

Struggling to hold drug addiction treatment talk and relapse in mind

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Abstract

Addiction is a common problem, as is relapse. People often struggle to come to terms with and manage the intoxicating effects of substances and consequently need treatment. This dissertation focusses on treatment talk as it relates to addiction counselling in a residential setting in order to understand relapse and the addict's return to treatment. Current treatment approaches that address addiction comprise several evidence-based approaches and yet relapse rates remain high. Attempts to explain this phenomenon are varied and interventions tend to have a disease model approach in common with one another. Neurobiological and psychological theories of addiction are examined to understand this treatment conceptualization and consider its efficacy as a means of directing counselling interventions. Mentalization theory and critical discourse theory are used as a discursive lens in an attempt to understand these interventions and consider their shortcomings. In order to approach the question of relapse and addiction treatment, twenty interviews were conducted with clients and their counsellors – 10 dyads – who had completed residential addiction treatment for relapse. Counsellors and clients were interviewed and asked about their treatment experience, either as a client or clinician respectively. Both sets of participants were also asked about counselling as a relapse prevention intervention. Focus on the counselling relationship was in order to elicit talk about mental states related to treatment for addiction and relapse. A critical discursive analysis of this data was conducted according to principles offered by Fairclough (Fairclough, 2001). The analysis found that disease model jargon mitigated against clients and counsellors thinking about relapse in any other but a largely self-fulfilling, non-psychological and limited manner. The implications of this are discussed with reference to the concept of mentalizing. Recommendations are made for therapeutic alliance between clients and counsellors in addiction treatment.

Table of Contents

Abstract	2
Acknowledgements	7
Dedication	8
Chapter 1: Introduction	9
Introduction	9
Chapter 2: Literature Review	16
Introduction	16
Current Definitions and Theories of Addiction	16
Significant neuro-scientific theories of addiction	21
<i>Neuro-scientific explanations of relapse</i>	27
Significant psychological theories of addiction	36
<i>Psychological explanations of relapse</i>	45
Current approaches to addressing addiction	47
Counselling as a component of addiction treatment interventions	48
Mentalizing	51
Definitions of mentalization	53
Mentalization and addiction	63
Critical discourse theory and critical psychology	65
Critical discursive psychology and addiction	67
Mentalizing, critical discourse and addiction: A synergy	72
Chapter 3: Methods	75

Introduction.....	75
Methodological framework	75
Critical discourse	76
Description of Method	94
Selection of the research design.....	94
The research sample	97
<i>Participants</i>	98
Selection of participants	102
Data gathering measures	103
<i>Biographical Information</i>	103
<i>Clinical Interview</i>	104
Data collection method.....	107
Site	108
Research procedure	109
Ethical issues	114
Informed consent	114
Confidentiality.....	115
Risk.....	116
Disclosure.....	116
Benefit	116
Conclusion.....	117
Chapter 4: An analysis of addiction illness discourse and relapse	118

Introduction.....	118
The Self as Diseased	120
The psychic equivalence of desire as illness: “I know the result will be jail, death or institution”	132
Self-will and Desire: Negotiating Addiction and Responsibility	148
Self-will as diseased	152
Concluding Observations	160
Chapter 5: A discursive analysis of the dilemma of desire in addiction treatment talk.....	162
Mentalization and curiosity as an ambiguous struggle in addiction treatment	162
Discursive self-definition in addiction treatment	163
Discursive self-definition and the construction of regulated desire.....	167
Holding desire in mind as a discursive dilemma	183
Concluding Observations	188
Chapter 6: Conclusions and Recommendations.....	189
Introduction.....	189
Conclusions.....	190
Talk is a primary means to understand individual and institutional non-mentalizing when delivering addiction counselling treatments.....	190
Institutional talk about <i>disease</i> suggests it is used as a discursive means to limit the expression of desire.....	191
Singular disease narratives erode individual agency when relapse treatment is negotiated.....	193
Recommendations	197

References	205
APPENDICES	229
Appendix A	229
Appendix B	234
Appendix C	239

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Dedication

To Maria del Mar.

“Love is most nearly itself

When here and now cease to matter.”

East Coker, Four Quartets (Eliot, 1963, p. 196)

Chapter 1: Introduction

“Testimony is a complicated form of evidence for research on addiction.

But it is extremely important for other reasons. Testimony helps us understand what it is like to live with addiction, at least for the particular addict telling the story. From a psychiatric perspective, personal history is unquestionably relevant to providing the best care and treatment: Treatment is likely to be most effective if tailored for the individual, never mind the therapeutic benefit to patients of simply having their voices heard” (Pickard, 2012, p. 7).

Introduction

Addiction is an immense struggle. Those who treat addiction and those who are dependent on drugs wrestle, often on a daily basis, with issues of psychological and at times, physical survival. In the South African context, this survival is coupled to apartheid’s legacy of undemocratic violent oppression, poverty and historically race-based unequal access to health care. It is in this context that the need for effective treatment is dire and opportunity is slim. Clients of private and state treatment services routinely want helpful interventions and hope for the best from their healthcare providers out of a desperate pursuit for health. Their struggle is often mediated by financial means, the accessibility of treatment and a desire for “more and better” treatment technology. Problematic drug use, considered metaphorically, in this sense is perhaps one of many symptomatic ways in which individuals, groups and organizations cope with a legacy of relational traumas of various kinds, exercise their choices and remain disempowered.

In addiction treatment settings worldwide, relapse is a common denominator. In the processes of relapse, the choice to use drugs is one people make regularly. Yet, addiction is undiscerning and enough use of a drug changes our brain chemistry and dependence is a

likely result. This affects marginalised people in ways that are likely to entrench poverty, violence and disempowerment. In this sense, relapse and the choice to engage treatment are explored in this dissertation as both human problems, as well as clinical ones, that highlight a question about the efficacy of current treatment interventions for addiction and relapse. Perhaps it is because I find myself in a privileged position, based on historical advantage, that I consider this research important. I have worked treating addiction in clinical contexts that exist based on this privilege, for more than a decade and yet relapse is a regular occurrence and recidivism is often seen with resignation and reticence. The access to treatment of an arguably high standard – for which people pay substantial amounts of money – has bought, at best, moderate success in dealing with the long term picture as it relates to addiction and relapse.

If this is the best that money can buy, so to speak, successfully negotiating the dilemmas of relapse, is likely to be deeply challenging. In the last fifteen years there has been an explosion of evidence-based treatments that have been both researched and manualized for addiction and relapse. A substantial portion of this research has used a disease model in order to understand the neurobiology of addiction, brain systems and structures affected by drug taking. One of the major challenges both in South Africa and internationally, has been for addiction treatment providers to blend the evidence of folk psychology, clinical addiction research, evidence-based practices and 12-step approaches to treat addiction successfully. In this context, *evidence-based treatment* has become a catch phrase that has gripped the imagination of addiction treatment providers in the last decade, and yet how this evidence is applied in the clinical treatment context is less clear. Take for example, the prescription of synthetic opiates like methadone which often courts controversy. Methadone is open to misuse, used by individuals as a “smokescreen” to

conceal other dependence problems, is sold or traded illegally and is relatively expensive to procure both legally and illegally. Yet opiate substitution as a maintenance treatment is comparatively speaking, a highly effective, evidence-based intervention for the treatment of sustained heroin addiction (Gossop, Marsden, Stewart, & Treacy, 2001). It is in this context of evidence-based treatment that available treatment is helpful and yet the rate of relapse remains high.

What this suggests is that, firstly, there are evidence of different kinds: biological, neurological, behavioural, psychological and socio-systemic. Each piece of evidence holds valence in a given context. In the current context the predominant model used to conceptualise addiction treatment is a biological disease model (Koob, 2008; Leshner, 1997; Volkow, 2013; Volkow, Wang, Tomasi, & Baler, 2013). The disease model substantially affects counselling interventions both implicitly and explicitly inasmuch as this is how addiction is thought and talked about in treatment with clients. Secondly, how this range of evidence is related to addiction treatment, is predominantly done from a biological and behaviourally informed perspective, and does not speak fully to issues of psychological development that possibly relates to the perpetuation of addiction. In addition, it is also unlikely, particularly in the last decade, that institutional addiction treatment providers search for evidence that foregrounds the idea of *psychological* processes in their treatment provision. The behavioural treatments or cognitive behavioural treatments that proliferate intervention programmes are a case in point – motivational interviewing, short-term cognitive behavioural interventions – and are often simply merged with the philosophies of managed, time-limited care. The example of heroin users and the prescription of methadone described earlier is a likely case in point, where issues of psychological development are often considered luxury or pointless endeavours when engaging in

treatment talk. A luxury, because of limited healthcare resources and managed care which can be exhausted by the enduring presence of addiction. A pointless endeavour, given the disease model's view of relapse in addiction as largely inevitable.

This challenge is amplified by thinking about addiction from a psychological developmental point of view, given that problems like substance abuse are “strongly related” to “mental disorders in adults [which] often began in youth or childhood” (Patel, Flisher, Hetrick, & McGorry, 2007, p. 1306). This is because treatment resistant mental health problems such as addiction, have developmental roots in infancy and problematic early development. Therefore interventions to treat recidivism, such as counselling, need to be able to incorporate evidence that is psychological and mind-focussed into thinking about treatment approaches.

This suggests that addiction counselling is an intrinsically untapped psychological process that has been overshadowed by disease model mind-sets. Perhaps however, most importantly, it suggests that there is further evidence to be discovered about the perseveration in addictive behaviour and that this evidence lies in the socially constructed mental states of individuals. In the arena of interpersonal and personal psychology, mentalizing theory has potential to provide both a mental model for understanding the relationship between psychological trauma related to addiction and recidivism, as well as enhancing “here-and-now” resilience that individuals exhibit. Mentalization theory is an evidence-based theory that has used a brain-biology model to underpin its fundamental premise – that minds change minds. The theory describes mentalizing as “the process by which we make sense of each other and ourselves, implicitly and explicitly, in terms of subjective states and mental processes” (Bateman & Fonagy, 2010, p. 11).

Mentalization theory also suggests, given its focus on “subjective states and mental processes” that a direction for addiction treatment should include the attempt to focus on the reparation of *psychological* ruptures caused by factors related to addiction (Bateman & Fonagy, 2010, p. 11). It is through the use of mentalization-based theory and therapy that insight may be derived from the psychological interaction between counsellors and clients and how they talk about the (dis)pleasure of using drugs again – either as liking, wanting or desire. How clients and counsellors approach one another, think about relapse and the reasons for relapse is the core question of this dissertation. In particular, mentalization theory has an important contribution to make to the addiction treatment field regarding how relapse is conceptualized, thought about or held in mind at individual and institutional levels. This suggests that by using mentalization-based theory, a great deal of the therapeutic value of addiction counselling, can be harnessed when exploring the talk clients and treatment providers have about relapse. Importantly, mentalization-based theory can offer a lens through which to examine current evidence-based approaches to addiction treatment and offer some insight as to why they tend to underperform as relapse prevention interventions. As such, mentalization can offer a particularly potent view of client-counsellor psychological interaction that as yet is to be examined from this point of view and because of this, the concepts of mentalization are foregrounded and given prominence throughout this research.

Mentalizing theory has already been applied successfully in the field of addiction. There is growing evidence that mentalization-based models of treatment and interventions have a chance of success where addiction is seen as a hard to treat condition (Suchman et al., 2010). Research about how youth and adults come to be addicted to substances in relation to mentalizing deficits in parenting, shows that there is hope when considering how

to conceptualise and treat relapse (Söderström & Skårderud, 2009). Addiction counselling talk therefore represents a context for research that uses mentalization theory given the theory's notions of mindedness, biological psychology and the views it holds about the profoundly social nature of the development of mental states. It is this aspect of mentalization that is important to this research – the social nature of the mindedness and its development – that needs evaluation in relation to addiction and treatment talk to see if there are alternative ways to psychologically conceptualise addiction and relapse talk in counselling relationships. This is important currently because addiction is predominantly spoken about in biological and medical terms that emphasise its material (brain-behaviour) dimensions.

A step forward is needed now to address the pragmatic, psychological concerns generated by relapse rates after treatment and the explanations for this that are fundamentally reliant on biomedical explanations of addiction. It is questions about treatment talk and relapse that this research will use mentalization theory to address. As such, the challenge that this research aims to address is whether mentalizing theory can be successfully used to understand treatment talk about addiction and relapse and shed light onto the reasons for the limited success of evidence-based therapies as regards addiction treatment. As such, it suggests that conceptualising addiction treatment and counselling psychologically is important because, in facing the complexity and ambiguities of relapse, a fuller treatment experience can be shared by those seeking treatment and those offering it.

These points of departure – addiction treatment, relapse and mentalizing – are starting points to understand and address the complex issue of problematic entrenched drug use whilst also being fundamental to understanding the need for effectively addressing

counselling talk about relapse. This dissertation is therefore grounded in the notion of addiction as a hard to treat condition in order to foreground the need for effective professional understanding within clinical approaches to relapse. This dissertation offers an alternative perspective to add to the range of treatments for addiction and how addiction may be more effectively approached than is currently the case.

What follows is a chapter that reviews current literature related to the theory of addiction and relapse. This chapter also examines treatment of addiction from the perspective of counselling talk. The third chapter outlines the methodological theory and method of the study. The fourth and fifth chapters employ the methods outlined in chapter three and are a critical discourse analysis of addiction counselling talk. The final chapter offers a concluding synthesis of the findings of chapters four and five, as well as recommendations based on these findings.

Chapter 2: Literature Review

Addiction: pronounced əˈdɪkʃən: root [L] dicere – “to say” (Merriam-Webster, 2004; Quinion, 2013)

Introduction

This overview of the research literature introduces the reader to the theory and recent research pertinent to the study of addiction, counselling and relapse. It is also an attempt to contextualise this study within the ambit of current clinical research and locate its findings within both clinical and academic domains. This review will also contextualize, guide and inform the analysis of data gathered for this research study.

This chapter discusses a number of knowledge systems needed to understand addiction and relapse in relation to counselling discourse. This research relies on the use of two particular theoretical models - mentalizing and a critical discursive approach - that will be used to understand counselling and relapse in addiction. After describing current theories and definitions of addiction, each will be introduced in order to foreground several concepts pertinent to mentalizing and critical discourse. How each theory conceptualises counselling, addiction and relapse will be outlined in relation to current research about addiction and counselling in order to show the value of using both. The chapter starts with a review of the literature on addiction, and then describes how the mentalizing and critical discourse analysis literatures may shed new light on addiction therapy and the problem of relapse.

Current Definitions and Theories of Addiction

Drug use and addiction is a complex problem, and correspondingly there is a wide range of theory about addictive behaviour. West (2001) identifies 43 behavioural and social theories of addiction, 18 biological theories of addiction and 14 that attribute addiction to

environmental factors (West, 2001). Clearly, defining addiction is a substantial task and one on which it is difficult to find consensus (Sussman & Sussman, 2011). Defining addiction is also a challenge due to the number of different clinical and theoretical models used to treat and understand addiction. However, the most enduring debate about defining addiction continues to be conceptual and clinical debates that centre on the notion of whether or not addiction is a disease (Dingel, Hammer, Ostergren, McCormick, & Koenig, 2012; Pickard, 2012).

Indeed, clinicians and academics have traditionally used diagnostic manuals like the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV, now the DSM V, and the World Health Organization's (WHO) ICD-10 criteria to define compulsive drug use (American Psychiatric Association, 2000; American Psychiatric Association, 2013; World Health Organization, 2013). In the DSM IV and V, substance dependence is aligned with the idea of this category of drug use as a "disorder" (American Psychiatric Association, 2000; American Psychiatric Association, 2013). Concomitantly, prominent researchers have described addiction as "brain disease" (Leshner, 1997, p. 46; Leshner & Koob, 1999; Volkow & Fowler, 2000). Similarly, the American Society of Addiction Medicine states that addiction "is a primary, chronic disease of brain reward, motivation, memory and related circuitry" (American Society of Addiction Medicine, 2013, p. 1).

Addiction is described and seen as a disease largely because the diagnostic criteria used to describe it, rely substantially on a "pathophysiological" conceptual model (Hyman, 2010, p. 156). This emphasises observing the neural brain structures that underlie physical dependence, withdrawal and the consequent neurochemical changes that drug use imparts on the brain (American Psychiatric Association, 2000; Leshner, 1997; Volkow & Fowler,

2000; Volkow , 2013). This has meant that as recently as 2012, the American Psychiatric Association defined addiction as a “substance dependence disorder” with subcategories that included substance dependence and abuse (American Psychiatric Association, 2000). In practice this distinction has made clinical diagnostic work potentially difficult because of a “grey” area between definitions of dependence and drug abuse which in clinical interventions are based on self-reported drug use. A range of other terms – misuse, problematic use, experimental use and social use complicate matters further.

A substantial part of this problem, both conceptually and diagnostically, is what emphasis is placed on biological and brain related factors and what mental and psychological factors are central to addiction. Historically, clinicians have relied on the DSM IV criteria that foreground physical drug dependence, to admit clients to treatment programmes although technically, a diagnosis of substance dependence can be made without the criteria of tolerance and withdrawal (American Psychiatric Association, 2000). The physical dependence criterion allows however for a focus on and sorting of drug abuse from drug dependence by excluding criteria for tolerance, dependence and a pattern of compulsive use to achieve diagnosis of dependence (American Psychiatric Association, 2000, p. 198). With the publication of the DSM V, the definition of addiction has changed in attempt to clarify matters.

The American Psychiatric Association’s (2000) DSM IV criteria to define drug use have been modified with the advent of the DSM V in 2013 and are now called “substance-related and addictive disorders” (American Psychiatric Association, 2013). In the DSM V, the disordered use of ten different classes of drugs are defined by 11 criteria and scored on a continuum as mild, moderate or severe. Each drug use disorder is defined in terms of use

criteria and features such as intoxication, withdrawal or other disorders induced by the drug use. There is also an “unspecified” diagnostic category that takes into account atypical features or use that do not fulfil all criteria of the use disorder (American Psychiatric Association, 2013). This categorization continues to have the disease model of addiction as a paradigmatic premise where drug dependence is still seen from the perspective of organic pathology and the major diagnostic criteria remain physical dependence and tolerance on a drug and its resultant neurological effects (American Psychiatric Association, 2013; Kalivas & Volkow, 2005; Potenza et al., 2012). The major shift in the recent psychiatric redefinition of addiction is a move from the dependence/abuse distinction to a continuum of physical dependence. This change overtly reflects an acceptance that there is a range of disordered drug use that is not simply categorised in a binary manner. However this acceptance continues to be based on research about the neural correlates for subjective experiences like stress responses and craving and reaffirms that addiction is constructed from a disease model and “genetic” point of view (Agrawal et al., 2013, p. 1501; Kalivas & Volkow, 2005; Moeller, 2012). The new concept of a continuum of disordered drug use allows for the idea of graded severity of illness by combining “the DSM-IV categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe” (American Psychiatric Association, 2013, p. 1). In the DSM V the definition of substance dependence has changed to describe disordered use that includes the broader idea of addiction and “addictive disorders” for the first time (American Psychiatric Association, 2013, p. 1).

These diagnostic systems – the DSM and ICD-10 - are typically used “nomenclatures” to define and describe substance use disorders from a disease perspective (Hasin, Hatzenbuehler, Keyes, & Ogburn, 2006, p. 59). The use and reliance on the DSM

classification has been “a critical platform for research that made possible shared understandings of disease models” and yet ultimately in their “reification” of mental illness, are “poor mirrors of nature” (Hyman, 2010, p. 157). Additionally, these disease model based criteria of substance use also hold a range of relevance in different contexts. Of importance for this study, clinicians are described as seeing these diagnostic criteria of the DSM and the ICD-10 as largely “irrelevant” “paperwork” whilst treatment researchers, neuroscientists and epidemiologists are perhaps more ambivalent about their utility, given that they provide a departure point for research (Hasin et al., p. 72). It is at this starting point that neuroscientific researchers and the proponents of the DSM and ICD hold the idea of addiction-as-a-disease in common.

The extension of a definition of addiction, underpinned by neuroscientific thinking, positions problematic drug use as primarily symptomatic of the toxic properties and residual effects of drug taking and as such represents a pathogenic “disease-model” approach to the treatment of mental and behavioural phenomena. This is in spite of diagnostically describing addiction as having a “cluster of cognitive, behavioural and physiological symptoms” (American Psychiatric Association, 2000, p. 192). In search of the causes of addiction, the disease model and diagnostic definitions based on this position, sees choices derived from mental states as mere epiphenomena secondary to gene-brain-drug interactions. Whilst these definitions appear to be an attempt to accommodate the reality of the complex presentation of drug use, they do this based on the conceptualization of addiction as a disease. This comes at the cost of offering an understanding of addiction as mental/psychological phenomenon. What follows is a discussion of some of the significant neuro-scientific views of addiction. This description is offered in order to position it

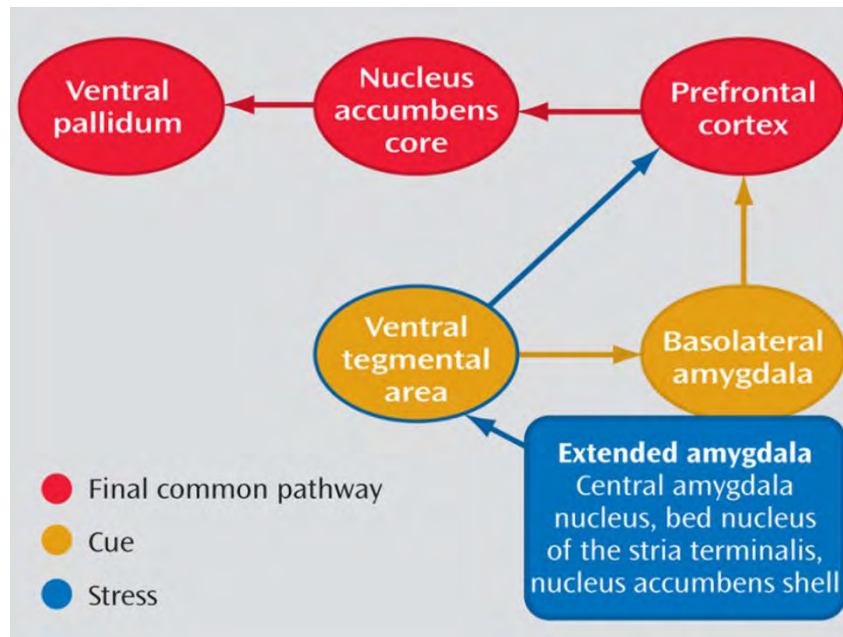
alongside the notion of agency and choice in addiction treatment and counselling, which will be raised in later sections of the chapter.

