use, in an attempt to create boundaries, leaves

them living a detached life. This detachment from their own experience makes connection with 'the self' virtually impossible, thus maintaining their fragmented identities. The splitting and suppression that occurs during relapse highlights the way substance use maintains their fragmented identities.

- Relapse is both a part of an ongoing cycle of self-destruction, in addition to being a part of the process of recovery.

Relapse as a method of detachment can be viewed as an example of symmetrical behaviour (Bateson, in Keeney, 1983), or feedback into the system, which keeps the system in a constant self-destructive process. The users' tendency to keep returning to substances in an attempt to escape realities with which they feel they cannot cope is a recursive loop in a system that is heading for self-destruction. This maintains their constant feelings of being 'out of control' and powerless and illustrates a system's tendency to maintain the status quo (Freeman, 1993). However, relapse is experienced by users as consisting of both negative and positive aspects. While a relapse has the potential to increase feelings of worthlessness and guilt, maintaining the cycle of self-destruction, when it is faced and accompanied by therapy or counselling from a support structure like Narcotics Anonymous, it has the potential for further insight into the self and allows for change. Thus, whether the user perceives the first use of cocaine or heroin after treatment a minor 'lapse' or a full relapse makes a significant difference to the eventual outcome of treatment (Gossop *et al*., in Broers, Giner, Dumont & Mino, 1999).

6.3 LIMITATIONS OF THE STUDY

- Obviously if the number of participants in the study was greater, the study would have yielded more categories and a better understanding of the process of relapse. However, the fact that the categories did begin to repeat after eight interviews, and the fact that it would have taken a greater number of interviews, exponentially, in order to yield fewer and fewer additional categories, which was not practical, contributed to the decision to stop interviewing.

- Although Phoenix House is non-profit organisation (NPO) and is semi-subsidised by the government, the costs involved in a three-month stay are still high. This means that the participants consisted only of those people who can afford to go there or who come from a family of origin who can afford to pay the fees involved. The majority of the participants in the study were from middle class families and this may have impacted on the information gained. Thus, the data gained from this study is highly context specific. However, the parameters of the study were clearly outlined in the introduction and thus, the results of this study are not meant to be generalised to other contexts.

- The fact that interviews were conducted with users who had experienced a number of relapses may have skewed information with relation to the category of identity. Perhaps there are users who enter treatment and then don't relapse as much due to a more integrated sense of self, but since the aim of the study was the experience of relapse, it was necessary to use interviewees with more experience in this regard. Another possibility is that having had more relapses results in a different experience of it, which also would have affected the data. The only difference having relapsed a greater number of times before seemed to make was with regards to the degree of severity of the experience. More guilt and shame seemed to be experienced. However, if treated after relapse this was also accompanied by more insight into their own processes of relapse.

- The fact that participation in the study was on a voluntary basis may also have affected the results. The possibility exists that there were candidates who refused to participate in the study and that this may have yielded different personality dynamics. The people who did volunteer to participate were further along their process of recovery and it could be said that their participation in the study was a part of facing their dragons and bringing back what they had learned on their Hero's Journey so far, by integrating this new information into the self.

- Lastly, the fact that this study attempted to combine a number of theoretical approaches to substance abuse in order to gain as full an understanding of relapse as possible, may have diluted the significant contribution that each of these approaches brings to the topic.

6.4 RECOMMENDATIONS

- Relapse is a complex phenomenon, which occurs simultaneously on a variety of systemic levels. It can thus not be separated from the context of substance use in which it occurs. Although viewing substance use and relapse through a specific theoretical lens offers specific, significant views of the problem, these views tend only to be part-arcs in the greater process that constitutes this problem. A flexible, multi-theoretical approach is thus recommended for the treatment of substance users.

- Connection seems to be the key to breaking the cycle of alienation that users experience. This is something that should be kept in mind by users, their families and friends, therapists and society alike. The stigmatisation of substance users maintains their behaviour. Falling into the trap of rejecting users without looking beyond their behaviour allows them to continue functioning in a way that confirms their view of themselves as unlovable, which, in turn, maintains their behaviour. This rejecting attitude held at a societal level may be an aspect of society as a system's attempts to self-correct, however this appears to be one of the maintaining meta-processes in the users' self-destruction. Perhaps society should face its dragons?

- Although the cycle of self-destruction described in this study is related specifically to substance abuse and relapse, it is possible that similar cycles could be found in relation to other forms of 'pathology' or psychological distress. This could be investigated by future studies.

- Further study is also recommended within the field of substance abuse. The possibility that different substances solve different conflicts within users' personality

structures needs further exploration and may reveal systems trapped in differing cycles of self-destruction. Further studies could also explore the role of the categories identified in this study in various treatment options available. Loneliness, maladaptive coping styles and a lack of an integrated identity need to be addressed. It would be interesting to see the degree to which and manner in which these issues are addressed by the different treatment facilities in South Africa.

6.5 CONCLUSION

Although limited in scope, this study attempted to present a multidimensional understanding of the problem of relapse, within which the various significant emotional, cognitive and social factors that maintain the substance-using systems were identified. Further study in this area needs to be conducted in order to provide more effective treatment for the growing number of people seeking help for substance use disorders.

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