Mapping the Maintenance Stage of Recovery: A Qualitative Study among Treated and Non-treated Former Alcohol Dependents in Poland

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Abstract — Aims: The study provides an in-depth qualitative understanding of the maintenance stage when recovering from alcohol dependence with a focus on the broader social context of change of addictive behaviour. It explores the recovery as a subjective process within the abstinence-oriented Polish treatment system organized on the basis of the Minnesota model and is probes for group differences between treated and non-treated populations. Methods: The study is based on qualitative data from a media-recruited sample of 29 treated and non-treated former alcohol dependents (ICD-10) in Warsaw/Poland 2006/2007. They reported a recovery time of at least 2 years ($M_{\text{recov}} = 11$, SD = 9). In-depth, semi-structured interviews were analysed according to the problem-centred interview method using ATLAS.ti software. Results: A wide range of maintenance strategies potentially contributing to the stabilization of recovery from alcohol dependence was identified. However, from the respondents’ point of view, the change process is contingent upon the subjective weighing of specific maintenance factors and the importance attributed to their interplay. This includes time management as well as one’s ability to invest available resources and strengths in shaping and pursuing personal goals. Conclusion: More commonalities than differences can be observed between groups during the maintenance stage, regardless of respondents’ type of the pathway out of addiction. However, when confronting professional concepts of recovery with subjective accounts, only a subgroup conforms to the invasive, potentially normative definitions of recovery, while others do not link their recovery with identity transformation.

INTRODUCTION

Most of the studies on alcohol dependence are concentrated on its individual and social consequences and on early recovery phases; less is known about the maintenance stage of recovery (Prochaska and DiClemente, 1984; Prochaska et al., 1992), among both treated and non-treated subjects. Moreover, the definitional boundaries of recovery remain blurred, since professionals—addiction treatment researchers and policy makers have not yet reached a consensus on the definition of recovery that would meet the criteria of precision, inclusiveness, exclusiveness, measurability, acceptability and simplicity (The Betty Ford Institute Consensus Panel, 2007; White, 2007; Kleining, 2008). There is also a gap between theoretical discussions on the meaning of recovery and operational criteria used by researchers who tend to define recovery as rather short periods ($M_{\text{length}} = 1.2$, SD = 0.7), (Carballo et al., 2007). Consequently, less is known about the long-term processes involved in maintaining recovery-related changes and about the impact of time on the stabilization of the recovery process. Only some authors suggest that the maintenance stage can be divided into phases. Klingemann (1992) identified the sequence of phases during the maintenance stage of recovery: (a) tricks and a renewed self-confidence, (b) protecting the achievement, (c) a new life and (d) peace of mind and reconciliation with others. The last phase can be characterized by the internalization of new social roles and by the successful completion of a search for meaning in one’s life (Klingemann, 1992). Similarly, in a Mohatt et al. study (2008) the last phase, named ‘the life as it is meant to be lived’, follows the active coping phase.

From ‘an outer perspective’, maintenance studies are focused on the measurement and observation of factors co-varying with successful recovery. Prior studies have shown that receiving social support from family members and friends or having significant others, goes along with individuals’ well-being and thereby seems to enhance their motivation and self-confidence to maintain the change of addictive behaviour (Moos et al., 1982; Longabaugh et al., 1993; Higgins et al., 1994; Beattie and Longabaugh, 1997, 1999; Fichter et al., 1997; Billings and Moos, 1998; Finfgeld, 1998; Blomqvist, 1999; Sobell et al., 2000; Moos and Moos, 2006, 2007). Blomqvist (1999) emphasizes gender bias; in his study men, significantly more often than women, cited the role of the partner as an important maintenance factor. Lack of family resources is often compensated by spiritual or religious involvement and support received from a religious community (Klingemann, 1992; Finfgeld, 1998; Blomqvist, 1999; Sobell et al., 2000; Granfield and Cloud, 2001). In Blomqvist’s (1999) study, women were more inclined than men to report esoteric or spiritual experiences as important part of their recovery. In addition to family resources, the work and financial resources (Moos and Moos, 2007) are considered to be the most important ingredients of stable recovery. Maintenance studies show also an intervening effects of maintenance factors such as: improved health and feelings of well being (Burman, 1997; Moos and Moos, 2007); self-confidence (Moos and Moos, 2007); self-control and willpower factors (Blomqvist, 1999; Koski-Jäntes and Turner, 1999; Sobell et al., 2000); sense of pride about what has been accomplished (Finfgeld, 1998) and a more profound sense of life (Blomqvist, 1999). These findings point out, that the meaning and individuals’ importance attributed to these ‘factors’ may considerably differ and consequently determine different outcomes.