Significant neuro-scientific theories of addiction

Neuro-scientific theories of addiction are a range of neurological, medical and psychiatric views on addictive behaviour and symptoms. Broadly grouped together here, they offer a neuro-scientific model of addiction which is a wide-ranging causal explanation for addictive behaviour. This perspective includes neuro-biological, neuro-chemical and genetic factors alongside their behavioural correlates that aim to confirm a disease, pathology or disorder is present in individual's brain structures (Koob & Simon, 2009; Leshner, 1997). The neuro-scientific model frames addiction from a physical disease perspective by explaining and linking addictive behaviour to hereditary factors, biochemistry and brain structures to call addiction, a "brain disease" or "brain disorder" (Kalivas & Brady, 2012; Volkow, Chandler, & Fletcher, 2009, p. 1881; Volkow & Fowler, 2000; Volkow, Fowler, & Wang, 2003; Volkow & Li, 2004). Consequently, addiction has come to be defined and treated as a disease where drug dependence is primarily seen as a function of drug-altered neurocircuitry which causes consequent loss of personal control with negative consequences.

The following model, originally proposed by (Kalivas & Volkow, 2005) was recently used by Moeller (2012) to explain addiction from a stress-diathesis perspective. It describes the neurobiological processes that underpin neurological reaction to environmental stress, drug cues or the exposure to actual drugs which ultimately "increases dopamine release in the prefrontal cortex" (p. 352). This primes "glutamenergic plasticity" in the nucleus

accumbens core which promotes access to the “final common pathway” for reward expression in the ventral pallidum:



(Moeller, 2012, p. 352).

Conceptions of addiction and relapse have been derived from this model that show that a disease is both present and activated by drug use. It shows neurologically, how the ventral pallidum and nucleus accumbens, in particular, have come to be recognised as critical brain structures in the regulation/dysregulation of motivation, reward and the positive and negative reinforcement of drug seeking behaviour. As such, these structures are seen as the drivers of addictive behaviour such as finding drugs and responding to their rewarding effects in spite of their longer term negative consequences.

These recent, critical and relevant advances of the neuroscientific model of addiction necessarily focus on the description and identification of physical disease processes at this neural reward level. These explain how drugs precipitate and stimulate longstanding neural changes and “utilise” plasticity in the brain to impact motivation long after the active

ingredient in the drug of choice has passed from the body (Feltenstein & See, 2013; Kalivas & Volkow, 2005). Recent and past neuroscience also shows how “compulsive behaviours, like addiction, can take hold when the neural circuitry that instantiates adaptive habits is thrown off balance by exposure to drugs” (Koob et al., 1998; Volkow, Wang, Tomasi & Baler, 2013, p. 1). As such, three neural “systems” are involved in addiction – the impulsive system, the reflective system and intensity/control system (Noël, Brevers, & Bechara, 2013, p. 632). The drivers of these systems are located in the reward pathways, particularly the dopaminergic and serotonergic neurotransmitter systems.

Addiction neuroscience has given particular emphasis to the influence of dopaminergic communication systems in drug dependence. These reward pathways are neural routes for the brain to communicate adaptive and reinforcing responses to drug use. There are four major dopaminergic reward pathways that modulate reward, pleasure and compulsion: the mesolimbic pathway which transmits dopamine from the ventral tegmental area to the limbic system via the nucleus accumbens; the mesocortical pathway which transmits dopamine from the ventral tegmental area to the frontal cortex; the nigrostriatal pathway which transmits dopamine from the substantia nigra to the striatum and the tuberoinfundibular pathway which transmits dopamine from the hypothalamus to the pituitary gland (Feltenstein & See, 2013). Additionally serotonergic systems as well as “other neurotransmitter/neuromodulator systems, including opioid peptides, GABA, glutamate, and endocannabinoids play a role in the reinforcing effects of drugs of abuse” (Feltenstein & See, 2013, p. 3; Koob & Le Moal, 1997). Psychopharmacological properties and toxicity of drugs on brain structures have also been identified to show the physical dimensions of the disease process of addiction, its aetiology and their influence of the dopamine “reward pathways.” (Koob & Kreek, 2007, p. 1149).

Why people continue to be motivated to use drugs in spite of their damaging effects suggests that drugs are both rewarding and reinforce drug seeking behaviour in spite of natural consequences. The study of the neural reward pathways provokes the question of mental motivational “appetite” which is a fundamental aspect to define in addiction. Motivation to use drugs from a neural perspective, suggests a drive or need is stimulated in the user that may be satiated by drug use. The motivational reward of drug use is linked to subjective representations of the “hedonic” properties of drugs in the orbitofrontal cortex (Cardinal & Everitt, 2004, p. 156). The neuroscientific approach also makes the case for drug use changing the “hedonic set point” of individuals and thereby rendering them vulnerable to further use (Koob & Le Moal, 1997, p. 55; Koob & Le Moal, 2001). Again, the appetitive reinforcement of drug use is seen as attributable to the nucleus accumbens (Everitt & Robbins, 2005). The appetite and motivation for drug use therefore, from the neurobiological perspective, involves both the mesolimbic and mesocortical pathways for combined but differing reasons. Examples such as these neural correlates of the appetitive brain systems, indicate the important and “multifactorial” role of brain structures in drug addiction (Cardinal & Everitt, 2004, p. 156). From this position, neuroscience demonstrates how “addictive substances produce ‘extremely stable changes’ in that part of the brain” (Cardinal & Everitt, 2004, p. 156; Khantzian, 2003, p. 55).

It is questions about motivation, persistent appetite and affect derived from drug use that show neuroscience relies largely on brain-behaviour models for the explanation of addiction. Historically, this has been a way of approaching addiction science to exclude psychological elements of behaviour that are subjective rather than directly observable, which is regrettable (Larkin & Griffiths, 2002). Techniques such as functional magnetic resonance imaging (fMRI) and other forms of neuroimaging have substantially improved

researchers' ability to link brain-behaviour relationships, and so to move toward including mental states when explaining addiction. Fecteau and colleagues (2010) describe the relatively recent shift to including the "largely overlooked aspect [that] relates to the cognitive neuroscience of the addict's mind" in addiction science (Fecteau, Fregni, Boggio, & Pascual-Leone, 2010, p. 1767). There are two examples that attempt to address this. The first is the bio-behavioural incentive sensitization theory of Berridge and Robinson (1998; 2011) and the second, discussed in a later part of the chapter, is the neuropsychanalytic approach to addiction of Zellner, Watt, Solms and Panksepp (Berridge & Robinson, 1998; Berridge & Robinson, 2011; Zellner, Watt, Solms, & Panksepp, 2011).

Incentive sensitization theory of addiction is a neurocognitive "biological" attempt to understand addiction and relapse that further develops the notion of drugs as reinforcing agents in instrumental conditioning (West, 2001, p. 6). Its inclusion here is warranted based on its relative longevity as a theory and utility of modelling addictive processes (Berridge & Robinson, 2011). Its foundations are biological but its scope suggests that it is a biopsychological theory of addiction (Berridge & Robinson, 2011; Cardinal & Everitt, 2004; Robinson & Berridge, 1993). It is chosen for inclusion here as it has important implications for this study because of its focus on distinguishing the wanting from liking of drugs – a common topic of conversation in counselling sessions.

Berridge and Robinson suggest that increased exposure to drugs affects "susceptible" individuals in "complex" ways (Berridge & Robinson, 2011, p. 21). Brain changes in the addict contribute to the development from use or experimentation with drugs to addiction. The most important psychological changes that parallel this are a "persistent sensitization or hypersensitivity to the incentive motivational effects of drugs

and drug-associated stimuli” (Berridge & Robinson, 2011, p. 22). The theory suggests that individual drug users develop an “attentional bias and pathological motivation for the drugs themselves” and that this change persists beyond “tolerance and withdrawal” (Berridge & Robinson, 2011, pp. 21-22). Crucially, this theory is invested in locating addictive appetites – wanting and liking – in both the psychological and neural domains. It must however be noted that the psychological elements of the theory are limited to a behavioural view of psychology. A range of factors affect drug use sensitization: “genetic factors, hormonal factors, gender differences, previous drug experiences and previous experiences with major stressors in life” as well as “the drug itself”, amount of the drug and use schedule (Berridge & Robinson, 2011, p. 23). Drug use and the mental representation by the drug user of the drugging experience both sensitize the brain and cue the mind (Berridge & Robinson, 2011). Drug use sensitises “mesotelencephalic dopamine neurotransmission” and awareness of subjective mental stimuli or responses to environmental cues rather than for the explicit purpose of experiencing “pleasure” (Robinson & Berridge, 1993, p. 260). These mechanisms also interact. However it is only “wanting systems” – incentive salience – that sensitizes the individual to develop intensity of desire for drugging and it may be independent of whether the drug is liked or not. Wanting the pleasurable effects of drugs, in this context, is the driver of motivation to use the drug rather than the liking of them. Indeed many addicts arrive at a point where they want drugs far more than they like them. This is to the extent that they may illogically compromise employment, relationships and their health in their pursuit of satiation of drug-desire (Berridge & Robinson, 2011; Robinson & Berridge, 1993). The implicit suggestion of this theory of addiction is that addicts become increasingly less able to manage their drug use responsibly and to tolerate its effects as their exposure to drugs increases or is maintained.

Using a neurobiological disease premise as a frame of reference, the neuro-scientific model of addiction explains addictive behaviour as a systemic illness affecting many different aspects of the individual either concurrently, e.g. liver damage and cognitive deficit, or progressively, in terms of significant consequences, e.g. Korsakoff Syndrome. A range of approaches that have neurobiology as a premise include the role drug taking has on affecting the prefrontal cortex and hence learning, reward, sensitization, compulsive and impulsive behaviour (Feltenstein & See, 2013). The relationship between the neurobiological activity of the brain's reward systems, loss of control and addiction, however reliant they may be on the brain for expression, are part of an intricate psycho-biological bidirectional interrelationship that involves the mental states that may mediate relapse (Fecteau et al., 2010; Panksepp, 2005; Zellner et al., 2011). This suggests that the neuroscientific view of addiction also needs to account for the substantial problem of relapse.

Neuro-scientific explanations of relapse

The study of relapse in relation to addiction is often described as an extension of the same disease process and is related to individual craving and the compulsion associated with conditioning of drug use cues (O'Brien, Childress, Ehrman, & Robbins, 1998). While neurobiological explanations of addiction examine brain areas that moderate addiction, explanations of relapse rely on these too. In this way relapse, as related to addiction, is often conceptualized as part of an addiction cycle and a relapsing illness (DiClemente, Holmgren, & Rounsaville, 2011; Kalivas & Brady, 2012; McLellan, Lewis, O'Brien, & Kleber, 2000).

It is through this cycle that both neurological and behavioural elements of addictive behaviour are rehearsed and relearned. The challenge is for neuroscience to explain relapse, after the individual has stopped using drugs for a period of time. This is achieved through theories that appeal to research about plasticity/brain change induced by drug taking as well as environmental cues (Buckland & Cunningham, 2013; Williamson, Buckland, & Cunningham, 2013). There are two parts to this challenge – almost immediate relapse and relapse after longer periods of abstinence. Relapse mechanisms and the “considerable advances made in delineating the distinct neural systems underlying relapse, following exposure to stress, drug-related cues or the drug itself” are emerging from recent research (Robbins, Everitt, & Nutt, 2008, p. 3109). The challenge of immediate relapse is seemingly easier to explain neurologically and appeals the idea that “the answer lies in the complex interactions of glutamate in the brain” (Williamson et al., 2013). This explanation centres on the already vulnerable, neuro-chemically changed brain and hyper-sensitivity to drug salience use cues and glutamate’s role as an “excitatory neurotransmitter in the vertebrate brain” (Williamson et al., 2013, p. 61).

The explanations for relapse after a longer period of abstinence rely more heavily on genetic vulnerability and psychological learning theories such as classical conditioning, stimulus-response models and incentive sensitization models (Robbins et al., 2008). The psychobiological argument for relapse after long term abstinence is that prolonged exposure to drugs from an early age induces brain changes that persist and permanently make the drug user vulnerable to relapse. This, in conjunction with a scarcity of dopamine receptors because of genetic factors (the D2 receptor gene DRD2) that can receive the “pleasure molecule” create ongoing conditions for relapse (Blum et al., 2012, p. 135). Drug use relies on dopaminergic brain communication systems to surpass the rush value of

pleasure derived from natural rewards like food and then hijack these so called reward pathways (Volkow, 2013).

Whilst abstaining from drug use is likely to be restorative of some of these neurochemical communication systems, these changes can take long periods of time, and there is an increase in the likelihood of testing or “priming” by addicts triggered by experiences of anhedonia (Buckland & Cunningham, 2013, p. 136; Blum et al., 2012). This is where addicts consume small amounts of a drug of choice that lead to “intense” experiences of reward and further drug seeking and use behaviour (Buckland & Cunningham, 2013, p. 136). Concurrently individuals may be exposed to substantial periods of potentially maladaptive, learned cues such as stress (Buckland & Cunningham, 2013).

Some of the predictive neurobiological factors of future relapse also centre on physiological stress responses. In “alcoholics, blunted stress- and cue-induced cortisol responses have been associated with poor alcohol relapse outcomes” (Sinha, 2011, p. 401) Similarly “nicotine-deprived smokers who were exposed to a series of stressors showed blunted corticotrophin (ACTH), cortisol, and blood pressure responses to stress” (Sinha, 2011, p. 401). ACTH appears to be linked to the amount of alcohol and cocaine consumed on relapse as well as the speed of relapse (Sinha, 2011). Evidence emerging “from preclinical studies shows chronic drug-related central changes in brain-derived neurotrophic factor (BDNF) and other growth factors during abstinence that have been associated with reinstatement of drug seeking in animal models of relapse” (Sinha, 2011, p. 401). Relapse, in animal studies, has also been shown to be linked to the ventral medial prefrontal cortex (Bossert et al., 2012). Consequently the current neuroscience tends to view addiction and relapse from a brain-based, harm reduction and preventative viewpoint with the recent

initial success of trials for a cocaine vaccine making headlines on the NIDA webpage (National Institute on Drug Abuse, 2013a).

The use of a neurobiological brain-behaviour model to develop ideas about addiction and relapse in many instances bypasses the idea of the (evolutionary) development of the mind as an aspect of addiction theory that is important to understand. Emotions are an element of addiction research that Panksepp and colleagues have paid particular attention to (Panksepp, 2003; Panksepp, 2005; Panksepp, Knutson, & Burgdorf, 2002; Zellner et al., 2011). Panksepp and colleagues' (2002) view of addiction relies on an evolutionary understanding of brain systems and the idea that "emotional feelings signal potential increases and decreases in fitness" of the individual (Panksepp et al., 2002, p. 460). Addiction from this point of view indicates that individuals need to manage and mentally track these signals which denote emotional states. This ability is developed through learning from early social bonds to "maximise pleasant feelings and minimize unpleasant feelings" (Panksepp et al., 2002, p. 460). This implies that if individuals use drugs, these can "act upon and alter emotional systems, [and] other hedonic process dependent on these systems (including but not limited to social relations) may suffer" (Panksepp et al., 2002, p. 460). This, Panksepp et al. (2002) suggest, means that consequently, poor social bonding may result in an "altered future tendency" in individuals to seek out "other (pharmacological) means" to address emotions (Panksepp et al., 2002, pp. 460-461).

Panksepp (2005) accordingly posits that there are neural systems that neurochemically regulate appetitive urges and wanting in the brain and form a "SEEKING/expectancy/wanting system" which can be altered by drug use (Panksepp, 2005, p. 17). This however is thwarted by drug taking that affects the brain in a super-physiological

manner. This in turn depletes people's capacity to form necessary and naturally rewarding social bonds (Panksepp et al., 2002, p. 460). Panksepp (2005) holds that the "SEEKING concept provides a coherent multi-dimensional psychobiological framework for understanding what this system provides for organismic psychobehavioral coherence" (p. 15). This is relevant to addiction neuroscience because it can assist in explaining the neuropsychological "appetitive 'desire' [which] mediates a coherent organismic urge to explore the environment and seek resources in response to bodily needs and external incentives" (Panksepp, 2005, p. 17). It is the emphasis on the "subcortical" evolutionarily developed capacity to track emotional states and seek out psychological satiation that is a powerful aspect of this theory of addictive behaviour (Panksepp, 2005, p. 35).

Brain-mind models of addiction that foreground conscious mental experience associated with drug using, however still reveal a substantial gap between depth psychological approaches and neuro-scientific ones (Koob & Simon, 2009; Lyvers, 2000; Panksepp, 2003, p. 21; Zellner et al., 2011). In particular, there are specific challenges to the biological focus of addiction neuroscience. Particularly, evolutionary psychology and neuropsychology have offered an understanding of addiction through the research of affective systems as they relate to addiction treatment (Khantzian, 2003; Zellner et al., 2011). Indeed, Panksepp (2003) sees the disjuncture between depth psychology and neuro-scientific approaches of biological neuroscience as looking at addiction from a "brain-behaviour" point of view rather than affective "brain-mind-behaviour" one (Panksepp, 2003, p. 22). The evolutionary neuroaffective approach of Panksepp (2003) is a notable exception and included for its relevance to both addiction and for the notion of affective self-regulation from an evolutionary point of view (Khantzian, 2003).

The idea that addiction is primarily subject to biological and neural factors, is central to the neuro-scientific model's explanation of why people continue to use and experience dependence and "loss of control" over their using behaviour when drug dependent. Seen from the perspective of neuro-biological vulnerability created by drug use, prolonged drug-brain exposure, concomitant dependence and tolerance, the disease of addiction progresses from intentionally chosen behaviour, to impulsive and finally, to compulsive behaviour. Understanding plasticity and change in brain regions, reward systems and structures involved in expression of the illness of addiction are therefore the key to its treatment (Panksepp, 2003). Models that include mental processes of the addict do so largely with reference to the brain structures that are seen to be grounded in neurobiology. Additionally, the diseased neural pathways that determine pleasure or anticipated relief in drug abuse have not been fully distinguished from the ones that respond to natural rewards - there is not an addiction-only neural circuitry in the brain.

In fact, the neural circuitry that may well regulate conventional non-drug induced pleasurable states is similar or possibly the same as dopaminergic pathways to addiction. In this sense it is a question of scale – a sandwich is not a competitive reward for a heroin addict withdrawing from his/her drug of choice and yet a non-addicted individual is likely to choose a sandwich over heroin when hunger calls. Indeed, at some point the heroin addict will need nutritive nourishment to continue drug using. Reinarman (2005, p. 309) concludes "[t]hat the brain is centrally involved in drug use behaviours is not in question; but whether this new neuroscience research has identified a specific locus of addiction-as-disease in the brain is another matter." Taking this point further, the neurobiological theories of addiction accommodate very little in the way of psychological and mental explanations for drug use and relapse. It would perhaps not be seen as necessary for neurobiological approaches to

include the mind in their models of addiction and perhaps to accommodate such subjective factors as mental states. In accordance with this, Cromby and others (2011) show that neuroscience cannot be as value-free and objective as it might claim (Cromby, Newton, & Williams, 2011). Additionally, Panksepp and colleagues (2002; 2005) point toward the way in this regard – that the ability to track and manage emotional states is (one) psychological task that addicts need to learn and develop to acquire psychological “fitness” in the evolutionary sense as much as in the neurological one. Indeed, in order to do this, a psychological capacity is needed to achieve these mental activities.

The argument for addiction as a complex psychobiological syndrome rather than a predominantly physical disease or an immutable biological phenomenon seems a compelling one. Yet this notion of addiction - as a problem of interpersonal biology - is unsatisfactory and problematic itself on two levels. One problem is that of logic, inasmuch as the realm of biology and interpersonal interaction are different orders of abstraction. The second is that whilst simultaneously true, the notion of interpersonal biology constitutes a collapsed dichotomy that is grounded in the idea that there is a clear way to being able to find the mind in the biology of the brain. Clearly this is fallacious. What is important here however, is how the mind is conceptualised in relation to the brain/body. In conceptualising this relationship, it would seem logical to pose the challenge here that the neuro-scientific model lays a basis for, but does not accommodate very comfortably, the psychological notions of mindedness, agency, choice and responsibility. Research about relapse to heroin use, for example, has been shown to occur (at least in rats) by projections from the ventral medial prefrontal cortex to the nucleus accumbens. This is clearly valuable research that suggests a neural inevitability about relapse (Bossert et al., 2012). Yet, the “cognitive sophistication of humans relative to rats poses certain problems for scientists” in their

attempts to understand addiction (Panksepp et al., 2002, p. 465). There is no pharmacological “magic bullet” to address addiction and individuals’ self-reported emotional states do not necessarily lead to self-administration of drugs (Panksepp et al., 2002, p. 466).

At best, it might be that the fine-tuning of neurological research will help reveal the neurological answers to some of the ambiguity that arises from a psychology of addiction and what role choice and agency play (Zellner et al., 2011). In so doing it may come to accommodate more fully the notions of graded, diminished or reduced capacity in addiction rather than disease or the absolutist notion of loss of control. At worst, neuro-scientific views of addiction appear to render the addicted individual psychologically inert and passive (Hammersley & Reid, 2002; Peele, 2000; Reinarman, 2005; Shaffer et al., 2004).

This raises the important issue of choice in treatment conversation and what the notion of the disease model means for psychological agency in addiction counselling initiatives. The implicit suggestion of a biological and neurological view of addiction is that medical and psychopharmacological initiatives are fundamentally necessary to treat addiction and that talk as an intervention is largely superfluous. However, all addiction treatment, including counselling, relies to some degree on the psychology of talk about mental states and how these precipitate addiction and relapse. This psychology is the grist of addiction counselling. Whether it is to talk about taking detoxification medicine or the symbolic value of a relapse, talk that generates a variety of meanings in treatment suggests that choice is fundamental to the treatment of addiction as much as its neurobiology is. It is through the construction of addiction as a disease that choices based on moral, psychological and social agency of the addict are punctured by ideas like those of

compulsion. By way of introduction the idea of compulsion is briefly discussed in order to show the dilemma of representing the mind in a strongly biologist discourse in addiction counselling.

Currently debates in literature related to the philosophy of addiction suggest that that successfully defining addiction is based on whether or not one can argue a position about an addict's ability to choose and act responsibly when taking drugs compulsively. That the development of the addiction affects the physical state of a drug user's brain is not in question. That brains are so changed by drug use that users cannot choose and act toward their drug use, is. Pickard (2012) and Di Nucci's (2013) competing views on this are a case in point. According to Pickard (2012), defining elements of addiction such as compulsion in relation to drug use from a disease-based point of view is problematic, given the implications that this has for agency, choice and responsibility. Conventionally compulsion is considered to be an "urge, impulse, or desire that is irresistible: so strong that it is impossible for it not to lead to action" (Pickard, 2012, p. 41). It is in the definition of compulsion as a symptom of the physical disease of addiction that its limitations are revealed. It cannot be assumed that when defining addiction as a disease that clients through their drug use lose their psychological capacity to choose from a set of alternatives.

Perhaps agency, the ability to choose and to be responsible comes in degrees, as Pickard suggests (Pickard, 2012). Addicts can become overwhelmed and their capacity to choose may be diminished. This does not mean that addicts cannot choose, or are so changed by their drug use that this is the case. This raises the important question when defining addiction, of whether all paths lead to the dopaminergic reward circuitry or if we can further clarify addiction through the use of the perspectives of philosophy and

psychology. Indeed the rise in the number of neuroscientific explanations for addiction constructs addicts as “constantly open to relapses that are not so much failures of will and courage as effects of morally blind neural systems” and “plasticity apart, neuroscience can generate accounts that minimise moral accountability, by transferring agency and culpability from conscious self to a-conscious brain processes” (Cromby, Newton, & Williams, 2011, p. 220). This poses risk, not least of all, to social and psychological conceptualizations and accounts of addictive drug use. In turn, this has major implications for how counsellors and clients frame their understanding of addiction as a “no-fault illness” or a “moral” failing. Both positions, commonly held by those in treatment, suggest a struggle to think psychologically about addiction. With this in mind, what follows are summaries of major theoretical perspectives on the psychological nature of addiction. The remainder of the chapter focusses on outlining the relationship between mentalizing, discourse and counselling to addiction.

Significant psychological theories of addiction

How theoretical links from neurobiology to psychological theories of addiction are made, has profound implications for how addiction is conceptualized and treated. This is especially because the “depth” of these connections and the reliance on biological models rather than psychological ones, may shape counselling talk in medical ways. Neuroscientific models that propose explanations for addictive behaviour as an organic disease are often contextualised within an evolutionary or medical discourse or sometimes both. This means that “disease model” conceptions of addiction based on neuroscientific research findings are extrapolated into psychological concepts such as compulsion, craving and treatment initiatives such as “relapse prevention” (Hutchison, 2000; Marlatt & Gordon, 1985, p. 85). This reasoning then becomes the link between the neuroscientific disease model,

psychology and interventions like addiction counselling. There have to date, been a range of explanations that account for addiction from a psychological point of view.

Some psychological writing suggests that theoretical “camps” of how to address and conceptualize addiction have become less rigidly exclusive and are, for example, increasingly accommodating of psychodynamic thinking from a cognitivist point of view and vice versa (Weegmann, 2002). However, this is perhaps somewhat naive a position, given the complexity of both addiction theory, treatment and the nuanced politics of these matters. Certainly notions of spontaneous remission have “raised an often emotional debate which was fuelled by contradictory views on the nature of addiction” (Klingemann, Sobell, & Sobell, 2010, p. 1511). An increasing acknowledgement and acceptance of addiction as a complex disorder or condition is a more likely position that is representative of the current state of affairs (Miller & Carroll, 2006). The most relevant and substantial of these theoretical models are the cognitive behavioural theories of Koob and Le Moal, Tiffany, and O’Brien et al. (Koob & Le Moal, 1997; O’Brien et al., 1998; Tiffany, 1990), Baumeister’s ego-depletion theory (Baumeister, 2002), the trans-theoretical model (Prochaska & DiClemente, 1982), contextualistic motivational models and the Minnesota model, each of which are reviewed. Lastly, the psychodynamic models of Khantzian, and Ulman and Paul (Khantzian, 1997; Ulman & Paul, 2006) are reviewed below.

Cognitive behavioural approaches

Cognitive-behavioural theory of drug use has largely been mindful of the brain-behaviour link to drug use. However, cognitive behavioural theory of addiction retains characteristic views about addiction and a wide variety of cognitive behavioural models of drug use exist. For cognitive-behavioural psychology “addiction is understood as an

irrational thought process or behavioural pattern produced by conditioning, social learning, stimulus and reward, and positive and negative reinforcement” (Karasaki, Fraser, Moore, & Dietze, 2013, p. 195).

Addiction is theorized by Koob and Le Moal (1997) to be compulsive behavioural cycle where drugs and withdrawal act as reinforcement to further use. This urge-based theory relates drug use to the disruptive effects that drugs have on the homeostasis of an addict’s brain (Koob & Le Moal, 1997). Tiffany (1990) suggests that drug addiction is perpetuated, beyond drug urges, by “conditioning” from drug use cues that an addict is sensitised to and intermittently fails to avoid or unlearn (Tiffany, 1990, p. 147). O’Brien and colleagues put forward a theory of addictive behaviour that is based on the principles of learning theory, classical and instrumental conditioning to explain the “drug conditioning” in cycles of “remission and relapse” (O’Brien, Childress, McLellan, & Ehrman, 1992; O’Brien et al., 1998, pp. 15-16).

A more recently modified theory of addiction is the ego depletion theory of addiction. Ego depletion is a theory relating to the idea of self-control that was originally proposed by Baumeister and his colleagues (Baumeister, Bratslavsky, Muraven, & Tice, 1998). Baumeister proposes that self-control is the “capacity to alter or override one’s responses, including thoughts, emotions, and actions (Baumeister, 2002, p. 129). Levy (2011) puts forward an argument about addiction based on the “ego depletion” model that suggests that drug use and addiction fall into the domain of the negotiation of self-control (Levy, 2011). Interestingly, he contrasts the evidence that addicts have the capacity for self-control and that this, with drug use, involves episodes over time, where individuals struggle and ultimately fail to exert self-control over their behaviour. As such, addiction is related to

self-control, where self-control is seen as a “limited resource” related to episodic failures to utilize it (Levy, 2011, p. 99).

The model Levy (2011) puts forward suggests loss of control (over drug use) is a “local” or specific instance where the capacity for self-control remains globally intact. This suggests that individuals, psychologically, can lose control over parts or aspects of their behaviour and mental life, rather than experience a complete loss of control over these domains. Addicts as psychological agents are seen as having lost “responsiveness” loosely translated as understanding and “reactivity” - the ability to act on this understanding – to drug (using) cues (Levy, 2011, p. 90). It is the person’s ego strength which become exhausted. Levy (2011) puts forward that the ego-depletion model explains addiction as a failure to exercise judgement on the basis of reactivity because of the “judgement shift” preceding drug use, as a result of a failure to draw on “cognitive resources” because of ego depletion (Levy, 2011, p. 101). The notion of addiction stemming from depleted psychological resources brings us to reflect on motivation and drug using behaviour as a psychological process as described by the trans-theoretical model.

The trans-theoretical model

The cognitive behavioural theories of addiction are often dovetailed with the other theories such as the trans-theoretical model in clinical settings. The trans-theoretical model (TTM) developed by Prochaska, DiClemente (1982) is a commonly used model to explain relapse in relation to addiction and the cycle of addictive behaviour (Annis, Schober, & Kelly, 1996; DiClemente, Schlundt, & Gemmell, 2004; Prochaska & DiClemente, 1982; Waters, Holttum, & Perrin, 2013). This model describes addiction and relapse in the context of a cycle of “distinct cognitive–behavioural indicators that describe six distinct stages of

change” which includes pre-contemplation, contemplation, preparation, action and maintenance (Moore, 2005, p. 395). The pre-contemplation stage is where addicted individuals are seen as having little or no current interest in considering change, and the contemplation stage is where individuals evaluate and analyse the cost-benefit ratio of old/new behaviour. This leads to the preparation stage which involves commitment and planning to execute the decision, which leads to the action stage - putting the plan into action in order to arrive at the maintenance stage, where the new behaviour becomes familiar or usual (DiClemente et al., 2011; DiClemente et al., 2004). The TTM has been part of addiction counselling discourse in the last 15 - 20 years and has allowed counsellors to change their description of resistant or even difficult clients to that of a pre-contemplative one (Annis et al., 1996). This is indeed a valuable development and allied with the theory and practice of motivational interviewing and mindfulness-based relapse prevention are possibly the most widely accepted evidence-based approaches to addiction treatment as well as relapse prevention. ***Contextualistic cognitive behavioural approaches to addiction***

Cognitive behavioural motivational approaches reveal that recently “quite a number of behaviour therapies have emerged that do not fit easily into traditional categories within the field” that are utilised to conceptualize addiction (Hayes, 2004, p. 639). The range of theories centre on diverse theoretical positions but are essentially “contextualistic” (Hayes, 2004, p. 640). Two of these are acceptance and commitment therapy (ACT) and motivational interviewing (MI). ACT theory suggests that individual psychopathology such as addiction stems from a difficulty in accepting and tolerating current experience. The aim of ACT is for an individual to engage in a “valued direction, with all of their history and automatic reactions” (Hayes, 2004, p. 652). ACT is an “intervention” that seeks to draw individuals toward their values and the avoidance of mental experiences in order to accept

them in a psychologically flexible manner (Hayes, Luoma, Bond, Masuda, & Lillis, 2006, pp. 1-6). ACT based studies show that “there is a growing body of research illustrating the benefits of ACT for other substance abuse disorders” (Twohig, Shoenberger, & Hayes, 2007, p. 621).

Motivational interviewing is a widespread clinical intervention, theoretical model and “well-recognized brand” of therapy that aims to understand the role of motivation particularly in health-related behaviour (Lundahl & Burke, 2009, p. 1232). MI has had a significant impact on healthcare settings over the last 25 years and its popularity is also widespread. MI was developed by Miller and Rollnick “as a way to help people work through ambivalence and commit to change” (Hettema, Steele, & Miller, 2005, p. 92). In the field of addictive behaviour, MI has come to be seen as a short-term therapy and antidote to confrontational, directive and even punitive moralistic treatments for alcoholism and other substance use disorders. MI as a theory and response to the problem of addiction is focussed on the idea that change and readiness to change need attention in the (addicted) clinical population. MI assumes motivational states are inherently accessible and mislabelled by clinicians as resistance. MI suggests that an individual’s need for change is addressed by foregrounding the ambivalence that clients hold regarding their desire for change: a client’s desire to drink and their desire to stop their spouse complaining about their drinking, may be reflected and reframed for a client by their counsellor in motivational terms. This is with a view toward engaging clients to move from pre-contemplative positions through to contemplation and action positions regarding a particular therapeutic issue. It is in this way that the trans-theoretical model is combined with MI in clinical settings to understand and address addiction. This is particularly useful in conceptualizing why patients resist change to their drug using behaviour. Resistance to change in this context is reframed by MI

approaches as a high level of motivation (Flores, 2004; Prochaska & DiClemente, 1982; Hettema et al., 2005). Motivational desire is therefore a key concept and theoretically seen as located in the individual as a resource. Motivation is elicited in a dialectical manner by therapists, in order to avoid developing inherent client resistance to a treatment. This also has the effect of offering the individual a sense of agency over their treatment direction.

Minnesota Model

The Minnesota model is a longstanding treatment of addictive behaviour which was introduced to the United Kingdom in the mid-1970s and started in Minnesota, USA in the late 1940s. The Minnesota model is both a way of conceptualizing addiction and its treatment. The Minnesota model is based on four conceptual principles described by Cook (1998) as the possibility of change, the 'Disease Concept', treatment goals and the use of the principles of AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) (Cook, 1988, pp. 625-628).

These principles highlight a conceptualisation of addiction as a disease in the medical sense but include AA's conceptualization of addiction as a spiritual problem. As such, part of the psychology of this approach is to turn to a "higher power" when negotiating recovery from alcohol and other drugs (Alcoholics Anonymous World Services, 2001, p. 100). Peer acceptance and the notion of having a disease allows for the formulation of behavioural treatment goals, one of which is abstinence from drug using. The Minnesota model also holds the position that professionally accredited and trained staff should work alongside lay counsellors in recovery from drug dependence. This is in order to "blend" a therapeutic staff offering and capture the value and utility from a range of drug-addicted/non-drug addicted personal experiences when treating addiction (Borkman, Kaskutas, & Owen, 2007, p. 25).

The Minnesota model of addiction and treatment is intertwined with the principles and pragmatic philosophies of Alcoholics Anonymous. Due to the international popularity and helpfulness of Alcoholics Anonymous, treatment centres often use a twelve-step approach in combination with other clinical interventions. This has meant that the Minnesota model approach has become a widely known and utilised intervention for addiction treatment (Kurtz, 1979).

Psychodynamic theories

Many psychodynamic and psychoanalytic theories have been developed over the last century and have conceptualized addiction in libidinal, self-soothing and attachment terms (Flores, 2004; Khantzian, 1997; West, 2001; Wurmser, 1977; Zellner et al., 2011). Two psychodynamic theories describe drug use in terms of self-medication and traumatic/narcissistic failures in self-development.

The self-medication theory of drug use is a popular and prevalent theory of addiction used to understand addiction. Self-medication theory puts forward the notion that addicts use drugs to medicate painful psychological states (Khantzian, Mack, & Schatzberg, 1974). The theory suggests that addicts have drug specific psychological reasons for addiction. It suggests that addicts have a drug of choice for affective reasons in order to mediate painful affective states of mind. The search for and use of drugs becomes a primary psychological relationship for a drug addict that helps avoid negative affect (Khantzian, 1997; Khantzian, 2003).

Heinz Kohut, the founder of self-psychological theory, felt that the theory of self-psychology had valuable “explanatory power” to offer the subject of addiction (Kohut, 1977, p. vii; Ulman & Paul, 2006). The “self (viewed as a process or system that organizes

subjective experience) is the essence of a person's psychological being and consists of sensations, feelings, thoughts, and attitudes toward oneself and the world" (Banai, Mikulincer, & Shaver, 2005, p. 225). The self develops cohesion as its needs for mirroring, twinship and idealization are met by experiences of other people. These interactions with people fulfil selfobject "functions" (Banai et al., 2005, p. 227). To this end, Ulman and Paul (2006) put forward that the self is the "epicentre" of the personality and that addiction is a narcissistic disturbance of the self-selfobject matrix (Ulman & Paul, 2006, p. 305). Ulman and Paul's (2006) theory suggests that unconscious psychological relationships are generated to inanimate objects (drugs) to cope with traumatic experiences in earlier formative relationships. The drug (use process) fulfils a selfobject function in the addict-drug relationship because "selfobjects are valued for the internal functions and the emotional stability they provide" (Baker & Baker, 1987, p. 2). As such drugs fulfil a needed self-regulatory function that "becomes developmentally arrested, and addiction becomes the determinant of his or her models and values" (Carter, Johnson, Exline, Post, & Pagano, 2012, p. 165).

Psychodynamic attempts to theorise about addiction have until recently skirted neurobiology and biomedical addiction theory, therefore struggling to make a clear psychodynamic correlation between drug use and the brain (Johnson, 2003). This is despite these theories offering many insights into drug use (Khantzian, 2003; Ulman & Paul, 2006). Neuropsychanalytic approaches to addiction have begun to address this issue (Zellner et al., 2011).

Having examined the major psychological models of addiction, we now look at the role of psychology in understanding relapse.

Psychological explanations of relapse

Relapse has been described as both a process and an outcome in relation to addiction (Witkiewitz & Marlatt, 2004). A wide range of theories about relapse to drug consumption rely on neurological, behavioural, cognitive-behavioural and psychodynamic explanations for relapse (Conners, DiClemente, Velasquez, & Donovan, 2013; Koob, 2008; Leshner, 1999; Marlatt & Gordon, 1985; Mohammadpoorasl, 2012; Volkow & Fowler, 2000; Wurmser, 1977).

In many instances because of the complexity of addictive behaviour and the natural explanatory limits of these perspectives, modern theories lean toward overlapping bio-psychosocial and systemic models in their explanation of addiction and relapse. Relapse, in this context, is seen as a return to the old behaviour and a “successive learning process whereby the individual continues to redo the tasks of various stages in order to achieve a level of completion that would support movement toward sustained change from the addictive behaviour.” (DiClemente et al., 2004, p. 104). From the point of view of the trans-theoretical model, relapse is a significant factor in the process of change as behaviour is seen as regularly changing and being re-evaluated. This suggests that people can learn from relapse and develop a new set of healthier or more adaptive behaviour. Change toward or from using drugs is also conceptualised in a manner that includes a gradation from intentional behaviour (pre-contemplation, contemplation, preparation stages) to the overt behaviour (action, maintenance). Of course preparation can involve overt behaviour too and hence the preparation stage overlaps with intentional behaviour and overt behaviour in the trans-theoretical model.

Marlatt and Witkiewitz's (2004) mindfulness-based relapse prevention and Gorski's (2000) relapse prevention theory is conceptually related, albeit distantly, to the trans-theoretical model inasmuch as it is part of a group of modern cognitive behavioural explanations for relapse related to addiction (Witkiewitz & Marlatt, 2004). Marlatt and Gordon (1985) published the seminal text *Relapse Prevention*, locating relapse away from disease model thinking and directly in the theory and practice of cognitive behavioural therapy (CBT) and cognitive psychology. Mindfulness based relapse prevention and Gorski's (2000) Centre For Applied Sciences (CENAPS) are an extension and development of the relapse prevention treatment offering developed for addiction. Gorski's (2000) CENAPS relapse prevention is a cognitive behavioural approach that is well established and widely known internationally (Gorski, 2000). From this point of view, addiction and relapse are caused by "euphoric recall, positive expectancy, a trigger event, obsession, compulsion and craving" (Gorski, 2009, p. 39). Treatment for relapse addresses problem "thinking" and problem "drinking" from a "disease model" point of view (Gorski, 2009, p. 53).

Other cognitive behavioural relapse prevention strategies for addiction have come to involve the philosophy and practice of meditative mindfulness included in the development of approaches such as mindfulness based stress reduction (MBSR), mindfulness based cognitive therapy (MBCT), and relapse prevention protocol (Bowen, Chawla, & Marlatt, 2011). It has also mirrored the research trajectory and practice of research conducted into mindfulness as an effective treatment for depression. Clinically, MBRP centres focus on the practice of teaching clients to notice and attend to mental states and behaviour such as stress, depressed mood and self-harming behaviour. MBRP teaches how to deal with and accept a variety of "triggers" and "high risk situations" for addicts and alcoholics (Bowen et al., 2011, pp. 49-111). This is with a view toward avoiding the attempt to control behaviour

and fuse with heightened emotional arousal and rational detachment whilst practicing being present “in the moment” (Bowen et al., 2011, p. 36).

Cognitive behavioural approaches to relapse prevention have dominated residential treatment settings and even the Minnesota model approach to treatment, with its focus on goal setting, has a cognitive behavioural flavour. Of course there are many local varieties of intervention that are used to deal with addiction. Individual psychodynamic and psychoanalytic approaches have fallen from favour in residential addiction treatment with the advent of demands from clients and regulatory bodies for so-called evidence-based treatment. This point is elaborated on in a later section of the chapter related to mentalizing. Next, current counselling approaches to addiction are discussed below.

Current approaches to addressing addiction

Addiction treatment has increasingly come to be seen as a chronic disorder and illness that has many systemic qualities (Miller & Carroll, 2006). The US national institute on drug abuse (NIDA) has categorised several treatment modalities for addiction which include: detoxification and medically managed withdrawal programmes, long-term and short-term residential treatment, behavioural outpatient treatment programmes, individualised drug counselling, and group counselling (National Institute on Drug Abuse, 2009). These modalities are seen as effective treatments for addiction (National Institute on Drug Abuse, 2009). In particular, “medication and behavioral therapy, especially when combined, are important elements of an overall therapeutic process that often begins with detoxification, followed by treatment and relapse prevention” (National Institute on Drug Abuse, 2013b, p. 2).

The type of interventions that addiction treatment providers offer in these categories varies substantially and can depend substantially on their treatment philosophy

and setting. In both medical and psychological interventions, counselling talk often begins at the first point of contact with a client. In the medical treatment of addiction, a range of physical evaluations and interventions take place to manage the physical effects of a withdrawal process in conjunction with developing a treatment plan to deal with a client's health care concerns. These interventions can be extended where appropriate, into maintenance therapies or into the psychiatric domain for diagnosis of co-occurring disorders (National Institute on Drug Abuse, 2009).

In conjunction with this medical approach, psychological and counselling interventions are also initiated early during a treatment episode. Therapeutic talk about the problem of substance dependence with a client forms a crucial part of both the medical and psychological treatment of addiction. This talk may take the form of assessment questions or motivational counselling during a medical consultation. It may also be formal sessions dedicated to talking about addiction with a counsellor or psychotherapist. Counselling talk is therefore a fundamental part of the addiction treatment process (National Institute on Drug Abuse, 2009; National Institute on Drug Abuse, 2013a; National Institute on Drug Abuse, 2013b).

Counselling as a component of addiction treatment interventions

Providing advice, challenge or using talk as an intervention gives counselling an important role to play in the treatment of addiction, which means it has also come to be seen as a "profession" that almost all addiction treatment centres offer (Butler, 2011; Najavits & Weiss, 1994). Addiction counselling has developed additional dimensions and moved from face-to-face only encounters into the realm of telephonic and internet-based technology systems such as Skype (Tzelepis et al., 2011). Whilst technology advances, the exposure of addicted populations to counselling treatment programmes and interventions

continue to rely on the capacity of addicts and treatment providers to talk to one another. Whether this is to encourage medication compliance, explain genetic vulnerability or to address issues of psychological concern, talk is a de facto means of intervention at a number of clinically significant levels.

Literature currently suggests that medical and psychosocial models of addiction hold important dimensions for the explanation for addictive behaviour as mentioned earlier in this chapter. The idea of holding an inclusive or holistic view of mental illness in relation to addiction is at a point where describing it as such is in some ways clichéd (Butler, 2011). Seminal research like that of the Drug Treatment Outcome Study (DTORS) – a major longitudinal study of addiction treatment in the United Kingdom – show the now seemingly obvious findings that treatment for drug using can be broadly effective and reduce crime whilst improvements in individual physical and mental health are modest (Donmall, Jones, Weston, Davies, & Hayhurst, 2012). The idea of what evidence – disease model or otherwise – is used in addiction counselling talk and how this may assist clients remains. How disease model conceptualizations of addiction affect the psychology of the therapeutic relationship also remains an unanswered. Questions also remain about the efficacy regarding the conceptualization of addiction as an individual medical or psychological disease (and relapse an inevitable consequence of addiction) in relation to the activity of counselling talk.