Antonovsky’s salutogenic model accommodates this perspective suggesting that maybe the question which and how many resources are available to the individual in the process of recovery is after all not very relevant but the ability to use
them flexibly in coping situations comes to the foreground (Antonovsky, 1995). Also Marlatt and Gordon’s (1985) pathogenic model of relapse focuses on the role of low self-efficacy and lack of effective coping skills as risk factors for relapse. Indeed, in previous studies of treated and untreated individuals, fewer personal resources, such as lack of self-efficacy and coping skills, have been associated with relapse (Rychtarik et al., 1992; Brown et al., 1995; Connors et al., 1996; Miller et al., 1996; Moos and Moos, 2006).

Qualitative studies, focusing on ‘the inner perspective’ shed more light on maintenance strategies and the interplay and actual use of structural resources during recovery from addiction. Most remitters are conscious strategists; however for some, these coping strategies are only needed in the initial phase of recovery, whereas others continue to use them on a daily basis for years (Klingemann, 1992; Finfgeld, 1998). This refers to respondents’ commitments to reinvest in themselves and their longstanding values and interests; becoming more involved in or renewing their involvement in meaningful work, non-substance-related activities, volunteer work or artistic and creative endeavours. Some remitters engage in new, improved or more meaningful interpersonal relationships or a spiritual life (Finfgeld, 1998; Koski-Jännes and Turner, 1999). Work-related changes, changes in general lifestyle or in living arrangements (Finfgeld, 1998; Blomqvist, 1999; Sobell et al., 2000) as well as the resumption of leisure time activities (Klingemann, 1992) are strategies often mentioned in maintenance studies. Some strategies serve the practical task of avoiding temptations or former company (Koski-Jännes and Turner, 1999) and providing alternative rewards to those obtained from alcohol use (Moos and Moos, 2007). Other strategies include strengthening ‘the right attitude’: remembering of negative consequences of alcohol use (Burman, 1997; Koski-Jännes and Turner, 1999), positive thinking and future orientation (Miller et al., 1996; Koski-Jännes and Turner, 1999; Bischof et al., 2000) and rewarding oneself (Koski-Jännes and Turner, 1999). Former alcohol dependents are attempting their reintegration into society by socializing with non- or social drinkers and focusing on their own responsibilities and society’s role expectations (Klingemann, 1992; Burman, 1997; Finfgeld, 1998; Blomqvist, 1999). Engagement in volunteer work may provide a framework for self-forgiveness and since helping is much better regarded in our society than being helped, it may also improve the status of recovered individual (Klingemann, 1992; Burman, 1997). For those who have recovered by the use of professional treatment or self-help group, further participation in alcoholics anonymous (AA) as an ongoing reminder in conjunction with observable examples of recovery may also serve as a maintenance strategy (Blomqvist, 1999; Bond et al., 2003; Moos and Moos, 2007; Kelly et al., 2009).

Studies on the maintenance of alcohol addiction recovery conducted among naturally recovered individuals help to overcome the institutional bias created by treatment studies even though treatment samples still represent the lion’s share of research. Moreover, differences between treated and untreated samples are deduced mainly indirectly, because comparisons of those groups within one study are the exceptionals (Blomqvist, 1999; Bischof et al., 2000; Moos and Moos, 2006). In a Blomqvist (1999) study, self-remitters’ reports were mainly concentrated on the role of the partner or family members and on internal, emotional and/or cognitive changes, whereas the reports of treated remitters were more evenly distributed across a greater number of factors, including changes in living circumstances and various habits, as well as various forms of formal assistance. Self-help group members continued their involvement in AA activity, whereas natural recovery group members were absorbed by their families and leisure activities. Bischof et al. (2000) compared naturally recovered individuals with subjects who remitted with the aid of extensive self-help group participation. They identified no group differences in terms of coherence, satisfaction with life domains, temptation to drink and self-efficacy in remaining abstinent. The groups did not differ on supportive life domains except that self-help group subjects specified friends, family and religion more, and health less, as maintenance factors. Moreover, self-change investigated on grounds of longitudinal data showed high stability (Rumpf et al., 2006).