Addiction counselling has however developed in sophistication to consider and incorporate issues raised in meta-analytic reviews of psychotherapy such as attachment, individual coping style, patient expectations, and resistance (Beutler, Harwood, Kimpara, Verdirame, & Blau, 2011; Beutler, Harwood, Michelson, Song, & Holman, 2011; Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011; Levy, Ellison, Scott, & Bernecker, 2011). How

counsellors locate these and other considerations in the talk of the therapeutic alliance and within medical and psychological addiction counselling discourse, is a matter that research literature says substantially less about.

Effective counselling, focusing on individual and family systems in addiction treatment, is currently associated in the literature with counsellors being trained and acquainted with the latest evidence-based treatment methods (Martino, 2010). It would appear necessary however to take the point about institutional and counsellor awareness of their training needs a step further. Given that relapse rates are as substantial in addiction treatment as research suggests, being trained in the latest model of addiction treatment does not necessarily make for an effective treatment experience on the part of the client. Najavits and Weiss (1994) have argued that robust “interpersonal functioning” is an essential characteristic of addictions counsellors who achieve credible outcomes (p. 683). It comes as no great surprise that the only clear treatment outcome indicator relating to the “greater effectiveness” of the therapist dealing with addiction (and relapse), is that of a high level of “in-session interpersonal functioning” (Najavits & Weiss, 1994, p. 683). However, in some potentially concerning findings, from a limited range of studies based on Minnesota Multiphasic Personality Inventory assessments of counsellor characteristics suggested that “the best counsellors were more hypochondriacal, paranoid, manic, and were lower in ego strength” (Najavits & Weiss, 1994, p. 683). In an interesting contrast, peer evaluations of counsellor characteristics suggested that other counsellors saw “more dominant and less deferential” colleagues as being more effective in addiction treatment (Najavits & Weiss, 1994, p. 8). The conclusions drawn from this research were that counsellors “may require a set of traits uniquely necessary for this population” that include a willingness to be more

“active”, “less rigid” and more likely to be imposing of “values” in sessions whilst being “charismatic, emotional and inspiring” (Najavits & Weiss, 1994, p. 11) .

As regards counselling as an intervention, treatment outcome is linked to both counsellor’s characteristics and client outcome expectancies (Constantino et al., 2011; Najavits & Weiss, 1994). Given that relapse is a possible, if not likely outcome after treatment, how the counsellor and client develop therapeutic conversation would appear to be a critical factor in moderating recidivism. In particular, it is the outcome expectancies – what clients and counsellors believe about anticipated addiction (and treatment) experiences – that is critical to outcome (Shumway, Harris, & Baker, 2013). How clients and counsellors come to anticipate and notice issues related to addiction conversation that are important to treatment, relies on their capacity for thinking about their and each other’s minds. It is here that mentalizing is a useful concept to introduce.

Mentalizing

Mentalizing is a core psychological process through which people develop, negotiate and understand themselves and the world (Allen, 2006; Bateman & Fonagy, 2010; Fonagy, Gergley, Jurist, & Target, 2002; Fonagy & Target, 1997). Psychotherapy and addiction counselling implicitly rely on mentalizing to achieve its aims (Allen, Bleiberg, & Haslam-Hopwood, 2013). Ideally, the addiction counsellor’s capacity to stimulate a mentalizing process might be a core aspect of interacting with clients in a treatment setting. This may be achieved by the addictions counsellor showing enjoyment in developing alternate views that facilitate the client’s reevaluation of their psychological positions that they have adopted regarding a range of addiction related issues. It is “the continual reworking of perspectives and the understanding of oneself and others” as *psychological* human beings that is critical

to the counselling endeavour (Bateman & Fonagy, 2009, p. 277). The neuro-scientific and psychological theories of addiction and relapse that have been discussed above place a significant emphasis on cognition, behaviour and biology. They are theories that are also both empirically validated and widely used in clinical settings to deal with addiction. However they pay cursory or no attention to addiction as a developmental psychological disorder. Either brain structure or a failure to learn are the tenets they foreground regarding addiction. Yet the capacity to learn, understand and act as a psychological being relies on a broader range of mental capacities. One of these is the capacity to mentalize.

Mentalizing as a theory and a process, are the focus of this part of the literature review. Some definitions of mentalizing are offered and followed by a discussion of the core aspects of mentalizing relevant to this study. Mentalization as a concept was introduced into the field of psychoanalysis more than fifty years ago (Söderström & Skårderud, 2009). Mentalization has been empirically developed and popularized over the last 25 years. This is because of its utility as a clinical concept and the value it holds when considering the wide range of its theoretical applicability to domains such as relational attachment, psychopathology, psychoanalysis and theory of mind.

The theory of mentalization has a wide range of contributors including but certainly not limited to Peter Fonagy, Anthony Bateman, Jon Allen, Mary Target, György Gergely and Elliot Jurist. Many of these and other contributors to the theory of mentalization have commented that mentalization is not a “new” concept. They also note it is a technically satisfying but rather clumsy word for the description of a complex mental process. From its initial introduction into academic and clinical literature the idea of mentalizing, perhaps quite appropriately, has taken several forms.

Definitions of mentalization

Mentalization theory has origins in psychoanalysis, neurology and attachment theory. Definitions of mentalization from theory and clinical accounts populate a wide range of psychological literature that includes theory of mind, the philosophy of psychoanalysis and psychopathology. As mentalization has risen to prominence as a concept, it has been compared and contrasted with mindfulness, cognitive analytic and schema theoretical approaches, amongst others, with reasonable regularity in academic literature of the last 10 years.

Fonagy (1991) introduced the concept of mentalization in its verb form - to “*mentalize*” - as “the capacity to conceive of conscious and unconscious mental states in oneself and others” (Fonagy, 1991). Mentalizing has a number of conceptually similar relatives “such as *mind-blindness, emotional intelligence, insight, theory of mind* and *social cognition*” (Söderström & Skårderud, 2009, p. 61). In a review of the *Handbook of Mentalization-Based Treatment*, Robert Michels (2008) condenses several definitions into a paragraph that is worth quoting in full to capture the breadth of the effort required in defining the concept of mentalizing.

In Michels’ book, Holmes quotes Bateman and Fonagy’s 2004 definition: “the mental process by which an individual implicitly and explicitly interprets the actions of himself and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs and reasons.” Allen condenses this to “attending to states of mind in oneself and others,” and admires Fonagy’s even terser “holding mind in mind.” Allen and Fonagy think of it as a skill [they call it a “dynamic skill,” but Bateman and Fonagy make clear that by “dynamic” they don’t mean psycho-dynamic – that is, determined by mental forces

in conflict, but rather as developing in a relationship context and vulnerable to environmental deficiencies] (Michels, 2008, pp. 327-328).

Clearly mentalization is a broad concept that is not briefly explained. A few central features of mentalization however stand out. The first is that mentalization is about individual mental states in a social context. The second is that mentalization is a “capacity” and “process” that individuals use to construct intentionality with regard to oneself and others (Fonagy, 1991). Thirdly, mentalization has explicit, implicit and affective dimensions when considering mental processes in relation to self and other (Jurist, 2005). Five features of mentalizing are particularly important to this research. They are the relationship of mentalization to attachment, degrees of mindedness, emotional regulation, the development of language and addiction. These aspects are foregrounded here in order to use the theory of mentalization to “zoom in” on the dialogue of counsellor and clients in an addiction treatment context.

Aspects of mentalizing: The foundation of attachment

John Bowlby’s seminal works on attachment paved the way for Peter Fonagy and Mary Target, with Howard and Miriam Steele, to examine and operationalize the idea of mentalization as reflective function in attachment relationships (Fonagy & Target, 1997; Fonagy, Target, Steele, & Steele, 1998). Locating mentalizing in the context of attachment was crucial for two reasons. Psychoanalysis had been politically divided by Bowlby’s theories and he (Bowlby) had been “profoundly discontent” with the psychoanalytic view of his time (Wallin, 2007, p. 14). For Fonagy and his colleagues mentalization became a bridge or perhaps a labyrinth of pathways between orthodoxy, psychoanalysis and the emergent explanatory potential of attachment theories. Secondly, the Bowlbys’ focus on the infant-caregiver dyad, his “profound social concerns” and the developmental “vision” of

attachment theory was ground from which Fonagy and his colleagues could pursue the conceptualization of and treatment of intergenerational aspects of relational trauma (Wallin, 2007, pp. 44-45).

Fonagy and his colleagues' initial view foregrounds the critical place of mentalizing in the relational attachment environment: "This may well be part of the explanation of the intergenerational concordance in attachment security. Thus reflective self-functioning may be both an indicator of "ghosts" in the nursery and an indicator of the caregivers predisposition to transmit these." (Fonagy, Steele, Moran, Steele, & Higgit, 1993, p. 985). This research showed the critical place of intergenerational mind-mindedness as a factor for the transmission of mentalizing. As more evidence of the utility of the concept of reflective functioning emerged from research about infants' metacognitive capacities, mentalization was seen to be playing "a crucial role in the intergenerational transmission of attachment." (Slade, Grienenberger, Bernbach, Levy, & Locker, 2005; Wallin, 2007).

This in turn offered another way of conceptualizing psychopathology, and authors such as Flores (2004) have described addiction as an attachment disorder accordingly. In particular, understanding the role of attachment and emotional regulation in the development of the self was augmented by the study of the development of the self of the *borderline* patient (Bateman & Fonagy, 2010; Fonagy et al., 2002). This allowed for the development of the idea that mentalizing whilst relying on attachment, involved several states of mind.

Aspects of Mentalizing – Degrees of mind-mindedness

Mentalizing is a developmental "consequence" of effective attachment environments and infants having been exposed to these by primary caregivers. It is also both a cornerstone for successful attachment and also confers an evolutionary advantage in

social situations, allowing children to “read” social situations. The early development of the ability to engage in “perceiving and interpreting human behaviour in terms of intentional mental states (e.g., needs, desires, feelings, beliefs, goals, purposes and reasons)” allows young children to develop mentalizing (Fonagy & Target, 2006, p. 544). Fonagy & Target (2006) also show how mentalizing is intricately linked with the development of affect regulation and attentional control mechanisms in the context of attachment development. It also the product of interaction between the adult individual and their psychological environment over a lifetime and emphasises the idea that minds can change or be psychologically prompted to do so.

In a wide variety of communicative endeavours, individuals – such as clients and therapists in therapy – misunderstand one another for a range of reasons. This is due to the fact that mentalizing is not a static presence or absence in communication but a process that depends both on each individual’s mentalistic capacity and on context. Mentalizing is therefore a mode from which people reflect and a mental process by which they reflectively engage themselves and others. Developmental experiences may lead to a failure to mentalize effectively and are likely to have significant consequences for individuals developing a sense of self, deriving agency from self-structure and relational tasks, particularly in the context of attachment relationships (Allen et al., 2005; Bateman & Fonagy, 2003; Fonagy & Target, 1997; Gergley & Watson, 1996). The ability to mentalize potentially allows individuals to deal with misunderstanding and ruptures in communication and reflect on internal psychological experiences.

The continuous “stream” of conscious (and unconscious) awareness can be described as incorporating three mental modes preceding mentalizing - psychic equivalence, pretend-mode and teleological expressions of subjective experience (Fonagy et al., 2002).

These form various points at which an individual may express subjective experience or intentions in a way that is characteristically pre-mentalistic. These modes form a range of mental functioning that indicate the individual's capacity for non-mentalizing mental experiences. Individuals do not explicitly mentalize all the time; however they do rely heavily on their implicit mentalistic abilities to track and "read" their and others' intentions. Similarly, in interaction, people move between the different pre-mentalistic modes of engagement when interacting in a given context. As such psychic equivalence, pretend-mode and teleological thinking are all expressions of subjective experience that precede mentalizing modes of expression and rely on the process of mentalization in the development to the self (Fonagy et al., 2002).

In psychic equivalence mode, individuals' mental flexibility and imagination are replaced by concreteness of thought. The "external world" is seen as contingent and indistinguishable from their "internal world." This is reflected by the example of a client stating "How could I know that, you are the psychologist" whilst in therapy conversation. Suffice to say that this is a position of significant psychological rigidity. It is often portrayed in literature as the most basic non-mentalistic state given the solipsistic imprint it carries coupled to its very low psychological quality. Psychic equivalence, from an affective point of view, can be unassailably reassuring, terrifyingly real or deeply frustrating to engage others with in order to have them understand what is being communicated.

In pretend-mode mental flexibility and imagination are replaced by the disconnected *as-if* psychological experience. Here the individual's internal world is seen as having no bearing on reality or bridge to the external world. In conversation this mode of expression may have the impact of confusion and even boredom for the recipient, who may wonder how to stay 'on track' with what the individual is attempting to convey. This mode can

indicate either context-appropriate playfulness where, for example, a child may pretend that a chair is a space ship. Alternatively, pretend mode can occur and generate pathologically dissociated representations of the self, in expressions that are rigidly incongruent. This may result in a client reporting subjective experiences that are disconnected from affective states or lack a real quality. These tend to have the impact on the counsellor or therapist that allows for their mind to wander, become bored or detached from the client in psychotherapy.

Teleological expression relies on concrete experience to articulate psychological expressions of the self. It is evident when seeing others as objects that are part of a goal-oriented self-reflection and affective regulation – “my psychologist makes me better.” In the teleological mode, mental flexibility and imagination are also substituted by concrete confirmatory physical expression of abstract concepts e.g. a hug means “I love you” (Allen, Fonagy & Bateman, 2008; Bateman, 2012).

These modes of mental expression are not necessarily pathological states of mind (Allen et al., 2008). Allen and colleagues use the example of individuals with Borderline Personality Disorder who mentalize “normally” except in the context of attachment crises. This substantiates the point that, to use mentalization jargon, a variety of variables can influence whether or not someone is “online” or “offline.” It also contributes to the idea that reflecting on mental states is essentially a mentalistic process and can be interrupted by non-mentalistic modes of mental effort. It is in this context that we will explore the impact that affect, states of mind and self-regulation have on mentalization.

Aspects of mentalizing: Affective states of mind and emotional regulation

From its roots in attachment theory, mentalization theory developed to a point where problems of self-development and affect regulation were being addressed. Seminal

works such as *Affect regulation, mentalization and the development of the self* consolidated and began to define in detail the development of self and intolerable states of mind from a developmental point of view (Fonagy et al., 2002). True to its subject, the text incorporated a wide range of interdisciplinary perspectives to explain the complex ability of “mind-mindedness” and its vulnerabilities (Sharp, Fonagy, & Goodyer, 2006, p. 197). In particular, it adopted a “social biofeedback model of parent affect mirroring” in order to explain the development of the self-regulatory expression of emotion (Fonagy et al., 2002, p. 145).

The foundation of the proposal regarding the development of affect regulation is twofold – parent modulated affect that helps the infant develop its own modulated affect. In order for this to occur, the infant initially has “prewired, stimulus driven automatisms over which he has not control at first, affect regulation is carried out mainly by the caregiver... reading the infant’s automatic emotion expressions [and reacting] to them with appropriate affect-modulating interactions.” Secondly, this “repetitive presentation of external reflection of the infants affective-expressive displays ... serves a vital teaching function that results in gradual sensitization to the relevant internal state cues as well as the identification of the correct set of internal stimuli that correspond to the distinctive emotion category that the baby is in.” (Fonagy et al., 2002, pp. 160-161).

The ongoing offering of his/her mind by the caregiver, in order to mark emotions, shows the infant that s/he can indeed learn and can be aware of emotions and other mental states. Indeed “affects are crucial for self-representations as well as object representations” and are important to grow affect regulation in the development of the self (Jurist, 2005, p. 440). This idea was expanded upon in a study conducted by Fonagy and Luyten (2009) who showed that individuals with borderline personality disorder whose experience of stress “in combination with low thresholds for deactivation of the capacity for controlled

mentalization, particularly with regard to differences in mental states of self versus others, render[ed] th[eir] interpersonal world incomprehensible and lead to a cascade of impairments in other types of mentalization.” (Fonagy & Luyten, 2009, p. 1375).

It is evident that having a clear psychological grasp about feeling, in the heat of the moment, is a tricky business particularly for those in a clinical population who have substantial mentalizing vulnerabilities. Of course we do not hold all conversations in mind consciously or even actively, to manipulate at will, but we do turn from topics that are difficult and feel painful or uncomfortable. This difficulty may be related to how, in attachment contexts we have had experiences - some preverbal and some verbal - rehearsed, reflected and learned in a way so that we develop “blind spots” that are both psychological and located in the moral, ideological and political context. And so, “[t]he language of taming affects is more problematic, as it seems to smuggle in the assumption that affects—like wild animals—are dangerous.” (Jurist, 2005, p. 439). It is this aspect of mentalizing that is now explored.

Aspects of mentalizing: The language of mentalizing

Given the strong links that mentalization theory has with the ideas and theory of attachment, the near inevitably important question is how we (learn to) talk about emotion in relation to ourselves and others. Given this, it is also important to consider mentalizing theory’s position on language and talk from a discursive psychological point of view. A full developmental account of the acquisition of language as regards mentalization is not possible here. Neither are the problems and potential areas of overlap between language acquisition, neurology, addiction and developmental social science which are broad fields of study themselves. However, Cromby (2007; 2012) gives a substantial account of the use of qualitative research to study language, affect and belief and this relationship to the body

and addiction. Foddy (2010) discusses in some detail the relationship between philosophy, agency and addiction that are related to the argument of this section of the dissertation (Cromby, 2007; Cromby, 2012; Foddy, 2010). Nevertheless a pragmatic position on mentalizing and the importance of language relating to mental states needs explication for the purpose of this research. Clearly a hard or absolutist position from any theoretical model is not going to provide an answer to the overt or subtle complexities of understanding the relationship between mental states, language production and talk. For the sake of this research, mentalization and discursive accounts regarding activity and “development” of talk are positioned alongside one another within the discourse of psychology.

Mentalization is the culmination of a mental developmental process and has both implicit and explicit components on which language acquisition and talk rely. Whether these are constructed through genetic expression, observable talk, implicit “internal speech” or representations of an internal world, the ability to mentalize, be curious about and “play” with mental states relies on some notion of talk (Fonagy et al., 2002; Pinker, 2009; Vygotsky, 1966, p. 12). Indeed, as Mein and Fernyhough (1999) show, an important part of acquiring language relies on caregivers’ mind-mindedness as they assist children in their acquisition of language through understanding and vocalizing what the child *intends* to express by their utterances (Mein & Fernyhough, 1999). From a discursive point of view, explicit discourse about mental states is the province of dialogue and discourse which foregrounds the idea that language and conversation are to be seen as constructed to negotiate social realities.

Fonagy et al. (2002, p. 48) offer a position in this regard in relation to mentalization and language inasmuch as mentalizing is a “conversational opportunity concerning mental states [which] appears to improve children’s mentalizing performance” and go on to say

that “[s]ecure attachment may then engender patterns of verbal interaction between child and caregiver, which in turn support thinking about feelings and intentions”, what Jurist (2005, p. 426) calls, “mentalized affectivity” (Fonagy et al., 2002; Jurist, 2005). It is at this point where the parallel between mentalization theory and critical discourse becomes apparent and “we might also wonder how to integrate the language of affect regulation, which is usually described in terms of excess (too much or too little) or moderation (the right amount), with the rich and established psychoanalytic language about defences.” (Jurist, 2005, p. 441).

The actual conversation that people have, is the verbally enacted representation of their mind and mental state – words are deeds, at least in a Wittgensteinian sense. The process of mentalization is distinctly interrelated with language and action of dialogue, not only in the mundane activity of reportage but in an active, interactive manner with (non)verbal fluidity, curiosity and silence when talking, thinking and feeling.

Mentalization theory holds that the three modes in the process of mentalizing - psychic equivalence, pretend, teleological mode - precede our reflective thinking about thinking, feeling and talk (Fonagy et al., 2002). Given the centrality of affect and its relationship to mind-mindedness, mentalization theory’s conceptualization of the construction of talk about the affective aspects of the self is deeply significant for how addiction and mentalization are conceived (Fonagy et al., 2002, pp. 48-58). Specifically how affect in relation to addiction is thought and talked about has a significant bearing on how we understand and approach the dialogue of the counselling dyad that is the focus of this research.

Mentalization and addiction

Addiction and mentalization theory share a complexity in their theoretical approaches to understanding mental states and persistent drug use. We know “the onset of drug addictions is determined by a complex combination of constitutional (biological), social, and psychological factors” and mentalization has a similarly complex foundation of originating factors (Savov & Atanassov, 2013, p. 1). However, theorizing about addiction and mentalizing which has led to intervention in the field of mentalizing and substance dependence in the adult population “reveals that there is hardly any published research on drug addicted patients’ mentalizing functioning” (Savov & Atanassov, 2013, p. 4). This may be because mentalization, adult psychopathology theory and addiction have also relatively recently reemerged as a topic of interest from a mentalization point of view (Savov & Atanassov, 2013).

The talk, phrasing and construction of the development of the capacity to mentalize, comes from a tradition of developmental psychology, neurology, evolutionary psychology and attachment. This tradition focusses on foundational early childhood experiences and learning from a “social biofeedback” perspective to argue the emergence of a nascent self and mind-mindedness (Fonagy et al., 2002). Savov and Atanassov, (2013) suggest that the psychodynamic perspective of Khantzian’s (1997;2003) self-medication models most closely relate to mentalization’s view of addiction (Khantzian, 1997; Khantzian, 2003; Savov & Atanassov, 2013). This is because both have affect regulation as a theoretical cornerstone. It is particularly the large body of research about affect regulation and its relationship to mentalization deficits that suggest a substantial overlap with addiction research. Indeed, it has been shown that people with alexithymia and substance dependence disorders vary from the norm in their ability to express ideas about affective mental states (Haviland,

Hendryx, Shaw, & Henry, 1994). It is in developmental breaches such as these, that mentalization theory constructs addiction as a “personality deficit related to early environmental failures” (Savov & Atanassov, 2013, p. 5). Yet, “the apparent scarcity of empirical research on mentalization in addicted patients stands in contrast to the fact that the presented models have already been operationalized successfully”. (Savov & Atanassov, 2013, p. 4).

It would appear that addiction as a clinical phenomenon and symptom needed to be located in mentalization theory once this was developed sufficiently, rather than the other way around. Additionally, there may have been a hallmark of “fit” and theoretical range between the “old” and “new” psychoanalytic conception and neurological models of addiction that formed part of the historical subtext that predated mentalization-based theory that lead to its under representation in (psychoanalytic) literature. In the last five to ten years there has been an overt increase in research on substance dependence and mentalizing. However, this research has stayed close to mentalization’s developmental approach and the infant, and researchers like Slade (2006), Söderström and Skårderud, (2009) and Suchman et al. (2010) have used mentalization-based treatment to address substance misuse (Levy & Truman, 2002; Ostler, Bahar & Jessee, 2010; Slade, 2006; Söderström & Skårderud, 2009; Suchman, et al., 2010;). The initial findings of these initiatives appear both significant and encouraging for the children and the parents receiving this intervention.

Given mentalization theory’s primary focus has been on the infant-caregiver dyad and so-called borderline psychopathology, a substantial gap in research literature exists about mentalizing when addiction and counselling the addicted adult population is considered, which is “surprising” (Savov & Atanassov, 2013, p. 4). Given mentalization

theory's explanatory potential regarding affect regulation, mental states and addiction this strongly suggests that there is a need to research this area more fully. Indeed, the impact of mentalization theory on understanding addiction is possibly most powerful when considering the need to understand why recidivism is so prominent after addiction treatment. Additionally, it is an area that needs addressing given the disease burden of addiction and the dearth of theorizing about addiction from a mentalizing point of view. After looking at the five aspects of mentalization relevant to this study, the second theoretical model – critical discourse theory needs some introduction.

Critical discourse theory and critical psychology

Critical discourse is a broad range of theory with political, social and psychological foundations. Critical discourse aims to examine the patterns of signs, symbols, conversations and the writing of individuals and groups, in order to understand how subjects situate themselves and are positioned in a wide variety of contexts (Jørgensen & Phillips, 2002).

Patterns of language, seen from the point of view of critical discourse and psychology, are a “topic” rather than a “resource” (Edley, 2001, p. 190). This means that rather than language being evidence as to what is happening inside the mind, *how* things are talked about is what is of interest. Critical discourse theorists see this “how” of language, as “embedded within some kind of historical context” (Edley, 2001, p. 190). The use of words, language and meaning develops over time within a culture and may have a hegemonic function in relation to how individuals are constructed and positioned. In this sense, words and language are parts of a discourse that individuals and groups use to negotiate identity, relationships and power.

How individuals talk about themselves, events, actions or one another, positions them in a variety of social contexts. As such, this positioning is an accomplishment in that it achieves a discursive location for the individual in a social environment. Language in this context is itself a “form of practice” by which subject positions are constructed (Edley, 2001, p. 192). To this end discursive theory uses the idea of “subject positions” to describe “different discourses [which] give the subject different, and possibly contradictory, positions from which to speak” (Jørgensen & Phillips, 2002, p. 17). These different positions are a result of ongoing talk about material and social conditions. This talk invariably takes place from an ideological point of view, and individuals are therefore “interpellated” many ways and hold multiple roles, for instance, when “positions” of “doctor” and “patient” are specified (Jørgensen & Phillips, 2002, p. 41). Respectively, “in relation to these positions, there are certain expectations about how to act, what to say and what not to say” (Jørgensen & Phillips, 2002, p. 41). As such, positions and roles are constructed from a range of meanings that have valence with respect to ideas such as authority or equality in a given context.

The historical context that talk takes place in, allows various roles to develop and become entrenched within a social context. Language also becomes a vehicle for the development of interpretative repertoires by its repeated use of words and phrases. Interpretative repertoires can be defined as a “systematically related sets of terms, often used with stylistic and grammatical coherence, and often organized around one or more central metaphors” (Potter, 1996, p. 9). Seen somewhat differently, this can lead to the use of language to achieve discursive “shortcuts” and the development of jargon and tropes that may powerfully shape the meaning and “direction” language.

So, in everyday talk people discursively construct one another and are positioned by the use of language. People talk and are understood in ways that are meaningful because of how they are positioned, as well as how they can discursively construct meaning. This discursive activity is based on many ideological assumptions. To use the example of health, as Radley and Billig (1996) do, it can be shown that “ideological judgements” are central to the notion of health and illness far beyond what might be described as the “merely” “physical” aspect of health (Radley & Billig, 1996, p. 222). It is in describing and constructing health positions for one another during conversation that people draw on health discourse, of which addiction discourse is a part. It is through the use of addiction discourse that people label one another and construct notions such as expert, counsellor and patient. Conversation and the negotiated talk about the positioning of health in talk are inherently dilemmatic because of the prominence of “popular discourses” about addiction (Bailey, 2005, p. 535). Talk about health from the point of view of the disease model allows people to make judgements about addiction that are powerfully influential (Bailey, 2005). Critical psychology is discussed in the next section with reference to discourse and addiction.

Critical discursive psychology and addiction

Critical discourse and critical discursive psychology are means to talk about, reflect on, as well as construct, theories about human interaction. In particular, critical discursive psychology is interested in “how people use the available discourses flexibly in creating and negotiating representations of the world and identities in talk-in-interaction and to analyse the social consequences of this” (Jørgensen & Phillips, 2002, p. 7). It is in this sense that the application of critical discursive psychology to this research is relevant as both a theory and a method. Critical discursive psychology, like critical discourse theory, is less interested in internal states that are hypothesised to exist “behind” talk, like attitudes, and rather

focuses on the dialogue and texts people produce in social contexts. How people talk and portray themselves is valuable to understand, as critical discursive psychology sees talk as an essential aspect of negotiating meaning, power and position during human interaction.

Addiction has been variously described from a critical discursive perspective and located in the discourse of the social sciences, health psychology and addictionology as an “accomplishment”; a relationship of intimacy with a substance or events, and an “entangled identity”; an ecology or “space” where people are constructed as “in” or “out” of treatment when having relapsed and “unhealthy” “self-surveillance” (Benford & Gough, 2006, p. 435; Gibson, Acquah, & Robinson, 2004, p. 604; Keane, 2004; Reinerman, 2005, p. 308; Weinberg, 2000, p. 618).

Critical discursive psychology, in positioning talk as a negotiated endeavour, also acknowledges its ideological and dilemmatic dimensions. In particular, “The concept of a discourse is useful in understanding how we are both de-limited and defined by what we are able to say/represent. In other words, it is a concept that has implications for how we conceptualize power and powerlessness, for how we understand the relationship between mind and body, and – importantly – for what we conceive of the self” (Bailey, 2005, p. 536). Importantly, talk (about addiction) can be seen as a process by which “the self is constructed through discourse; people’s sense of who they are, of what is possible for them, and of how they act” (Bailey, 2005, p. 537).

A variety of researchers and experts actively write about addiction using the critical discourse framework to show how describing addiction is “at once both utterly normal and dangerously pathological” (Bailey, 2005, p. 539). Bailey (2005, pp. 539-541) has pointed to three particular strands in recent writing about addiction.

Davies (1997) – The “helpless addict” and the role of the expert

In addiction treatment much of the therapeutic conversation between client and counsellor is often based on the notion of a one-up, one-down, helper-recipient dynamic. Counsellors and other treatment professionals are typically seen as experts in addiction care. Clients on the other hand are considered to lack the knowledge or insight to change their own behaviour. In positioning the notion of addiction in discourse, Bailey (2005) notes that different claims about addiction are made which locate the descriptions in “popular” or “expert” dialogue (p. 540). This has consequences for individuals’ self-definition and it is how people come to make claims about themselves, others and the positions they occupy. These claims may be about the self – “I am addicted to ...” or a diagnostic claim such as occupying a drug addiction position, addicts as “helpless” and diagnosticians as “experts”, that is likely to construct an interchange based on “learned helplessness” (Bailey, 2005, p. 540). Of particular interest to this study is the claim that treatment and non-treatment discourse are functionally distinguishable from one another (Davies, 1997). This suggests that treatment talk is generated in order to be understood within a specific context. It may also mean that the talk generated in counselling may not have relevance beyond treatment itself.

Keane (2002; 2004) – Multiple discourses and the disciplining of pleasure

Keane (2004) notes that there are a wide variety of discourses about addiction that are related to the idea of tension between the pleasure of drug consumption and threat. She shows that “the definition and the boundaries of addiction [are] mirrored by a tension in addiction discourses between generality and specificity” (Keane, 2004, p. 190). This is because there is a search for the “specific mechanisms” in arenas such as neurobiology that define addiction and pleasure which occur alongside attempts to find “overarching”

explanations for addiction's risks (Keane, 2004, p. 190). This range of discourse has constructed popular positions for people in relation to addiction, such as expert and addict. Bailey (2005) shows that according to Keane (2002), the distinction between expert, addict and popular account is "essentially heuristic" (p. 540). Keane (2004) shows that this distinction has implications for the "expansion" discourse about addiction and how we understand the relationships between pleasure, the body and drug use. In particular, Keane (2004) suggests that in spite of the search for specific answers, the neurobiological discourse of addiction offers a "generic account of how reward and pleasure are produced" (p. 190). This has implications for treatment talk inasmuch as the use of disease model heuristics by addiction experts, when treating addicts, is likely to affect how the consumption of drugs comes to be constructed as excessive. How these dimensions of addiction discourse are inter-related is constructed by Keane (2004) as the disciplining of pleasure. As such, she suggests that addiction rather needs to be seen in terms "of the demands of intimacy and the needs that humans have to make connections with substances, things and other humans" (p. 191).

Valverde (1997) – Problematizing freedom

Bailey (2005) shows another important element about addiction discourse to be Valverde's (1997) "working out of the dialectic between personal freedom and control/self-control" in the governmental control of drug use. Indeed, "governmental discourses about drugs and alcohol, in particular, tend to remain silent about pleasure as a motive for consumption, and raise instead visions of a consumption characterized by compulsion, pain and pathology" (O'Malley & Valverde, 2004, p. 26). The absence and presence of pleasure defining discourses appears to aid the government of drug use where "liberal government has thus accumulated a battery of pleasure-denying characterizations, each with its own

discursive effectiveness, each linked with an appropriate set of governing techniques” (O’Malley & Valverde, 2004, p. 39). It is therefore their view that the exercise of freedom in the context of governmental control of drug use, problematizes the expression, understanding and regulation of pleasure relating to drug use. Valverde and colleagues’ work is relevant to his study because this argument shows the pervasive effects of discourse about addiction from a political level. It also indirectly links to the idea that the psychological territory of addiction discourse is both regulated and negotiated by competing discursive tensions. This in turn raises the question of how the addict may be (un)able speak about their desire to use drugs in different discourses (Valverde, 1997).

How addiction is conceptualised and talked about is a complex task relating to agency, self-definition of the ability to choose, construct and pursue a health identity. Karasaki et al. (2013) discuss addiction from the point of view of volition and how competing conceptual models used to treat addiction may hamper individual agency. They show individuals’ volition to be influenced and constructed as “susceptible” when there is a “lack of coherence” in treatment interventions (Karasaki et al., 2013). This susceptibility is related to the social and psychological issues constructing addiction as an aspect of self-concept related to control and loss of control over craving and drug use. Lastly, “addicts” defined as such, are likely to construct a self-fulfilling prophecy through being labelled and so fulfil a social function of addiction (Karasaki et al., 2013, pp. 198-201). This suggests that the ways of understanding addiction and how counsellors and clients talk to one another about volition can be limited and impinged upon for the reasons just mentioned. And yet, addiction predominantly affects those who are disempowered or disadvantaged in one or more ways like neurobiology, poverty, education or mental illness and personality disorder (Karasaki et al., 2013).

Critical discursive approaches to addiction emphasise the role of power relations, discourse and specific dimensions of dealing with the ideas of agency and pleasure to approach addiction. Whilst these are valuable approaches, much like the neuroscientific and biological models are for understanding addiction, they do not directly address how the question of individual psychology, mindedness and influence should be conceptualised in treatment talk. Put differently – the discursive “voice” of the addict needs to be heard in the research literature in order to identify what alternative discourse there may be about addiction treatment offerings. This then raises the question about the utility of an approach to understand addiction that utilises mentalizing theory from the point of view of a critical discourse analysis.

Mentalizing, critical discourse and addiction: A synergy

Perhaps unsurprisingly, from a discursive point of view, mentalizing is presented as a “profoundly social” construct (Bateman & Fonagy, 2010, p. 11). Mentalization appears to have strong potential conceptual connections to discursive psychology given that “mentalization is a form of social cognition. It is the imaginative mental activity that enables us to perceive and interpret human behavior in terms of intentional mental states” (Fonagy & Luyten, 2009, p. 1357). This statement is central to this study because of its emphasis on the idea that cognition and indeed mental states are essentially bound to social context. In the activity of being psychologically coherent, we “think about feeling and feel about thinking”, and individuals need both a psychobiological representational system capable of doing this, and the cognitive and linguistic ability to “implement” this into discursive action in a given discursive context (Slade, 2005, p. 271). People need the narrative means to talk about themselves and the political opportunity to do so. Without being located in some form of discourse, a search for non-contextual mentalizing fails itself. It becomes a

teleological object of study rather than a mentalized process of scientific discovery. To state this rather more obviously, mentalizing and discursive theory have the socially constructed mind in common. The distinction between liking, wanting and desire shows a subtle but important struggle around how talk about desire is constructed and thought about. Thinking about addiction and the repeated use of drugs, draws attention to drug use as having two important aspects. The first is that that drug use is 'liked' in the sense that the use of a substance is, at least in part, a subjectively pleasurable, hedonistic activity. The second aspect relates to the wanting of drugs and the 'high' they provide. It is here that the idea of wanting is a dimension of drug use behaviour that captures a 'seeking' or an "incentive salience" element that relates to the notion of motivation (Berridge, Robinson, & Aldridge, 2009, p. 3). What is interesting however, is the notion that Berridge, Robinson and Aldridge (2009) suggest which is that wanting is a cognitive word for desire. Whilst wanting and liking are usefully distinguishable from their point of view, the notion of desire is conflated or lost in a cognitivist retelling of drug use experience. It is in this context, that the idea of talking about an addict's desire is important: wanting and desiring drugs are not analogous. Desiring is suggestive of 'stronger', 'deeper' and a personally felt 'drawn-towardness' experience that is less intelligible than the explicitly conscious notion of 'want'.

It is in the domain of talk about desire that Discursive theory has the potential to be a conceptual ally in a synergy of the two models. Discursive methods and theory have the capacity to highlight how during dialogue, from the point of view of mentalizing theory, elements and topics that are difficult, are intuited or turned away from or underrepresented and "repressed" (Billig, 1999). To necessarily misquote Wittgenstein here and emphasize the point, what is psychologically expressed is constructed through language and what is not able to be expressed is discursively repressed into the silence of the unconscious. Given

this, one can draw the conclusion that the spoken or written word with its silences and subtexts in dialogue is no more or less real than any other psychological or neurobiological phenomenon. Mentalized and non-mentalized discourse are based in the representational systems of thinking, feeling and meta-representation and in fact, is a psychological experience we have direct access to, whether seen “internally” or “externally”.

Furthermore, a discursive context framed by mentalizing theory, assumptions and the mental positioning of the interviewer and participant in dialogue, recursively shapes this individual-context interaction and hence its meaning. Mentalizing in this arena is therefore not only “profoundly social” but profoundly socially constructed (Bateman & Fonagy, 2010). It is therefore an important synergy – mentalizing and discourse – that this argument relies upon. Indeed, as a theory and practice, critical discursive psychology and mentalization are used to analyse addiction counselling discourse in chapter 4. Chapter 3 outlines the method that this exploration will follow.

Chapter 3: Methods

“unless appropriate methods and data are deployed the ineffable dimensions of the affective might completely elide QHR: its traces might simply fail to appear within data, or to get rendered tractable by analysis because research which presumes a linguistic epistemology will tend to ignore, obscure or distort meanings that are more affective and processual in character” (Cromby, 2012, p. 8).

Introduction

This chapter describes the method used to explore and address the question of how participants in residential addiction treatment may or may not use individual counselling to mentalize the notion of relapse. The chapter is divided into two major parts. The first part offers an account of the methodological framework for the study, including the theory of critical discourse and critical discursive analysis as a method of investigation and how these are held alongside the assumptions of mentalization theory . The second part of the chapter shows how the data has been gathered and analysed for this research. The chapter concludes with a discussion of the ethical implications for this study.

Methodological framework

Critical discourse theory and critical discourse analysis (CDA) are not an homogenous grouping of theoretical perspectives although they may hold similar epistemological foundations (Meyer , 2001). Firstly, critical theory is constituted by the theory of many thinkers including Billig, Potter, Wetherall, Edwards and Fairclough who represent a diversity of views within this framework (Antaki, Billig, Edwards, & Potter, 2003; Billig, 2006; Chouliaraki & Fairclough, 2010; Potter, 2012; Wetherell, 1998). Each offers a theoretical

positions in relation to critical theory and consequently have unique means of understanding and analysing social reality. Each theory holds epistemological positions that influence the articulation of theory and shape the construction of CDA. These range from the primacy of subjectivity in social relations, a range of (critical) realist or relativistic notions about the constructions of reality, discourse and the importance of power and context and their relationships to discourse (Van Dijk, 1993; Wodak, 2001).

Critical theory is therefore a framework of conceptual constructions that offer ideological positions about the nature of social reality. Critical discourse is framed by critical theory and is an approach that challenges, comments on and is used to study this social reality of which language is a part. As such, a CDA is a research tool that, with its own ideological assumptions, can be used to understand the use of language in health care systems and organizations such as those that are the focus of this study. Critical discourse and critical discourse analysis have an important contribution to make to addiction treatment discourse which is outlined below.

Critical discourse

Critical discourse theory is a broad grouping of theory, research and critical commentary that aims to evaluate and describe social and cultural discursive practices. The theory of critical discourse is “based on social constructionism” and has three particular premises: “a critical approach to taken-for-granted knowledge”, “historical and cultural specificity” and a “link between knowledge and social processes” (Jørgensen & Phillips, 2002, pp. 4-5).

In this sense, the strands of critical discourse theory described below can be seen as critically “realist” in their ontology inasmuch as they hold a “dialectical view of the

relationship between structure and agency” and a “relationship between discourse and other elements or ‘moments’ of social practices and social events” (Fairclough, 2012, p. 453). This suggests the “active role of discourse in constructing the social world” (Jørgensen & Phillips, 2002, p. 7).

Critical discourse’s aim, by reflection and critical evaluation of current cultural and social norms, is to arrive at a point where systemic change/stasis processes in interpersonal systems can be described, engaged and challenged. This is in an attempt to conceptualise how change and stability in social systems occurs and functions. Looking at social systems from this point of view, it becomes possible to see the social arena as a “network” of social discursive practices that are “more or less stable, more or less fluid” (Fairclough, 2000, p. 170).

In relation to modern science and scientific aims of social science research, critical theory has consistently argued for the place of discourse in the understanding of social phenomena in a manner substantially different from the cognitivist empiricist traditions in social science (McLaughlin, 2009). Critical theory challenges the notions of hidden and linear causality that construct research questions in order to search for constructs such as attitudes inside the mind. Instead, research aims within this perspective, from Fairclough’s (2012) point of view, to understand the relationship between “social practices” and “social agents” situated in particular discursive situations (Fairclough, 2012, p. 457). It is in this context that Potter (2012) gives an account of the utility of the discursive perspective (and by extension critical discourse analysis) that emphasises a relativist epistemological position. He shows critical discourse’s difference from “billiard ball” social science as being a view “that causality (however understood) is not the *sine qua non* of a scientific approach. Rather

we can look to observation, rigour, system and prediction – things that are characteristic of contemporary discursive psychology” (Potter, 2012, pp. 12-13). The point indeed in particular for a critical discourse analysis is that psychological processes and events are located in context, observed as acts of speech, text and language, studied in relation to other “systems”, with a view to estimating what future responses might be likely to occur (Potter, 2012, pp. 12-13).

Fairclough (2012) takes this idea further and suggests “this approach entails working in a ‘transdisciplinary’ way through dialogue with other disciplines and theories which are addressing contemporary processes of social change” (Fairclough, 2012, p. 452). Describing a discursive approach in this way assumes that discourse is an activity rather than an experience. Discourse is also a process or sequence of activities that fall into a particular category of logical description rather than an event or experience that lies hidden behind a social façade. Fairclough’s (2012) view of discourse suggests that discourse can be described “in an abstract sense as a category which designates the broadly semiotic elements (as opposed to and in relation to other, non-semiotic, elements) of social life (language, but also visual semiosis, ‘body language’ etc.)” (Fairclough, 2012, p. 453). This particular critical realist view of discourse is valuable for this research because of its emphasis on dialectical elements of discourse and word meanings, in this case in the context of addiction counselling conversation. Fairclough’s (2012) view of discourse as “dialectical” and “semiotic” suggests that CDA can be successfully utilised to analyse the discourse of addiction counsellors and clients who are talking about relapse with a view toward understanding hegemonic discursive elements in the assumptions that influence their talk.

Critical discourse theory informs critical discursive psychology and CDA and both are useful perspectives to use in order to understand talk - in theory and practice - between individuals in settings such as residential addiction treatment because of their emphasis on the notion of talk as a means of understanding social interaction.

Several types of analysis derive from critical discourse and two of these are used in this research - Billig's rhetorical /critical discursive psychology and Fairclough's critical linguistic view of CDA (Billig, 2006; Fairclough, 1989). Both are helpful to this research for two reasons. The first is that Fairclough's interest in language is that it is "in use" in the construction or "production" of power relations and hegemonist influence (Fairclough, 1989, p. 1). This is useful because this research aims to understand how addiction treatment talk is "embedded" with the ideology of the dominant disease model discourse in residential addiction treatment and "what speakers are doing when they use psychological terminology" when they talk about their addiction (Billig, 2006, p. 18; Fairclough, 1989, p. 2). Secondly, Fairclough's emphasis on "language" as a discursive "practice" and Billig's notion of talk as an activity suggests an important consonance with mentalization theory's developmentalist positioning of talk as a crucial, albeit inherent capacity that is used to *acquire* mentalisitic ability and express mental representations (Fairclough, 2001; Fonagy, Gergley, Jurist, & Target, 2002, p. 49).

In this context, Bateman and Fonagy's (2010) description of mentalization as a "profoundly social construct in the sense that we are attentive to the mental states of those we are with, physically or psychologically" further substantiates this point (Bateman & Fonagy, 2010, p. 11). This definition of mentalization foregrounds the notion of the activity of acquiring the ability to attend to mental states. Mentalization theory however, proposes

biological, neuropsychological and psychoanalytic epistemic positions to construct psychological discourse about “mental states” and relies on a “social biofeedback model” of interaction to construct the notion of mindedness that mentalization suggests (Fonagy, Gergely, Jurist, & Target, 2002). The use of critical discursive methods in this research, aims to draw attention to the notion of talk about mentalistic process and in so doing, move away from the idea that mental states are represented ‘internally’ and ‘tie’ this methodologically to Fairclough’s idea of “discourse as a moment of social practices” (Fairclough, 2001, p. 122). It is in this context that mentalization theory and the act of mentalization are indeed both profoundly social as acts of both psychological and discursive representation. In order to achieve this, three points that Fairclough and Chouliaraki (2010) make are important both in theory and in the practice of the CDA.