The study presented here explores issues related to maintenance of recovery from alcohol dependence in Poland among a sample of individuals who have recovered by means of self-change, self-help group participation or specialized outpatient and inpatient therapy for alcohol dependents. The article explores dependence as a social rather than biological state: defined socially and embedded in social acts that condition it; specific resources or recovery strategies are not equally distributed within societies and their recovery potential may differ in different cultures.

The analysis presented here provides an in-depth qualitative understanding of what maintains recovery with a focus on the broader social context of change of addictive behaviour and including the impact of time on the recovery process. Results of the addiction recovery studies show that subjective accounts of addiction and recovery differ (Larkin and Griffiths, 2002; Klingemann, 2011). The article discusses recovery as a subjective process linking it with a conceptual framework of the meaning of recovery. In Poland, no previous systematic research has, to the author’s knowledge, addressed these issues.

METHODS

Sample

The study is based on extensive interview data from 24 men and 5 women (M_age = 52 years, SD = 10 years, age range: 34–73 years). All participants had previously been alcohol dependent according to ICD-10 diagnostic criteria (M_dependence = 13 years, SD = 8 years). All participants had to have at least a 2-year period of recovery (M_recovery = 11 years, SD = 9 years), meaning no symptoms of dependence or harmful use of alcohol or other drugs. Complete abstinence was not a criterion for inclusion in the study. However, the majority of respondents were abstainers (n = 24). Others were moderate drinkers: their alcohol consumption did not exceed 16.3 g/day (M_consumption = 6.5 g/day, SD = 7.1 g/day).

Data collection

Lack of predictive power with quantitative statistical data may result from an insufficient knowledge of the variance in meanings attributed to the same terms used in structured
questions by the respondents. Qualitative research shed light on the subjective variance of meaning. This qualitative study was conducted in Poland (Greater Warsaw) between October 2006 and June 2007 using media recruitment to establish the sample (Klingemann, 2011 for the text of media call and detailed methods description). Respondents were not remunerated for their participation. In order to ensure data reliability and validity, source triangulation and methodological triangulation procedures were applied. More specifically, to ensure synchronic reliability, different methods were used to collect data from the respondents and to ensure diachronic reliability, respondents were contacted several times in several-week intervals and some of the questions were repeated (refer to Table 1 for the overview of the data collection procedures and instruments). Two sociologists, each of whom was trained in qualitative methods of data collection, conducted the interviews. Each possessed previous research experience with substance users from different cultural backgrounds. Interviewers followed the interview guidelines of asking questions in a flexible manner, in order to merge with and facilitate the narrative flow. Consequently, the interviews were structured by interviewees, not by the guidelines. Ad hoc questions were asked only if certain topics were left out by the interviewees to secure comparability of the data and completeness of topical areas. Two trained students of social sciences meticulously transcribed the interviews recordings. Transcripts include information on non-verbal communications such as laughter, crying, silence, interview interruptions, as well as comments from the person transcribing the interviews facilitating the interpretation.

In order to check the validity of the data, information was gathered both from the respondents themselves and from collaterals (meaning the person indicated by respondent who witnessed his/her addiction history, i.e. partner, adult child and friend), (Konecki, 2000; Silverman, 2001). However, to avoid biasing the sample in favour of subjects with intact social networks, nomination of collateral informants was not a criterion for eligibility. Information gathered from collateral informants was used to validate respondents’ addiction history and help-seeking status. No inconsistencies were found.