Fairclough and Chouliaraki (2010) use three points to identify the role of CDA in relation to organizational (e.g. residential addiction treatment) analysis which are “(1) attending to the simultaneous articulation of moments of the social (including language and text), (2) focusing on the discursive operation of power relations, and (3) working within a framework of interdisciplinary research.” (Chouliaraki & Fairclough, 2010, p. 1214). Specifically this Faircloughian “arm” of the research will allow for the analysis of the activity of counselling talk about relapse, located at a confluence of social, neurobiological and psychological positions whilst taking into account the role of the dominant discourse about addiction as neurobiological disease (Bailey, 2005; Pickersgill, 2013).

It is in the study of treatment discourse, of which dialogue of is one element, that the idea of a critical analysis is important. The study presented here is an analysis of a particular discourse and a case of studying counselling talk. As Antaki and colleagues point

out: “analysis must mean doing something with the data, but not just anything” (Antaki, Billig, Edwards, & Potter, 2003, p. 4). The “not just anything” refers to critical discourse analysis living up to its name and being “critical” which Billig (2003) takes to mean the capacity to show or reveal causes and connections that are obscured. It is in this sense that the word or claim to be critical has the meaning of conducting an analysis of the discursive relationships that subjects hold with one another. A critical analysis is therefore a “critique of existing patterns of dominance and inequality” that are hidden, obscured or unexamined (Billig, 2003, p. 38). The next section takes up this point to describe how a critical discourse analysis is considered a suitable method of investigation for addiction counselling dialogue.

Critical discourse analysis

Critical discourse analysis is a wide ranging discipline of the study of spoken and written language in such forms as texts, recordings, newsprint and electronic media. It can also include the investigation of images, signs or signals that are embedded in communicative endeavours.

In this research, the analysis of research material (spoken word; text) is grounded in critical theory and relies on discursive analytic presuppositions from discursive psychology and critical language analysis in order to understand “mentalizing” in counselling talk. This offers an ‘over-arching’ framework that includes the discursive psychology of Billig and the critical linguistic work of Fairclough (Billig, 2006; Fairclough, 1989).

This means that the analysis of treatment talk is an analysis that focusses on the activity of talk as a state of mind in context. This is as opposed to the notion that research can be conducted as a process of discovery regarding private conversation that is behind

words or is internally located within the person. In this sense, this aspect of the analysis examines what *is* being done with language (Billig, 2006).

On the other hand, as summarized by Fairclough and Wodak (1997), critical discourse analysis (CDA) of treatment talk from a critical linguistic point of view, centres on the notion that “power relations are discursive” and that “discourse analysis is interpretative and explanatory” whilst “discourse is a form of social action” (Fairclough & Wodak, 1997, p. 353). In this sense, the analysis aims to examine what *can or may* be done when using treatment language in a given socio-cultural context such as a counselling session (Fairclough, 2012).

Yet, critical discourse analysis is not an “anything goes” method (Antaki et al., 2003, p. 3). Critical discourse analyses of various kinds have five common elements. The first is how texts are “produced (created) and consumed (received and interpreted)” in order to constitute the “social world”, “identities and social relations” (Jørgensen & Phillips, 2002, p. 61). The second is that a critical discourse analysis “does not just contribute to the shaping and reshaping of social structures but also reflects them” (Jørgensen & Phillips, 2002, p. 61). Third, a critical discourse analysis “engages in concrete, linguistic textual analysis of language use in social interaction” (Jørgensen & Phillips, 2002, p. 62). Fourth, critical discourse analysis claims “that discursive practices contribute to the creation and reproduction of unequal power relations between social groups” and therefore is inherently “ideological” (Jørgensen & Phillips, 2002, p. 63). Lastly, a critical discourse analysis is not “politically neutral” (Jørgensen & Phillips, 2002, p. 64). The purpose of a critical discourse analysis is at least in part, to be “critical of the present social order” and not simply to describe social patterns associated with psychological life (Billig, 2003). From this, three

themes further identify a critical discourse analysis. First, that “discourse is primary”, second that “discourse is constructed” and lastly, that discourse is an “action medium” (McLaughlin, 2009, p. 52). This suggests that a critical discourse analysis is centred on the the discursive use of language and talk, its meaning and how this is linked to a social, cultural and historical context. As such, discourse can be seen as a discursive “category” closely related to psychological activity in a socio-cultural context (Fairclough, 2012, p. 453). These views construct a critical discourse analysis as means that can be used to subject the language used in everyday talk to scrutiny. This also means that a critical discourse analysis is conducted in order to reflect, expose and challenge implicit ideological and hegemonic effects of social groupings such as institutions.

In order to do this, a critical discourse analysis relies on the notion of understanding a subject, its position(ing) in discourse and the ideological dilemmas that are likely to be inherently related to that positioning. An individual can occupy a subject position necessarily defined in relation to the context of current discourse and ideology. Furthermore, each position that a subject occupies is constructed, in part, using language and as such, exercising discursive agency. So when doing this, individuals actively occupy and construct many subject positions, some potentially contradictory, in any given discursive context. Each subject’s position is dialectically related to, and yet limited by, the dominant ideology of a given discourse. As such, subject positions that people construct are developed by a process of recursive “self” definition (Jørgensen & Phillips, 2002).

An element of this stance is that people use interpretative repertoires to negotiate positions for themselves in discursive contexts. Interpretative repertoires are shorthand or jargon that can be used as a means of linking, referencing and avoiding differing agendas in

communication. They also tend to be based on shared assumptions about reality and the nature of social relationships, and hence are not necessarily full or accurate reflections of these. In this sense, interpretative repertoires are a tool to negotiate the meaning and “depth” of conversation in everyday talk and in institutional settings. They can be used to turn toward and from multiple meanings and as such, are rhetorical devices that can be used to account for how individuals repress thoughts and feelings (Billig, 1999; Billig, 2001; Billig, 2003).

This research will use critical discourse analysis to understand the construction of subject positions and interpretative repertoires constructed during counselling talk, to show some of the dilemmatic psychological situations that may occur in addiction treatment. In particular, this research will use a critical discourse analysis to select and describe and analyse these subject positions and interpretative repertoires as situated in transcribed talk about treatment that interviews with research subjects elicited. This is not to perform a semiotic or linguistic analysis but to examine the (reflective) narrative that participants use to describe their treatment experiences. In so doing, the aim of using a critical discursive analysis is to establish how this narrative reflects the relative mental positions that participants as subjects occupy in relation to their counselling talk, in their treatment context. From a mentalizing theory point of view, the use of a critical discourse analysis of treatment talk is to examine whether or not this treatment talk as a narrative, displays mentalistic qualities described by mentalization theory in the face of the dominant disease discourse. Given that there are many ways to conduct a critical discourse analysis that can place emphasis on a range of data sources, Fairclough’s (2001) approach to conducting a critical discourse analysis is outlined below with particular reference to the idea of intertextuality.

Fairclough's 2001 critical discourse analysis.

In order to contextualise Fairclough's (2001) view of critical discourse analysis, his view of discourse is offered as a starting point. Fairclough describes discourse as "an important form of social practice which both reproduces and changes knowledge, identities and social relations including power relations, and at the same time is also shaped by other social practices and structures" (Jørgensen & Phillips, 2002, p. 65). The recursive nature of this position – the dialectical relationship between social structure and discourse – creates a context for the examination of talk from a critical realist point of view, in institutional settings which is particularly useful for this research.

Fairclough's (2001) view of discourse is an opportunity to analyse how addiction counselling discourse shapes meaningful talk about relapse from an "interactional" point of view (Fairclough, 2001, p. 239). There are two aspects to the interactional nature of discourse that Fairclough describes – the intertextual and intersubjective – that have implications for the use of a critical discourse analysis in this research. The focus of this critical discourse analysis will be on the intertextual approach rather than an intersubjective approach. Intertextuality has several meanings and definitions that convey the notion that texts stand in relationship to one another through "dialogue" (Fairclough, 2001, p. 233).

For this research, intertextuality is taken to mean the psychological relationships between individuals, text, reader and social context. In this sense, the transcription of the research conversation about relapse between the researcher and participants is intertextual, as is its analysis. The use of the notion of intertextuality in conducting a critical discourse analysis is helpful to explore how talk is constructed and referenced in relation to the institutional addiction treatment context under investigation.

Fairclough (2001) outlines five dimensions of a critical discourse analysis. The first is the development of the focus on a problem that is social by nature and has discursive qualities. The second stage is the identification of obstacles to the problem being addressed; third, is the consideration of whether the social order relies on the problem that has been identified; fourth, is the identification of ways to address the obstacles. Lastly, the analysis should acknowledge the social position of the researcher in relation to the research (Fairclough, 2001). These principles are expanded upon below.

Addiction counselling discourse as a social problem

The current research relies upon an investigation of how counsellor-client talk during individual sessions in addiction treatment is constructed by the communication of information and the type of communication that occurs. Fairclough's critical discourse analysis is useful for this kind of approach as it typically focusses on a "text-oriented form of discourse analysis" where language is seen as a "social practice", within a specific "field" and a "way of speaking that gives meaning to experiences from a particular perspective" (Jørgensen & Phillips, 2002, pp. 66-67). This position is important because it suggests that how individuals talk in the addiction treatment context may have implications for how they construct legitimacy in relation to one another. It is particularly this question of legitimacy and what talk about the wanting/not wanting to use drugs is acceptable, that is part of a discursive negotiation between client and counsellor. It is in this sense that this research will focus on the "articulation" of addiction counselling discourse to investigate "representations of how things are and have been, as well as imaginaries – representations of how things might or could or should be" (Fairclough, 2012; Jørgensen & Phillips, 2002, p. 70).

Meaning as related to addiction and relapse are likely to be constructed in particular ways that relate to the counselling relationship, but whose meanings are also contingent on the institutional setting in which they occur. This critical discourse analysis will investigate what “genre” of discursive practice may support this order of discourse within addiction treatment to understand the communicative endeavour that happens in this context (Fairclough, 2012, p. 456). In order to do this, the idea of the “social field” is helpful as it suggests a certain delimitation of the institutional treatment arena as a discursive “space” to investigate. There are, of course, different orders of discursive analysis such as a political or media analysis of how addiction discourse shapes that manner in which individuals talk to one another but this is not the point of focus in this research. This research is undertaken at a micro-interpersonal level within an institutional context and will analyse the immediate and intimate politics of counselling talk in an addiction treatment setting.

Fairclough’s (2012) notion of articulation suggests that language is used as a tool for the expression of ideas, beliefs and felt experiences. How counsellors and clients use the tool of language is social and yet has several potential pitfalls such as jargonised counselling interventions. This is because how counsellors and clients come to rely on arrangements of text/dialogue and how this is effected, is dependent on the current ideology of a given context. Indeed, this may even be counter-therapeutic. As such, how articulation is achieved is based on the idea that orders of discourse are constituted intertextually and interdiscursively – texts and dialogue have a history that means that they are understood in specific ways and are also limited by particular hegemonic structures. Participants therefore, through talk, construct from embedded ideological orientations, subject positions and conventional common sense ways of talking that include interpretative repertoires. This means that counselling talk, in part, derives its meaning from being situated in layers of

institutional discourse relating to addiction as well as subjectively constructed meaning. When text/talk is articulated, this activity constructs and maintains different dimensions of discourse in various treatment contexts or networks such as addiction treatment. As such, the meaning derived from the discursive construction of talk are drawn upon in order to produce meaning that is addiction treatment and counselling.

Obstacles to addressing the discursive problems of addiction counselling

In the South African context, addiction treatment, its accessibility and provision, is mired in problems that are cast from a social, political, moral and economic perspective (Myers, Fakier, & Louw, 2009). In a country where access to basic health care can be limited by factors such as strategic planning, limited resources and service provision alongside deeply rooted historical inequality, the notions of health, substance addiction and recovery are complex (Myers, Louw, & Fakier, 2008). Clearly, addiction treatment discourse is located in a series of organizational networks like treatment facilities. How these networks maintain and generate meaning salient to addiction discourse influences how relapse is negotiated and understood.

Fairclough (2012) suggests that language is a tool that people use to negotiate meaning in social contexts and the challenges of each context that I have just described. Of course this implies that there are several means by which this negotiation can succeed, stagnate or fail. The idea of dominance in discourse is essential here to convey the idea that hegemony with respect to addiction treatment and counselling in an organizational context is a potential obstacle to clients and counsellor engaging equitably in treatment. The dominant discourse of addiction treatment is both popularly and primarily neurobiological, cognitive and behavioural (Keane, 2004). It is influenced in no small part by socio-political

factors related to treatment provision by both privately funded and state institutions. It is in this sense that addiction treatment is part of a broader discourse of “managed” health care that leads to, from a “Foucauldian” point of view, a “proliferation of pathologizing and normalizing discourses, each producing a uniquely disordered subject” (Keane, 2004, p. 190). These discourses maintain a hegemony where addicted clients are positioned in relationship to organizations as consumers seeking relapse treatment and yet unwell and therefore limited in the choice they may be able to exercise.

The idea of change and its implementation itself is problematic. Initiatives that aim to understand the role of organizational change by institutions that offer substance abuse treatment suggest that South African addiction treatment organizations see themselves as open to change and “evidence based practices” and yet face a “plethora” of challenges (Bowles, Louw, & Myers, 2011, p. 318). Indeed, it is alarming that directors and staff of these treatment institutions “perceive a fairly low level of urgency for change” in addressing the reality of drug use in South Africa, given the impact of drug addiction on society at large (Bowles et al., 2011, p. 316). Perhaps one of the substantial challenges that treatment institutions face when considering change is the embedded notion of addiction-as-a-disease.

Particularly “race” is still a significant factor in relation to addiction treatment because the directors of treatment institutions are still affected by “the legacy of apartheid” and where the “race profile of clients at specialist treatment facilities still does not reflect the demographics of the general population” (Bowles et al, 2011, p. 317). Alongside these substantial problems are important suggestions of how there is still a need for challenges to “stigma” and “negative beliefs” about treatment of addiction in South Africa (Myers, Parry,

& Plüddemann, 2004, p. 30). Indeed, Fairclough's (2001) challenge to those conducting a critical discourse analysis is to answer why the current status quo of a social context "needs" the defined problem – in this instance relapse (Fairclough, 2001, p. 238). The answer is complex and is related to several themes that McCarty and colleagues (2010) have identified: "(a) organization and delivery of care, (b) quality of care, (c) evidence-based practices, (d) access to care, and (e) financing, costs, and value of care" (McCarty, McConnell, & Schmidt, 2010, p. 87).

It is these themes that raise the question of how to address pragmatic and pressing concerns of individual and organizational responses to relapse management. These concerns emanate from a health discourse about addiction treatment and care as a service and product in a manner that asserts a consumerist stance. Addiction and relapse constructed as a disease-commodity are necessarily addressed and "needed" as a problem because of their substantial personal cost, social prevalence and economic consequences and incentives. How challenges to these limitations such as treatment delivery can be addressed are via a "shift in discourses", "service quality" and debunking "myths and misconceptions" about addiction and its treatment (Myers et al., 2004).

The placement of the problem in addiction discourse

What addiction and relapse mean are both contextually bound and personally negotiated issues. Treatment for addiction is often considered in a monolithic manner, low on a list of other healthcare priorities. This is particularly pertinent from the client's point of view. The South African Medical Research Council's Alcohol and Drug Abuse Research Unit recently showed that, when researching addiction treatment facilities, there was information that "prevented us from linking the level of organizational functioning with

rates of client retention” (Bowles et al., 2011). This seems to strongly suggest that the voice of the client and how they dis/engage treatment services, remains largely marginalized from an organizational point of view, where service delivery is likely to be “fragmented” (Myers et al., 2008, p. 156). It is in this context that this research is important, at a *micro* level, to explore and examine the talk of addiction counsellors and their clients. This is in order to see how people in treatment milieus talk, and what impact institutional discourse may have on their sense of agency. Specifically, it is to see the influence of ideas about addiction and relapse and how they may influence the distribution of activity and change as a consequence of treatment.

Possibilities for change

Part of the reason for conducting a critical analysis of addiction counselling talk is to see what change might be possible when participants in the addiction treatment context engage one another to negotiate issues of health, like understanding relapse. Indeed, it is important to consider whether the stated aim of addictions treatment counselling – recovery – brings about the order of change necessary to achieve this, and if the intended change in counselling is responsible for stasis or radical alterations in living without being dependent on drugs. To reiterate a point made earlier, all addiction treatment (including medical aspects like detoxification) is inevitably accompanied by some form of conversation between counsellor/doctor and client/patient. This negotiated construction of health positions involves a capacity to represent, negotiate and track change.

It is here that that the use of the concepts from mentalization theory are of value. Mentalizing is the psychological capacity to track implicit or explicit intentions, thoughts, feelings and behaviours in others and oneself in a relatively coherent manner. Mentalizing

theory about individuals' ability to understand one another, places childhood learning and psychological experience of the caregiver at the centre of this theory. Psychological interaction, from the point of view of mentalization, is achieved by people learning to "read" their and others' intentions and constructing theories of mind based on this. Verbal and facial expression, touch, mirroring and contingency are all elements used to characterise infant-caregiver interaction in mentalization theory. This creates a context in which mentalization interaction in the child-caregiver dyad can be seen as discursively constructed psychological developments. From this, individuals' mentalizing depends on their capacity to (learn to) draw on several different orders of discourse to construct psychological positions in a given context. One of these layers is language and talk. Whilst mentalization theory sees mental states as internally opaque, critical discourse theory and critical discourse analysis sees mental states as psychological positions represented by discursive turns in talk and "text" (Fairclough, 2001). This critical discourse analysis is therefore supplemented by mentalization theory's position that psychological interaction relies on a meaningful, reflective self-other narrative.

Following from this, this research aims to understand the psychological problems that people encounter in addiction counselling when they try to talk about why they want to use drugs repeatedly. It also focuses on the difficulties that counsellors have when trying to understand this when talking to clients about relapse. This research therefore reflects on how talk during addictions counselling is affected by (non)mentalized meaning that is discursively constructed in the therapeutic dyad. Furthermore, the focus of this research will be to analyse, as tracked by transcribed conversation, how the various subject positions that clients and counsellors construct in relation to one another, expand or limit the possibility of understanding a client's motivation for relapse.

The researcher's position

In “ethnomethodological” traditions from which some of the critical discursive psychology origins can be traced, this research aims to include and rely on the view of the researcher to both record and interpret participants’ accounts of treatment (Jørgensen & Phillips, 2002, p. 66). This position – to deliberately acknowledge the subjective elements attached to the researcher’s position – is to consider the notion of agency and power in relation to meaning-as-talk that this research has generated. This raises the question of how this research might be positioned within a broader episteme.

Whilst considering this research, from its formative stages, I thought about the notion of its values and subjectivity and the choice to use a method that precludes a “neutral” stance (Jørgensen & Phillips, 2002). As the research (question) has developed, changed direction and ideas have taken shape, I have come to the conclusion that the value of this research is an acknowledgment of its subjectivity. Specifically, it is the acknowledgement of the subjective participation of individuals recorded as talk that allows the social construction of belief and desire about addiction treatment to be “seen”. And whilst this is not a private narrative of experiences, this research is not (politically) neutral either. This research takes place in a social context and its implicit aim is to provoke thought and action that may challenge the dominance discursive practices of biomedical discourse about addiction. Theoretically, it follows a broad tradition of research and research principles, from which elements have been chosen to both develop a research question and attempt to answer it. Specifically, according to Jørgensen and Phillips, from Fairclough’s perspective, it aims to foster a “critical language awareness” to show how language can be used in addiction treatment to make people “more aware of the constraints on their

practice and of the possibilities for resistance and change” (Jørgensen & Phillips, 2002, p. 88).

Additionally, the roles that I have played during the time of this research have changed substantially too. As a clinical psychologist, I have moved from the position of being a staff member of the organization to a clinical psychologist in independent practice. I no longer work at the research site yet I still occasionally consult on the unit. I had, at the start of this research, been interested by the idea of relapse and negotiated with the clinic management to have the clients of the clinic participate in this study, with a view to giving the organization feedback on the outcomes of the research. This, in spite of the substantial staff and organizational changes, remains my aim.

Description of Method

This research is a qualitative study that has been undertaken in order to “further ... scientific objectives” in an “exploratory” manner (Scholz & Tietje, 2002, p. 11). It follows the theoretical outline of the critical discourse analysis described above and has critical discourse and mentalization as a general theoretical foundations. The following section follows from the first inasmuch as it is a description of activity of the research process needed to produce material for analysis whilst being grounded in theory. This section of the chapter describes how the research design was decided upon, sample chosen and participants were selected. The data gathering measures and analysis procedure are also discussed. Lastly, the ethical implications for the study are considered.

Selection of the research design

This study used a multiple case design to gather dialogue from individual clients and counsellors that was used as data for the study. The rationale for using multiple case studies

was that this method represented a useful, sufficient and accessible means to demonstrate elements of “intertextuality” generated during the process of counsellor-client dialogue (Fairclough, 2001, p. 233). Additionally it was chosen to reflect on a “network of social practices” and “to bring out the details from the viewpoint of the participants” (Fairclough, 2001, p. 239; Tellis, 1997). The application of case study methods in the design of this study was also used in order to facilitate the access to and observation of the role of language and mentalization as an aspect of relapse treatment as experienced by both the client and counsellor (Fairclough, 2001).

In this way transcribing, on a case-by-case basis, the therapeutic experiences of relapse treatment reported during an interview provided the researcher data for analysis. The multiple case design additionally offered the opportunity to consider the idea of mentalizing and relapse, situated in treatment context, to examine possible discursive positions, themes and treatment narratives present in the participant’s dialogue. The case-by-case design also lent itself to a discourse analytic approach so that the researcher might consider the manner in which participants made sense of mental experiences through the activity of talk about addiction counselling. The theory of mentalization was therefore used as a frame of reference to understand discursive positioning of participant’s talk as mentalistic or not. The dialogue of the participants was analysed from a critical discursive point of view to see if (non)mentalization was evident in participants’ talk. Taking a critical discursive approach to understand how participant’s constructed treatment talk was also important because psychotherapy is a key intervention in addiction treatment offerings. In particular, the use of mentalizing theory as a frame for understanding counselling conversation was consonant with a case-based critical discourse analysis for two reasons.

The first reason is related to the idea of context and psychological process. Mentalizing has different aspects – implicit and explicit mentalizing – on which individuals rely to describe or represent constructs e.g. self, others, relationships and psychological processes e.g. feelings (Allen, 2003). Mentalization is an individual ability that is theoretically positioned in a relational psychological context. Mentalizing and treatment talk about mental states in the therapeutic alliance is a (spontaneously) constructed phenomenon – an individual capacity – occurring in a given discursive context (counselling). Whilst mentalizing clearly could be examined under quasi-experimental conditions, or many other naturalistic scenarios, a case study suited the purposes of this research because it allowed for reflection on how mentalizing is related to its treatment context. If the data were to be investigated differently, the construction of treatment talk would take a different meaning. As such, the meaning of data would change and even the data itself under investigation.

In this regard, qualitative research is ultimately an interpretive endeavor and in this study an attempt to capture mentalizing in its natural setting is therefore considered an important starting point (Stake, 1995). Intensive study of the discourse of participants, on a case by case basis, provided the data for analysis by including the context from which it is situated. Case-based critical discourse analysis, similarly, represents a means to examine the use of language (as representative on mental states) in a discursive context.

The second reason for choosing a multiple case design is with a view toward being pragmatic. The research data for the study was gained from individuals engaged in a confidential treatment process for an often stigmatised behaviour. Using a case study approach meant that it was possible to obtain situated, significant and useful data that meaningfully reflected participants' experiences of treatment processes. Using a case study

design method also allowed for a data to be gathered in a relatively unobtrusive, confidential manner. Using this approach meant, from the participants' point of view, that the subjective experience of receiving or offering treatment as well as its outcomes would reflect the context in which they occurred.

Multiple case study method was used in this study to give an indication of the potential value of this approach to addressing recidivism and whether or not further "hypotheses, models or theories" might be generated and researched from this perspective (Scholz & Tietje, 2002, p. 13). How counselling talk may impact and even amplify drug using behaviour is a new research direction in the field of addiction research. Similarly, discovering whether this affects relapse management and prevention interventions currently offered, also appears to be a new perspective in the field of treatment of relapse. In order to describe how the data for the research was generated, the research sample and the participants are described.

The research sample

The sample for this research study was sixteen individual participants. Ten were clients who were being treated for their addiction and six were counsellors at the research site. The participants in the study were individuals making up 10 treatment dyads who talked about relapse and their counselling relationship with the researcher. Some counsellors participated in more than one interview. The participants in the sample were described as clients and counsellors in keeping with the descriptions conventionally used at the research site. The sample of participants therefore consisted of ten therapeutic dyads or sixteen participants and twenty interviews. The sample size of 10 dyads was considered sufficient to address the exploratory, qualitative aims of this study. This was primarily because case studies traditionally emphasize qualitative and phenomenological factors and

are “labour-intensive” given the nature of the analysis (Smith & Osborne, 2008; Wetherell, Taylor, & Yates, 2001, p. 24). This is evidenced by the fact that the research dialogue generated more than 125 thousand words which were transcribed to more than 225 pages of dialogue for analysis.

Participants

The following table describes the sample’s age, gender and drug of choice.

Participants were given a gendered pseudonym in order to protect their anonymity.

Participants						
Client	Drug(s) of choice	Age	Gender	Counsellor	Age	Gender
Aaron	Poly-substance dependence	24	Male	Walter	29	Male
Andrea	Alcohol, amphetamine dependence	51	Female	Donna	50	Female
John	Heroin dependence	21	Male	Donna	50	Female
Jane	Poly-substance dependence	19	Female	Desiree	30	Female
Jerry	Alcohol dependence	52	Male	Jeff	61	Male

Rebecca	Alcohol, amphetamine dependence	20	Female	Desiree	30	Female
Rose	Benzodiazepine, codeine dependence	37	Female,	Donna	50	Female
Jessica	Amphetamine dependence	42	Male	Donna	50	Female
Aubrey	Alcohol, amphetamine dependence	28	Male	Gina	36	Female
Ariel	Alcohol dependence	44	Female	Sophy	30	Female

Clients

A sample of ten clients from the research site were selected for this research. They were men and women who had completed their detoxification and had enrolled in an addiction treatment programme at the research site for further treatment of addiction. Clients selected for the sample were older than 18 years of age. These individuals were selected for the sample after they had completed treatment at the research site in a “first-past-the-post”, convenience manner. The sample was drawn from a treatment population that may, at any given time, include South African and African nationals as well as international clients from diverse cultural and ethnic backgrounds. Given that this is an exploratory qualitative study, no control was imposed on these participant characteristics as

exclusion criteria for the study. The research interviews were conducted before they left the research site.

The clients who participated in the research met the criteria for a substance dependence disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders and were admitted to treatment under this diagnosis (American Psychiatric Association, 2000). These clients had several characteristics in common with addicts in general but were not chosen specifically because of these characteristics. Clients in addiction treatment tend to have a tendency to show greater impulsivity, show some signs of neuro-cognitive dysfunction or impairment and aspects of character that indicate deficit in the ability to self-soothe as well as an “inability to sustain experiences of agency, self-empowerment, and esteem [and an] incapacity with affect regulation and executive function” (Kirby, Petry, & Bickel, 1999; Kissen, 2006, p. 205; Volkow & Fowler, 2000; Volkow et al., 2003; Yücel, Lubman, Solowij, & Brewer, 2007).

Clients who formed part of the sample had particular psychological characteristics common to those with a substance dependence disorder. This suggest that individuals with a diagnosis of substance dependence such as alcoholism, show that use of their drug of choice is an integral part of overall sensation-seeking behaviour, is used as a means of reducing worry and anxiety, to cope with an over-control of tension and depression and to deal with peer pressure issues, affiliation and conformity (Kunze & Newton, 1989). Clients are also likely to have additional concurrent psychiatric diagnoses alongside their substance use disorder. Likely diagnoses are those of Bipolar Mood Disorder, Social Phobia, Panic Disorder, Post Traumatic Stress Response as well as personality disorders (Skodol, Oldham, & Gallaher, 1999).

The individuals in the sample were likely to have these characteristic similarities but also had differences from the population of addiction treatment seekers as a whole, relevant to the South African context. All client participants had privately/corporate funded Medical Aid Schemes that paid for a part or the whole of their treatment process. This meant that participants were drawn from an economically privileged socioeconomic stratum in the population. Participants had at least one of the official languages of South Africa as “mother tongue” and a sufficient mastery of colloquial English to participate effectively in the treatment programme. Clients of the treatment facility from outside of South Africa, had similar proficiency in spoken colloquial English. Clients’ age, gender and drugs of choice are documented in a table on page ninety-nine.

Counsellors

The counsellors who participated in the research were employed at the research site. They had conducted counselling sessions with the selected clients during their treatment programme and were included to complete the sample group on that basis.

The participants were male and female staff selected from the research site’s addiction treatment programme and were counsellors of one or more of the patients in the research sample. Counsellors selected for the sample were older than 18 years of age as described in the table on page ninety-nine. As part of the treatment milieu, all staff who were assigned to offer patients psycho-educational and therapeutic interventions - professionals and para-professional - were referred to as “counsellors” irrespective of the professional training or affiliations. Counsellors came from middle or upper income socioeconomic strata in South African society and were in that sense privileged. One of these privileges was that they had a wide range of formal qualifications. The qualifications that existed in addiction counsellors’ sample ranged from school-leaving certificates to Master’s

degrees. In South Africa, addiction counsellors currently have no formal statutory or regulatory body and are employed for both their aptitude gained in clinical settings, studies or on an internship basis as well as their time in recovery from drug addiction. Often patients who graduate from a treatment centre become “recovery assistants” before they “graduate” to counselling work and are selected because of their time in recovery. Two years “clean” is considered a usual minimum amount of time before recruitment or employment as a counsellor is considered by the organization. However, this yardstick varies widely and refers to no standard recruitment practice. Therefore, the participant’s skill and experience levels varied widely. The highest level of formal education was a Masters level degree and the lowest a school leaving certificate and college diploma.

Selection of participants

Two groups of participants were selected for this research - clients and counsellors from the research site’s addiction treatment programme. The first group were clients selected as a convenience sample of individuals admitted to the research site for the treatment of their substance dependence disorder relapse and who met DSM IV criteria for this condition (American Psychiatric Association, 2000). Individual clients who returned to treatment prior to the data collection phase being completed because of further relapse, were also eligible for inclusion in the sample. Counsellors were selected in conjunction with the clients who agreed to be interviewed. Counsellors were selected having been allocated the client as “their” patient. The counsellors were interviewed no more than a week after the clients had left the treatment programme.

Data gathering measures

Two particular sources were used to gather data for this research. The first was the biographical information about the clients and the second, the conversation recorded during the research interviews.

Biographical Information

The researcher, as part of the staff at the research site, had access to clients' treatment files. These were, in agreement with the clinic and consent of the clients, accessed prior to the research interview. Biographical data was reviewed from the clients' files that were compiled during their admission to treatment. The researcher read the files to gather data such as drug(s) of choice, age, gender, diagnoses in order to develop a frame of reference to understand how the clinic treatment staff – nursing and medical staff in particular – constructed their view of the client. This was done to develop a descriptive point of reference regarding the treatment context the counsellor and clients participated in. Client files were also read to establish if there were any reasons not to approach or interview the client, in spite of their offering consent to be interviewed, such as intoxication or current psychosis.

The researcher also discussed with staff members their treatment, training and work experience. Occasionally, the clients and staff volunteered anecdotal information about themselves before or after the interviews that was relevant to the context in which the research took place. The researcher used this biographical and contextual information to locate the research in the clinic's addiction discourse and used this as a contextual point of reference in which the research interview was conducted.

Clinical Interview

The clinical interview was considered as the primary data gathering method for this research. The clinical interview was offered primacy as a data gathering method in order to record treatment talk so that a critical discourse analysis of the conversation could be conducted. Several ways of conducting a clinical interview exist and are utilised in research – structured, semi structured and unstructured interviews (Brewer, 2003). A semi-structured clinical interview was utilised for this research to gather information about the participants' interactions. This was in order to have participants report subjective experiences of their drug use and the experiences of their involvement in the therapeutic relationship whilst in treatment. Clinical interviews have particular relevance to qualitative research that is described below.

Relevance of the clinical interview

The clinical interview was of substantial importance for this research because it created a context in which participants expressed their views on treatment and relapse in their own words. In so doing, the use of the clinical interview became a “naturalistic” observation of how participants used language to situate themselves in the addiction discourse of the treatment programme. This approach is consonant with the utility of the research interview, which aims to capture the “narrative” of research participants (Gillham, 2005, p. 45).

The clinical interview was also utilised in order to record individual participants' talk about drug use and how their use of language was arranged to articulate accounts about their treatment. The clinical interview, in this way, promoted conversation about experiences related to several contexts – subjective meaning, counselling relationship,

treatment programme jargon, and institutional addiction discourse. The clinical interview was also used to gather data that related to how participants talked about other discursive contexts – drug using subcultures, treatment varieties and modality as well as the notion of relapse as it related to their ideas of recovery and health. The clinical interview in the context of this research was considered a form of explicit mentalizing where two parties - researcher and participant - met and engaged the other in a “safe intersubjective context .. for exploring .. [complex] states of mind” (Allen et al., 2005, p. 65). This raises the question of how the clinical interview can be used as a data gathering method.

Use of the clinical interview

Skårderud (2007; 2011) shows that the clinical interview can be usefully applied to the study of psychiatric conditions to achieve the aim of capturing data from a mentalizing perspective (Skårderud, 2007; Skårderud, 2011). Indeed, the point is well made that the use of a clinical interview is inherently suited to research clinical populations about mental states and processes because of its reliance on inherent mentalistic qualities. This is with the proviso that researchers acknowledge their “bias” in this regard (Skårderud, 2011, p. 81). For this research and its methodology, the clinical interview is an ideal means to generate dialogue, text and discursive context for analysis.

The researcher’s use of the semi-structured interview was to collect data regarding a wide range of experiences about treatment from both counsellor and client. The choice to use the semi-structured interview in favour of a structured or unstructured interview, was made in order to retain a level of clinically appropriate structure and flexibility whilst retaining focus on the research question. The core issues of interest to the interviewer will be the experience of relapse for both counsellor and patient, participant’s view of the

therapeutic relationship, commentary and metacommentary on the therapeutic relationship, subjective experiences reported about the self in treatment and relevant previous therapeutic encounters. Sample questions for the semi-structured interview are detailed in Appendix C.

The clinical interview and a critical discourse analysis

Wetherell et al. (2001) note that when approached from a *discourse analytic perspective*, transcribed language of the clinical interview can reveal “naturally occurring” interpretative repertoires located in discourse (p. 27). The clinical interview was used during this research to engage and “capture” the participant’s use of language such as interpretative repertoires for use in the critical discourse analysis. An interpretive repertoire is generally considered to be an often contradictory yet common-sense, customary manner of conversation that people rely upon to construct identities in talk and account for their experience of the world. These interpretative repertoires represent a means to negotiate the number of identity possibilities located in discourse (Reynolds & Wetherell, 2003).

Given the likely problem posed by the use of common treatment jargon by the researcher and participants scaffolding the interview, the researcher needed to “mark” his talk/mentalising so that it could be distinguished from the participant’s involvement both in the interview and in the data analysis. This speaks to the point made by Fairclough (2001) about the researcher’s perspective being included in the research. In this manner the circularity of the interpersonal interaction of the clinical interview is “punctuated” at various points by interview/research questions. Bateman & Fonagy (2010) show that a clinical interaction and interviews require a stance that is curious, evidenced by the use of “what” questions rather than “why” questions, doubt as well as “taking time to identify differences in perspectives”, emotional closeness and reflection on the *other* (Bateman,

2012; Bateman & Fonagy, 2010, p. 13). These characteristics were incorporated in the interviewing in order to “mark” the researcher’s interview narrative and reflect a mentalizing stance during the clinical interview. So, the reciprocity of conversation during the clinical interview and the use of “psychological words, such as ‘I believe’, ‘I think’ and ‘I feel’ are not used as simple reports of inner states ...[they] are part of outwardly observable social interaction, opening up the possibility that the supposedly inner, individual and hidden psychological world is theoretically and methodologically directly observable through examining the practice of talk” (Billig, 2001).

Interviewing relies on mentalizing ability to generate theories of mind, and dialogue is one of the means through which the mind is constructed by language in social interaction. The research interview is no different in that sense, to everyday social interaction. It does however differ in that this interview talk is situated in a specific residential treatment and research focussed context. Analysing research dialogue will require the acknowledgement that mental representational systems (prementalistic and mentalistic) are inextricably linked to the dialogic expression of the thinking, feeling and talking of social interaction in this context. This poses the question of how this data was collected.

Data collection method

Clinical interviews, as discussed above, are the primary method that was used for data collection in this study. The clinical interviews for this study were conducted by the researcher. These interviews relied on the treatment paradigm, clinical skills and the theoretical orientation of the researcher and were therefore influenced by subjective aspects of his perception and interpersonal interaction. To this end a series of questions were developed by the researcher to use as theoretical and clinical reference points in order

to retain the structure of the interview. The use of semi-structured interview in this way was to allow the individual participant an opportunity to give a personal account of their experience of relapse treatment and for the researcher to engage in a process of “discovery” (Gillham, 2005, p. 45).

The interviews were conducted in a private consultation room for approximately one hour. The researcher began the interview by introducing the research topic as it was described on the consent form. The consent forms were filed in a file, and locked in a secure cabinet. The researcher used sample questions or similarly phrased questions to maintain the focus of the interview. The interview was recorded on a voice recording device placed between the researcher and the participant and not concealed from view. At the conclusion of the interview the participants were again invited to ask further questions or raise concerns about the interview or their subjective experience of the interview with the researcher. Questions were addressed by the researcher.

The recordings of the interviews were electronically transferred onto a digital disc from the recording device and given to a transcription service. The transcription service transcribed the voice recordings into text documents in a word processing package. The transcription service did not retain copies of the disc or the transcribed documents once the process was completed. The researcher filed and read the documents on a password protected computer. This procedure was followed in order to provide a standardised data collection process.

Site

The research site for the study was an addiction treatment centre in Cape Town. The treatment centre is a private sector psychiatric hospital providing both psychiatric and

addictions treatment. The addiction treatment unit has 24 beds, support, nursing, counselling, psychological, psychiatric and medical staff who work with patients who are usually resident in the addiction relapse programme for either 14 or 21 days. The research site, at the time of the research, employed six permanent staff and one contract staff counsellor. The addiction treatment programme offers “[p]ersonalised Continuing Care Programmes, Assessment, Medical Detoxification, Residential Treatment, Outpatient Services, Extended Care options, Consultation, Managed Care, Family Counselling” (research site webpage, 2010). The clinic management were asked for permission for the facility to be used as a research site by means of a presentation of the proposed research topic. The management committee of the clinic gave permission for the study to proceed.

The research site has many characteristics of a privately funded treatment centres that are found internationally. An internet search using keywords “addiction treatment” shows established centres worldwide that make claims to offer low client-staff ratios, interventions founded on evidence-based practice and individualized treatment plans. The research site is therefore not dissimilar to many found internationally.

Research procedure

The research study had a recruitment procedure and a data analysis procedure.

Recruitment procedure

The recruitment of client participants occurred in two phases. In the initial phase, potential participants were informed about the proposed research during their orientation to the treatment process at the clinic. Staff at the clinic informed the researcher about possible clients for the study. Information about potential clients was also gained by the researcher, during the course of his work, attending handover meetings and ward rounds in

which client details were discussed. Participant recruitment was be done by the researcher informally introducing himself and informing potential participants about the study. No interviews were conducted with participants during their treatment process. This was in order to avoid influencing the treatment process and outcome of the clients.

In the second phase, the researcher made contact with the participant 3 days before the completion of their treatment programme. Contact was made with the participants at this point in treatment because the participants had had significant treatment exposure. Contact at this point was considered to be minimally disruptive given that clients would have likely received the majority of the treatment benefits from their treatment programme. Similarly, at this point the participants would have had sufficient time to develop and express their notions of relapse and recovery during treatment. At this point the researcher invited the client to become a participant in the research study. A verbal agreement to participate in the study was followed by a request to obtain written informed consent from the potential participant. Written informed consent about participation in the study included: agreement to a 1-hour semi-structured interview, recording of the interview and retaining this material for analysis, and retaining biographical and personal contact details until the study was completed.

An interview was held with each client/participant on his/her day of discharge, before leaving the research site. The interview was conducted in a private consultation room at the research site. Logistical arrangements for the time to conduct the interviews were made with the programme manager and unit coordinator so that clients did not miss any commitments to the treatment programme on the day of leaving. Within one week of the client's discharge from the treatment programme the researcher conducted a semi-

structured interview with their counsellor who had been assigned to them during treatment. This interview was also conducted in a private consultation room at the research site. The counsellor discussed their therapeutic relationship and treatment of their clients relapse with the researcher. All data – both client and counsellor interviews – was recorded by means of a data voice-recording device. The researcher also made notes about the impressions he obtained during interviews.

Data analysis procedure

Neuman (2000) recognises the utility and suitability of the analysis of content contained in transcripts in the domain of psychological research with a view toward identifying meaning implicit in human communication (Neuman, 2000). Additionally, Aronson (1994), describes that this inquiry focuses on recognisable themes and patterns behaviour (Aronson, 1994). Data that was derived from the clinical research interviews was professionally transcribed from an audio-recording device. Participants were allocated gendered pseudonyms, to conceal their identity for the purposes of confidentiality. None of the data relating to participants' drug of choice, age or gender was altered. After data for the study had been collected and transcribed, it formed the sample data material and was read and listened to by the researcher.

A critical discourse analysis was conducted on this material in the way described in the methodology section earlier – including elements of both the CDA methods of Billig and Fairclough in order to identify interpretative repertoires, subject positions and ideological dilemmas (Billig, 2001; Potter, 2012; Reynolds & Wetherell, 2003; Wetherell et al., 2001). The analysis of the transcribed interview conversations relied on the hermeneutic “tools” of discourse analysis in conjunction with the psychodynamic concept of mentalizing to

describe the co-construction of relapse. The analysis considered the manner in which, through interpretative repertoires the participants edited, directed, turned and replaced elements of their discourse in order to convey, construct or avoid particular issues in conversation (Billig, 1999). The text chosen for analysis was identified by asking the question of the speaker(s) “what is being achieved by saying this?”. In another way, the researcher asked of the speaker(s), what is being “expressed” and what is being “repressed” in this conversation (Billig, 2001; Billig, 2003; Billig, 2006). This was done to address the research question of how talk in addiction counselling contributes to negotiating desire, relapse and mental states. In so doing, these questions both acknowledged the activity of ‘construction’ of meaning by research participants as well as demarcating what might be being done/achieved by speaking in this way.

Fairclough’s (2001) general structure for a critical discourse analysis has already been discussed in some detail earlier in this chapter. This section shows how this structure was implemented for the research study and held alongside the Billigian elements of the analysis (Fairclough, 2001). The data gained from the interviews between the researcher and the participant represented the “text” that was analysed in an attempt to reflect on its particular discursive meaning (Fairclough, 2001, p. 240). The meanings of text of both the researcher and participant was analysed “interdiscursively” to examine interaction between the researcher and participant and the co-constructed dialogue-as-text generated by talk (Fairclough, 2001, p. 241).

In particular, when analysing interview conversation, the clusters of dialogue representing particular meaning groupings were chosen for analysis. They were chosen on the basis that they may reflect the assumptions and hence ideologies that counsellors and

clients may have used in treatment conversation to construct notions of illness, desire and relapse. These excerpts were analysed for the presence of particular interpretative repertoires in dialogue about addiction treatment, illness and disease and were considered alongside the idea of wanting or desiring drugs. The transcribed text was read and listened to for interpretative repertoires “are the recognizable routines of arguments, descriptions and evaluations found in people’s talk often distinguished by familiar clichés, anecdotes and tropes” (Reynolds & Wetherell, 2003, p. 496). These interpretative repertoires were understood to derive from the constructed “subject positions” that lead people to define themselves in terms of various “ideological dilemmas” during talk (Reynolds & Wetherell, 2003, p. 496). These interpretative repertoires were seen to serve as a means to mark the participant’s “expression” or “repression” of their understanding of a social interaction at a given point in conversation and suggest a particular state of mind. The interpretative repertoires were also specifically, from a Faircloughian point of view, analysed to understand how agency and power were assumed and controlled in treatment conversation. In this sense, the language of participant’s treatment talk was analysed to highlight the potentially hegemonic effect of using disease-based discourse when understanding drug use. This approach also aimed to highlight how, by using these interpretative repertoires, counsellors and clients accommodated preformulated notions of addiction that influenced their ability to reflect critically on and psychologically regulate experiences of drug use.

In this way, the data from the clinical interview was then used to critically reflect on the discursive limits of counselling talk and approached the transcribed language of the clinical interview as an “activity ... investigating the to-and-from interactions” as well as “looking for patterns in the interaction associated with a particular topic or activity” of the

participants and then relating these to the “larger context” (Wetherell et al., 2001, p. 7).