**Analysis**

Data were collected and analysed according to the problem-centred interview (PCI) methodology using ATLAS.ti software (version 5.5.3). The concept of a PCI

<table>
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<tr>
<th>Phase</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
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<tbody>
<tr>
<td>Purpose</td>
<td>(a) Informing the callers about the study aims and procedures</td>
<td>(a) Informing the study participants about the benefits and risks of participation</td>
<td>(a) Obtaining written informed consent</td>
<td>(a) Checking validity of the data</td>
</tr>
<tr>
<td>Respondents</td>
<td>All respondents to newspaper advertisements (n = 53)</td>
<td>All subjects meeting inclusion criteria and consenting to participate (n = 31)</td>
<td>All subjects meeting inclusion criteria and consenting to participate (n = 29)</td>
<td>All collaterals nominated by study participants and consenting to participate (n = 20)</td>
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<tr>
<td>Means of contact</td>
<td>Telephone</td>
<td>Postal</td>
<td>Personal</td>
<td>Telephone</td>
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<tr>
<td>Instruments</td>
<td>Telephone questionnaire</td>
<td>(a) Information sheet</td>
<td>(a) Self-administered questionnaire</td>
<td>Telephone questionnaire</td>
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<td>(b) ‘Life history chart’</td>
<td>(b) Life drawing, (c) In-depth semi-structured interview</td>
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<td>Topics</td>
<td>Socio-demographic characteristics, dependence criteria and alcohol-related problems (life-time), help-seeking history, perceived treatment availability, previous and current alcohol consumption, decision to quit/moderate consumption</td>
<td>ad. (a) research aims, contact information, confidentiality issues, benefits and risks of participation ad. (b) chronological order of events in personal and professional life, events connected to substance use, place of living</td>
<td>ad. (a) drug use and abuse, dependence criteria and alcohol-related problems (last year) ad. (c) perception and experience of dependence and related problems, characteristics of the process of overcoming the dependence, available resources, factors facilitating or hindering recovery, health status and behaviours, other then alcohol substance use and abuse, future plans</td>
<td>Pre- and post-resolution drinking patterns and level of alcohol consumption, alcohol-related problems, drug use, help-seeking status, time and perceived cause for recovery, own role in recovery</td>
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<tr>
<td>Time to complete</td>
<td>20 min</td>
<td>30 min</td>
<td>90–240 min</td>
<td>15 min</td>
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<td>Time period from initial contact</td>
<td>—</td>
<td>1 week</td>
<td>4–8 weeks</td>
<td>6–10 weeks</td>
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Table 1. Overview of data collection procedures and instruments
borrowed largely from the theory-generating procedure of
grounded theory (Konecki, 2000); however, the insight

gained through data analysis is organized as an inductive–de-
ductive mutual relationship. The deductive–inductive scheme
allows utilization of theoretical concepts and findings from
previous research, without lowering the chances for serendip-
ity. This implies a two-step coding procedure.

Initially, the transcripts were inductively coded ‘sentence
by sentence’. The applied open-coding procedure captures
the meaning of data and ‘sentence by sentence’ procedure

guarantees that no data are left out.

Afterwards, the inductive codes were linked with the more
general categories derived from the interview guidelines
(‘code by list’ procedure). That second step linked the inter-
view data with the deductive, theoretical categories. Finally,
the codes and quotations were compared within each cat-

gory, and new categories were created if needed. In order to

identify and deduce inductively typologies, the constant
comparative method was applied—different types of data as
well as the categories, codes and finally the cases were com-
pared, and similarities and differences identified and inter-

preted (see Witzel, 2000—for a detailed description of PCI

methodology).

**Ethics**

Consent was treated as a continuous process—respondents
were advised at every stage of data collection that they could
terminate the interview at any point and that they could also

refuse to give answers to certain questions if they felt they
could become distressed while answering them. After the

phone interview, respondents received an information sheet
describing, in detail, the research objectives, contact informa-
tion, assurance of confidentiality of the data and information
about the benefits and risks of participation. Written

informed consent was obtained from all respondents. No re-
spondent who volunteered to participate in the interviews
refused to discuss any of the pre-determined topics identified
by the interviewers.

**RESULTS**

The analysis of the respondents help-seeking history led to
the identification of five subgroups adopting different paths
of overcoming dependence: (a) self-changers (SC), (b) con-
sumers (CR), (c) AA, (d) outpatients (OP) and (e) inpatients
(IP). The group assignment was the result of the analysis and
interpretation of addiction history narratives: not only the
contacts with addiction treatment (failed and succeeded)

were taken into consideration, but also its subjective
meaning (i.e. a respondent who recovered without therapeutic
help, but who believes that the failed treatment attempt

few years earlier was crucial for his recovery was qualified as
IP). The paths differ due to the type of support used to

overcome dependence and served as baseline/background for

assessing-related maintenance strategies. SC used exclusively
lay support and lay strategies. Those respondents have not

been in touch with any therapeutic help during their recovery
period. CR used some amount of professional help. How-

ever, these individuals were not ‘treated’ in the classical
sense—they included rather, some proactive elements of

professional assistance in their lay recovery programs. They


**Mapping the maintenance stage of recovery 299**
their way of how to maintain change was taken into consideration; consequently the results of the analysis are presented for all groups by specific theme, not by type of recovery.

### Multidimensionality of change

After identifying the range of specific aspects of change, the joint appearance or the linking of these aspects in the narratives was highlighted in a second step of the analysis. Combining a multitude of change elements emerged as an important theme from the respondents’ accounts which was perceived as helpful in their decision to stop drinking; 19 respondents (65%) referred to all five analytical categories describing their maintenance efforts and another quarter of them (28%) referred to four categories. A closer look shows that not only the pattern of drinking changed but also the respondent’s whole life changed, practically, symbolically and often spiritually. Some respondents took advantage of the opportunity to make a new living in a new environment, without the burdening consequences of dependence: ‘Change of house, new job. Completely new people who did not know about the problem. This was more than just quitting drinking. Quite by accident, everything, whole my life began anew’ (M36, CR-A). Symbols in parentheses: gender (M, male; F, female), age, type of recovery strategy (SC, self-changer; CR, consumer; AA, Alcoholic Anonymous believer; OP, outpatient; IP, inpatient), present alcohol consumption pattern (A, abstinence; M, moderation).

Multidimensional change of environment helped respondents to maintain their recovery. A new place of residence, new job, new friends—all that helped to start a new life: ‘The system transformation in 1989 … the wholesome change of functioning and quitting alcohol … Maybe I am wrong but it seems to me that in some way the history of my country has influenced my personal history. At some point I have changed my environment, place of living, work …’ (M52, OP-M). Change sometimes was connected to a birth...
of a child or grandchild: ‘My granddaughter was born and I was taking care of her while my daughter-in-law was at work. I saw it as a chance to have somebody who trust me, who does not think bad of me’ (M58, SC-M) and sometimes to a new (or revitalised) relationship: ‘I’m 52 and am still going to enjoy life. My wife came back to me. We plan to marry again’ (M52, IP-A). Improved relations with partners and children are very important in maintaining recovery.

Some respondents—in order to stop or to cut down on their drinking—significantly changed their life situation: their living and working arrangements, circle of friends; however, they did not intentionally and consciously go through any identity transformation—for them it was rather the return to previous (and satisfying) life and normal social roles: ‘The return to normality. I used to be punctual, responsible – when I gave my word, I kept my word. Now again I can make plans and promises and I can be trusted’ (M36, CR-A). Others emphasized the spiritual nature of their changes: ‘At some point I have stopped attending therapeutic meetings, but I started to spend more time in my religious community. More I was praying to God, more I received from him’ (M50, OP-A). Overcoming dependence was also connected to personal growth leading to internal transformation: ‘Self-work. (…) That was the hardest part. You have to make a great effort to change. (…) You have to become somebody to be sober’ (M60, SC-A); ‘When I started therapy I have noticed, that my life is not empty anymore. I even felt better then other ‘normal’ people who spend their lives watching soap-operas, because I am doing something with myself’ (F43, OP-A).

Coping with stress and cravings

Respondents from all groups reported the change in coping with everyday life problems: they try not let the problems to accumulate: ‘Everybody has problems, I am just not letting them to accumulate anymore’ (M52, IP-A), they perceive them as easier to overcome, and they feel more confident in coping with them: ‘One can say, a sober person has small problem, but a drunk person perceives it as enormous and impossible to solve’ (M45, SC-A).

Cravings tend to appear in relatively early stages of the maintenance phase: ‘Twice I dreamt that I got drunk. I cried through my dream. I was so sorry and I could not understand why I did that. I woke up all sweated. It was after two or three years of abstinence’ (M43, SC-A, recovered since 6 years). Strategies used in such situations include weighing pros and cons of drinking and recollecting the negative consequences of dependence: ‘To recall the problems – my memories of unpleasant physical effects are completely blurred but my psychological condition that I do remember, it’s hard to let yourself be pushed back into something like that once again, it was terrible, indescribable … I felt completely stripped of self-respect… The thought of being in such a position once again definitely motivates you not to drink. You could easily mess everything up again. The older you are, the less time you have to pull yourself back up. (…) I am fully aware of the danger’ (M52, OP-M). Also contact with people who need support helps respondents to remember about the problems they have already overcome.

Impact of time on consolidation of life changes

The changes once introduced in respondents’ lives, stressful and turbulent at the beginning, become an inseparable part of the new life style. ‘Time, certainly. Every year sort of accumulates… Bit by bit, thoughts about what you’ve lost, becoming reconciled with your losses, stabilization, organizing your life anew’ (M48, OP-A). Respondents perceive their recovery as complex process requiring strength, balance and patience - the life situation gradually stabilizes.

The experience of dependency is often reframed and is no longer perceived as a source of weakness: ‘There is this saying ‘If it doesn’t break you it will make you’. And that’s very true as far as I’m concerned. I’m much calmer now than I used to be when I drank, more balanced. I think that I’ve crossed a threshold and learned something. I needed this fragment of my life to teach me something. It has strengthened me’ (F70, SC-A).

DISCUSSION

The article addresses the subjective experience of the maintenance stage of recovery from alcohol dependence within a broader socio-cultural context. Findings of the first Polish study of available paths to recovery, including self-change, are presented. A triangulation procedure was adopted in order to ensure reliability of the data and validity of the data analysis.

Although people change for a wide variety of reasons, they share a more similar repertoire of techniques to maintain the change. Our findings support the assumption that, independent from help-seeking status, more commonalities than differences exist within successful recoveries from alcohol dependence (Koski-Jännes and Turner, 1999; Bischof et al., 2000; Sobell et al., 2000). The aftercare treatment services and support of self-help groups can be perceived as additional (and helpful) resources in reaching a stable recovery, especially if similar resources in the daily life context of an individual are missing. However, recovered subjects are striving toward their societal reintegration and as over time, other resources in their life circumstances become available—professional assistance tends to be less and less needed, and at some point may even impede the consolidation of life changes.

Multiple maintenance factors and strategies contributing to the stabilisation of recovery from alcohol dependence were identified. Findings from our study support results from maintenance studies among treated and non-treated subjects within other cultural contexts. However, our study shed more light on the subjective relevance and interplay of those factors and resources. Not the specific components, but the multidimensionality of change emerges as the most important feature of maintaining the recovery from addiction. Recovery appears over time as an interplay between individual actions, societal reactions and positive and negative life events while subjective accounts of maintenance stage are being continuously constructed and reconstructed. That is especially visible in our study where subjective accounts of recovery experiences from different points of time—subjects’ recovery time varied from 2 to 40 years (M = 11, SD = 9)—were analysed.

The results from this qualitative study point to the more general aspect discussed in the literature, that the questions
recovery from what?’ or ‘what has to be maintained?’ are negotiated during therapy and professional definitions might converge or clash with the ideas of the ‘recovering’ individuals. Concepts which represents ‘a sustainable’ problem resolution and the reasons for long-term maintenance are part of the framing of the meaning of recovery. The attempts of professionals to define recovery from addiction do not focus on the ‘normalization’ of deviant behaviour but rather on ‘voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship’, where the citizenship implies working towards the betterment of one’s community through participation, volunteer work and efforts to improve life for all citizens (The Betty Ford Institute Consensus Panel, 2007). Professional perception of recovery is in fact quite demanding: it is not merely expected that individuals would cease his/her drug use, but it is requiring a major re-structuring of his/her social networks as well as values, knowledge and skills. It is also believed that recovering alcoholics want and should pay back or re-compensate to the society for their antisocial behaviour (The Betty Ford Institute Consensus Panel, 2007; White, 2007). Recovery definitions that place recovery within the context of global health (Foster et al., 2000; Rudolf and Watts, 2002) view the resolution of substance-related problems not as a focal point but as a by-product of broader personal and interpersonal processes. Such definitions withhold the status of recovery from someone who has achieved abstinence but has failed to achieve levels of physical, emotional, relational and ontological (spirituality, meaning and purpose) health (White, 2007). It has been increasingly recognized that the search for ‘standard recovery’ and conditions attached to such a normative endeavour may sometimes set the bar too high. Even though humans are remarkably resilient, they cannot always erase the effects of whatever it is that afflicts them (Kleinig, 2008). Moreover, the demand of total abstinence may also be seen as societal form of punishment (Room, 2004).

Turning objectives of the change and recovery process to the individual perspective we can clearly see that some recovering addicts do in fact meet even very harsh definitional criteria of stable recovery according to the terms mentioned above: both our and other studies on recovery show identity transformation and striving for honourable social identity, adopting the most valued goals of mainstream society, achieving peace of mind, personal growth, taking up creative activities as important components of recovery process (Koski-Jänes, 2002; The Betty Ford Institute Consensus Panel, 2007). However, addiction is a heterogenic phenomenon: in our study the second group of recovering alcohol dependants was identified who, in the same way as ex-smokers (Koski-Jänes, 2002), resolved dependence without any remarkable identity or values change. That is especially true for some of SCs and CR—groups not affected by treatment ideologies. This group effect can be interpreted in the background of the make up of the Polish treatment system, which is based on the medical model of addiction. Since the 1980s, alcohol dependence was treated as a chronic, progressive and incurable condition and its abstinence-oriented treatment is organized on the basis of the Minnesota model [The State Agency for the Prevention of Alcohol-Related Problems (PARPA), 2008]. The view that addiction resides solely within the individual fosters significant limitations across the Polish alcohol treatment system.

In Poland professional ideologies also embraced concepts such as dry drunk, emotional sobriety and serenity. One can only graduate from a treatment programme in Poland as ‘cured’ if one has become a completely new person, a person who will always be in ‘recovery’ (Larkin and Griffiths, 2002; Klingemann, 2011). The language of addiction-as-illness contains layers of assumptions and implications that ultimately render viewing addicted persons as ‘sick’ and lacking the capacity, for the most part, to control their own actions (Larkin et al., 2006). At the same time, some Polish studies show that the professional concepts of dependence imposed on a patient during therapy or while attending AA meetings seem to fade away when the person does not stay in touch with the institution or AA group. The new social roles are internalized and addiction gradually becomes part of the past, despite the therapeutic notion of its incurability (Klingemann, 2011).

Limitations

Firstly it should be noted that this qualitative study with a sample size of 29 participants cannot provide epidemiologic information on the prevalence of the identified categories in a wider population of alcohol-dependent individuals but it explore the dimensionality of subjective constructs. Secondly, qualitative data can be biased by self-attributions and social desirability. This effect has been additionally addressed in this project by the inclusion of collaterals and the triangulation of various data sources that allowed checking for inconsistencies. Furthermore, even though the validity and reliability of self-reports have been shown in addiction research (Maisto et al., 1979; Sobell et al., 1979; Cooper et al., 1981), memory effects might have an effect on the retrospective data. This potential bias has been addressed and narrowed by providing the respondents prior to the interview with ‘life history charts’ to be filled out thus cross-checking the assessment at the time of the interview with diaries and other personal records. Overall this data supports the accuracy of subjects’ reports and are consistent with findings in previous studies using similar retrospective methods (Tucker et al., 1994; Blomqvist, 1999).

CONCLUSIONS

We perceive addiction as a social, cultural and political construct and recovery as a complex, dynamic and multifaceted process. In this process, multiple maintenance elements come together in a combination of tangible and intangible subjective attributions and decisions. Physical and socio-environmental structures, cultural context and related life circumstances affect one’s capacity to reach stable recovery from alcohol dependence. Results of our study support the usefulness of a holistic view of the maintenance stage and insight into the multidimensional ‘mind mapping’ during the endeavour of individuals to maintain their problem resolution.

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