The presence or absence of interpretative repertoires will allow the researcher to reflect on the notions of power, restriction and their reciprocal influence in the respective participants’ construction of relapse.

The possible impact of potentially embedded, jargonised notions of relapse in the dialogue about treatment, 12-step recovery and social environments is to be examined. The talk of participants about relapse will be analysed and located in the context of the therapeutic alliance; treatment programme and institution and addiction treatment. This meant that the researcher aimed to identify interpretative repertoires constructed during treatment talk and that were reflective of prementalistic states such as psychic equivalence, as described by mentalizing theory. By gauging the constructed presence/absence of particular interpretative repertoires in the dialogue of participants the researcher hopes to obtain an indication of participant mentalizing or other modes of pre-mentalistic expression when thinking and talking about the therapeutic alliance.

Ethical issues

Informed consent is a fundamental aspect of ethical research endeavours and similarly was considered in that light for this research study. Two particular aspects of informed consent are discussed here – access to clinical information and consent to participate in a research interview. After this, issues of confidentiality, risk, benefit and disclosure are also considered in relation to the study and its participants.

Informed consent

Written informed consent was obtained from individual participants to conduct a research interview in order to collect data for the study. Participants were informed verbally

about the study and given written informed consent forms to read and complete. Questions about the study were answered by the researcher or his supervisors before the beginning of the research interview. Each participant indicated their agreement to be involved in the study by verbal and written agreement and s/he signed a pre-prepared consent form that indicated this consent (see Appendix A and B). Clarity about the voluntary nature of the study was made explicit. Additionally, emphasis was placed on the fact that in the event of a client relapse, s/he would not be coerced to return to treatment or the study or refused participation in the study.

Staff at the clinic were given information about the research to be conducted at the clinic. Management and staff of the clinic were afforded the opportunity to voice and discuss queries and concerns they may have had about the proposed research at a formal meeting with clinic management. Counselling staff were invited to participate in the study and information about their acceptance or refusal to participate in the study was kept confidential. Informed consent was obtained from the counsellors to review their written materials in clinic client files for the purpose of the study as well as to use information gained from interviews conducted with them.

Confidentiality

Participants in the study were assured of their anonymity. This confidentiality was agreed in the consent document participants signed. Confidentiality of information about behaviour in or after treatment and clinical matters in treatment reported to the researcher was not divulged to the treatment centre or entered into the public domain in any way. The participants' names were also changed to protect their identities and they were allocated a gendered pseudonym. Additionally, research interviews were conducted in a consultation

room at the research site where confidentiality was maintained about research interview appointments, and where documents were filed in a locked filing cabinet and kept secure at all times.

Risk

There were some mild risks involved for participants involved in this study. Interviews required participants to talk about behaviour and events that may have embarrassed or upset them slightly. However, the researcher, practising as a clinical psychologist, undertook to assist participants to manage these emotions, should they occur during the interview. The clients also had time to access their counsellor before discharge from treatment to process any thoughts or feelings they may find have found difficult to deal with after the research interview.

Disclosure

In keeping with the notion of confidentiality, any disclosure regarding participants remained strictly confidential. From a research point of view, there was no need to withhold information about the study from participants. The researcher provided time for participants to ask questions about the study they participated in, in addition to their receipt of an informed consent document and information leaflet.

Benefit

The outcome of this study will chiefly benefit the advancement of practitioner knowledge in the scientific and clinical domain. There will therefore be no direct benefit to the participants. An increase in knowledge in the area of client-therapist interaction in the context of addiction treatment is sorely needed. As evidenced by a review of the literature on relapse prevention, there are several approaches to relapse from a number of

perspectives with limited success. The additional information gained about the role of mentalizing as it relates to relapse would likely augment therapeutic efforts of practitioners in dealing with this complex phenomenon.

Conclusion

The critical theory that includes the approaches of Fairclough and Billig suggests that not only is a critical discursive analysis of addiction counselling talk possible, it is necessary. This theory also suggests that it is indeed possible to hold several theoretical perspectives together – Fairclough, Billig and mentalization theorists - with the aim of evaluating how mental states are constructed, negotiated and maintained. This approach indicates a viable analytic method using the rhetorical and discursive devices described earlier, to analyse the language of treatment talk and how this may or may not represent particular modes of mindedness.

Having developed a methodological framework and proposed a research method for this study, the next chapter focusses on its application to the analysis of talk about relapse and substance dependence. This will be done in order to address the question of whether or not addiction, relapse and desire can or cannot be mentalized in a therapeutic counselling relationship in a residential addiction treatment context.

Chapter 4: An analysis of addiction illness discourse and relapse

"Here is how it works: first you decide to treat the object whose behavior is to be predicted as a rational agent; then you figure out what beliefs that agent ought to have, given its place in the world and its purpose. *Then you figure out what desires it ought to have*, on the same considerations, and finally you predict that this rational agent will act to further its goals in the light of its beliefs. A little practical reasoning from the chosen set of beliefs and desires will in most instances yield a decision about what the agent ought to do; that is what you predict the agent will do" (Dennett, 1989, p. 17 italics added).

Introduction

This chapter foregrounds themes of addiction and mentalizing pertinent to the therapeutic alliance in addiction treatment. This is to be done from the point of view of a critical discourse analysis where the research conversations are seen as constructing complex, situated and layered narratives about treatment and relapse. It is in this context that I will surface elements of conversations in order to consider notions about how treatment models and mental states compete and impact on talk in the therapeutic dyad. I hope that the discussion and perspectives that I propose will provoke curiosity about complex, discursive elements of addictions counselling.

In particular this chapter aims to foreground the influence of (non)mentalized discourse on participants' ability to position themselves and negotiate ideas about relapse. The structure of this chapter, the concepts and themes to be highlighted and discussed follow. I will argue that from the point of view of critical discursive psychology, counselling

conversation where the individual is constructed and talked about as “diseased” by the “illness” of addiction, constructs relapse as a psychological dilemma. This is a dilemma, not because physical elements of addiction and its associated behaviours are not real or even true – they are, often painfully so. I will argue that a psychological dilemma is realised by participants who use disease model language. The use of this disease model talk discursively constructs mental states and psychological positions that are particular to the addiction counselling relationship. These positions in conversation are achieved using mental models that describe physical qualities of the addiction phenomenon at the expense of psychological description. Used by participants in the context of the treatment institution, in this manner, this is dilemmatic because firstly a reification of psychological artefacts of the counselling relationship is suggested. Second, this dilemma positions participants so that they may tend to conceal elements of themselves in order to be treated and understood. I will utilize theory related to notions of mentalizing and the concept of psychic equivalence developed and described by Fonagy and his colleagues to further understand this argument and show how these mental states are present in counselling talk (Allen & Fonagy, 2002; Bateman et al., 2009; Fonagy et al., 2002; Fonagy & Target, 1997).

Following from this, I will argue that participants use language to construct agentic aspects of the self in order to develop and negotiate positions of responsibility and action in the counselling relationship (Billig, 1999; Billig, 2006; Pearce & Pickard, 2010; Radley & Billig, 1996; Reynolds & Wetherell, 2003; Reynolds, Wetherell, & Taylor, 2007). This agentic sense of self, seen from the point of view of mentalizing and discourse, shows participants constructing role positions in relation to one another, and through these they achieve self-expression and claim responsibility about their health and relapse. This chapter lays the foundation for chapter five, where I will discuss the notion of psychological curiosity as an

ambiguous psychological struggle in the context of addictions counselling based on disease model thinking. In particular, how participants achieve mentalistic and non-mentalistic states of mind in counselling discourse will be discussed in relation to the thesis of this dissertation.

First however, the argument originates in an arena of seemingly disparate parts – mind, disease, relationships and conversation. How these aspects are related is the path that the narrative of this chapter will follow.

The Self as Diseased

Assigning meaning to psychic experiences through affect, cognition and language, is fundamentally a sense-making or psychological process that relies on the relationship between the brain and mind. It involves the psychological capacity to become aware, talk about or reflect on subjective psychological phenomena that involve the construction of an “I”, “me” and “your” as part of a self-experience (Ulman & Paul, 2006, p. 305).

The problematic use of mood and mind altering chemicals such as alcohol, street drugs and prescription medication presents a challenge to the drug user in terms of how to psychologically represent and talk about his/her wanting or not wanting the effects of drugs. Indeed, language in this context is “not an arbitrary bystander on the way to truth” and represents a challenge to the drug user as to how to talk about their addiction inasmuch as “language itself contributes to truth” (Kemp, 2012, p. 1). This is a challenge because, in part, the discourses available for addicts to talk about what it is they want, vary by context. When in treatment, the discursive construction of drug use is foregrounded differently as compared to when an addict is *out there* using. As such, addicts who describe using events are likely to describe pleasure and relief-seeking that is narcissistically ubiquitous to their

engaging in problematic drug use. Similarly addict's language is indicative of their involvement or enmeshment in a drug using subculture. This is juxtaposed with the idea of the addict needing or wanting treatment and agreeing to treatment. These competing constructions are fundamentally important inasmuch as they are seen as self-referentially regulatory endeavours (Ulman & Paul, 2006; Zellner et al., 2011).

Much is known about neuro-chemically induced changes when people are intoxicated. We know that parts of the brain called the reward pathways are "hi-jacked" and a pattern of physical drug dependence develops (Koob, 2008). These changes are likely to prompt, over time, substantial behaviour changes in the drug user. In particular, a drug user's overt dependence on and tolerance for a drug of choice are allied to a near inevitable compulsion to seek out the drug. Whilst there are many prominent researchers who have advanced the description of addiction as a "disease of the brain", their premise for doing so is largely in aid of exploring the valuable dimension of addiction as a neuropsychiatric or neurological problem (Leshner, 1997; Leshner & Koob, 1999; Volkow & Li, 2004, p. 963). Yet, the notion of addiction as a disease is at least as problematic as it is useful from a psychological point of view. Pickard (2012) offers an excellent account and clinical appraisal of the distinct limitations of the "disease" position and its restrictions from a psychological point of view. Others advocate that the disease concept is no longer a model for alcoholism and rather that alcoholism itself has become (constructed) as a disease (Young, 2011). Neuropsychiatric advances in addictions medicine usefully and importantly point to organic correlates of addiction. However "too much of modern behavioral neuroscience has tried to leap from brain molecules and similar mechanisms directly to the behavioral facts of addiction and depression ..." where "neuroscience approaches which marginalize felt subjective experiences can lead us down blind alleys." (Zellner et al., p. 2001).

There are many neuropsychiatric advances in the understanding of addiction, but less is known about how these experiences of drug wanting/not-wanting are talked about by counsellors and clients and what these conversations achieve. What is becoming known is that “motivation, treatment readiness and positive previous treatment experiences” aid the development of a good therapeutic outcome in substance dependence counselling and are likely to be crucial to treatment outcomes augmented by factors such as “greater confidence in treatment” (Meier, Donmall, Barrowclough, McElduff, & Heller, 2005, p. 13; Meier, Donmall, McElduff, Barrowclough, & Heller, 2006, p. 61). As such, the “early therapeutic alliance appears to be a consistent predictor of engagement and retention in drug treatment” (Meier et al., 2005, p. 12)

It therefore stands to reason that conversations about drug use and the desire for drug using are conceived and languaged not only during the events of an addict’s life experience during their using time but in a treatment context as well. Addiction treatment centres specifically offer counselling as part of a range of interventions, in order to change the behaviour and conversation individuals have about their drug using (Leshner, 1999). Counselling efforts to treat drug dependence bring the construction of addiction-as-a-disease as expertise to clients in order to reframe the client’s problem with a view toward assisting them with their problematic drug use (Cook, 1988). In the context of individual, group and milieu interventions, talk about addiction and relapse as a “no fault” illness is introduced, shaped and reshaped from this point of view. As such, clients are encouraged to re-author their life-story with a disease narrative in mind.

In conversation, when individuals talk colloquially about their drug using desire in ways related to their addiction, they talk about how they want to get “high”, “stoned”,

“pissed”, “smashed” – to name but a few. Counsellors, for their part, tend to talk of “recovery”, “the disease of addiction” and “relapse management” or at the very least have the counselling conversation arrive at that point. When individuals participate in addictions counselling talk using words or phrases such as these, we are not *only* interacting with their diseased brains but concurrently with their minds. As such, each person uses self-defining language to reference their participation in the using and treatment cultures. Naturally, substance dependence, addiction treatment and recovery are talked about during counselling during treatment. Hence, the language of the addict’s and counsellor’s desires – the wanting of drugs, abstinence, and treatment - are a negotiated part of treatment discourse and a conversation about health and illness.

Conversations between the client and counsellor that involve the notion of wanting in relation to illness and wanting health, rely on the commonplace words and phrases. These conversations shape the meaning of interaction in addictions discourse at this research site. Critical discursive psychology calls these instances, colloquially named as jargon, interpretative repertoires; they are a “habitual line of argument comprised from recognisable themes” (Wetherell, 1998, p. 22). Importantly, these research interview conversations take place in the context of a dominant medical twelve-step discourse that is constructed in part by *local* discourse with particular interpretative repertoires. When clients and counsellors talk, they reference the discursive context by using a *lingua franca* of interpretative repertoires in order to put forward what they intend, need and mean effectively during counselling. An important interpretative repertoire that clients and counsellors construct is the notion that addicts are diseased and are therefore seen as ill or sick. These interpretative repertoires position people as “ill patients or clients” and others as “addiction counsellors”.

Davies and Harré (1990) describe the development of a subject position as “the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines. There can be interactive positioning in which what one person says positions another. And there can be reflexive positioning in which one positions oneself” (Davies & Harré, 1990, p. 48). Given the social and mutual nature of the discourse between counsellor and client, interpretative repertoires and subject positions about disease – “illness” and consequently the desire – “wanting” of treatment and “recovery”, are constructed during psychotherapy conversation. In this sense treatment jargon fluidly becomes a psychological artefact of counselling conversation and allows for participants to be interpellated in subject positions and become “clients”, “addicts” and “counsellors” to construct treatment identities (Althusser, 2006). These interpretative repertoires and subject positions are not homogenous and often conflict with one another, having a powerful bearing on the outcome of how addiction and relapse are understood and negotiated during treatment. Words and phrases such as “disease”, often become “shorthand” for meaning in relation to treatment identities within the addiction counselling context, and assist those using them to locate themselves in a particular discourse. This treatment jargon such as – “disease” or “getting high”, and other jargon, informs and marks how desire – “wanting” – in the context of counselling is negotiated in relation to individual’s addictive behaviour.

In order to locate the interview conversations from this research in the context of addiction treatment, it was important to establish a paradigmatic starting point. Indeed I considered it crucial to establish what health position the research site took both publically and internally on addiction and its treatment. In order to do this I looked at the research site’s internet web page for its treatment position on addiction and addiction treatment

which described addiction as “a complex, difficult disease with which to deal ... a serious, often chronic condition” (reference withheld for confidentiality purposes). The construction of addiction and by extension, its treatment, in this manner clearly indicates that a “disease” view of addiction prevails in the research context. This view of addiction becomes a central consideration when thinking about the development of the counselling conversations during the therapeutic alliance during substance dependence treatment at the research site.

Addictions counselling and psychotherapy are particular kinds of conversations, with jargon and rules all of their own. Counsellors and clients give “[a]ccounts of health and illness [that] are more than a reporting of a mundane state of affairs, either external (what happened) or internal (as attitudes). Instead, they are expressive and constitutive of a way of being that is invoked in the telling about health and illness” Radley and Billig (1996, p. 236). Counsellors and clients, when giving their accounts of health, construct many psychological positions for themselves. These include a constructing health and treatment identities through conversation in counselling relationships which may be either consonant or dissonant with the research site’s notion of health. Developing this health identity relies on and relates in part to the deliberate development of conversation in this direction. As an example of this, participants in this study, as well as the researcher, used interpretative repertoires about “recovery” and “addiction” to talk about the experience of the addiction treatment.

Traditionally, and from the treatment position outlined on the research site’s web page, addiction treatment and by extension addiction counselling discourse is predominantly constructed from a bio-medical point of view (Leshner, 1997; Meyer, 1996; Volkow & Fowler, 2000). This suggests that counsellors at this research site have

conversations during clinical assessment and therapeutic contact that relies on the brain-disease-addiction discourse. This constructs a position in which they can treat elements of treatment conversation as objective and factual evidence of the “disease of addiction.” This evidence is based on criteria stipulated for defining addiction by using psychiatric references such as the DSM IV-TR (American Psychiatric Association, 2000) and DSM V (American Psychiatric Association, 2013). In turn, this information is introduced into addiction treatment conversation through a range of clinical interventions such as individual psychotherapy or counselling. Following from this, counsellors use medical, psychiatric, psychological and spiritual frames of reference to construct models to account for areas of the brain, motivation and behaviour that become “hi-jacked” by the chemicals that addicts and alcoholics consume.

Accordingly, these research participants – clients and counsellors – variously describe their view of addiction using locally derived interpretative repertoires. For example, Aaron describes addiction as an “illness” that the counsellors “attack”. In another instance, Desiree talks about the need for “formal diagnosis” of Jane because of her “splitting” and “borderline” qualities. Jane suggests “treatment centres” address and treat addiction. This is whilst Aaron sees relapse treatment as “a refresher in terms of disease model stuff” to learn to respond to the notion of having a “disease.” These, and other positions, show treatment conversation to be deeply engrained in a medical, psychiatric and disease discourse.

Addicts and counsellors, based on this, construct health positions and interpretative repertoires through conversations related to the dominant discourse of treatment in order to be understood. Certainly, they talk in ways that construct intricate, unique meaning

systems relating to their notions of addiction that form during the therapeutic alliance and process. This is achieved, in part, by constructing theories of the other's mind through talk, using local discourse and implicit, personal mental models. This treatment talk is a means that counsellors and clients use to develop, construct and attribute psychological motivations, relational attachments, normative roles and the meaning to the individual's behaviour. So, during counselling conversation, discursively constructed psychological factors compete with and at times complement the dominant discourse.

Counsellors and clients engaging the dominant discourse in a search for coherent health positions, participate in the construction of a "sick role" that develops in a treatment context [that] obscures the fact that recovery can fundamentally depend on the patient's own active effort and will" (Pearce & Pickard, 2010, p. 831). This position is particularly important when considering talk about relapse and relational factors influencing the counselling relationship at this research site. This is because, in particular, exploring the *psychology* of addictions counselling conversation raises the question of how the use of language of illness, addiction and relapse impacts on the reflective quality of talk about these experiences. This suggests that aspects of mentalizing during counselling conversation need examination.

Typically, psychotherapeutic interventions during the initial phase of addiction treatment give primacy to neurological, organic explanations for addiction. Whilst these hold true, general treatment interaction and counselling conversations are also necessarily part of the initial phase of addiction treatment. These interactions as well as those related to offering bio-medical intervention, all rely on talk and a relationship with the treatment provider. During the exposure of the client to the treatment milieu, the counsellor's use of

language to describe addictive behaviour during residential treatment is often saturated by medical jargon and predominantly located in a twelve step, psychiatric context. It is during these treatment conversations, when counsellors and clients meet one another to discuss the client's addiction that many potential complications arise.

Given that the notion of disease is central or implicit to many treatment models – including that of the research site – commonplace treatment conversation is likely to affect the manner in which individuals perceive and talk with one another in counselling conversations in a way that is “normal” or “to-be-expected.” Talk of addiction as a physical disease, being called a “patient” or “ill” are likely to have powerful and complex ramifications for how clients come to simplify their personal psychology in order to accommodate their desire for using drugs from a disease point of view. As John describes his view of the inevitability of the disease of addiction he says: “the most important thing is, I'm killing myself slowly by continuing because bad things happen when I pick up [relapse].” It is collections of imperatives such as these that counsellors and clients use to frame their understanding of addiction as a disease. These in turn prime *psychological* attachment responses in the therapeutic relationship.

Therapeutic interactions like counselling (aim to) have some of the core hallmarks of the psychological negotiation that happens in early attachment relationships - which are cued to activate the attachment system in order to attempt to regulate affect (Fonagy et al., 2002; Jurist, 2005). Clients, in response to being in treatment, develop particular mental stances that enable them and counsellors to manage affective states. They construct subject positions conventionally understood as a "sick role" when they are being treated for

addiction (Pearce & Pickard, 2010, p. 831). The following example offered by Aaron is instructive:

Researcher [R]: What would you have done in his scenario if you had been a counsellor?

Aaron: The same. I don't know about the sectioning¹ though. That's the thing: I know he is a good counsellor. I know he is. He wouldn't have got to me the way he did, if he wasn't – if that makes sense.

R: Help me understand it a bit more?

Aaron: They are here in primary-care² to push people's buttons and to get into places that not everybody can get into. And if I came in here and I didn't get pissed off with that kind of stuff, he won't be doing his job, apparently! (Laughs). I haven't quite understood that yet, but if I ever become a counsellor, I'll understand it. Because they attack ... I walk into a treatment facility, knowing that they are not attacking me as a person – they're attacking the part that's an addict.

Aaron in this instance can notice that a counsellor might see him as sick, and “attack” the part of him that needs treatment. He accommodates the conventionality of his sick role and the range of behaviour constructed as acceptable in treatment, to deduce that the treatment facility staff are not attacking “him as person.” The sick role allows him to construct a position of a sick non-person and receive treatment. According to this logic being sick would seem deeply psychologically influential. The influence of adopting a sick

¹ A process of legal involuntary or voluntary committal; being committed to a psychiatric treatment facility by a mental health professional such as a psychiatrist and the State.

² “Primary care” refers to initial treatment interventions, typically residential treatment programs which in the South African context are paid for by medical aid / insurance and generally 21 days in length.

role is reflective of "how we typically treat illness: namely, as turning a person whom we would otherwise take to be a responsible agent into a passive victim of disease." (Pearce & Pickard, 2010, p. 831). This in turn profoundly affects the individual's ability to develop ideas and conversations about health-illness and drug use experiences and in particular how these relate to affect and choice. The very idea of being mind-minded, an active implicit and explicit psychological process during counselling talk, has the potential to be supplanted by a construction of the individual as a passive, voiceless, sick person.

The assumptions of disease model thinking are present in Jessica's statements about the "craving" and "symptoms" that lead to relapse attest to this point:

Jessica: Then I started having cravings, and then I started going into dangerous areas in terms of it's where drug dealers frequented. And this is all a pattern of setting myself up, even though I wasn't perhaps consciously aware of it. It was just a pattern until eventually, one day, I couldn't handle feeling the way I feel now: irritable, moody, aggressive towards my family, and I went and picked up immediately after that.

And goes on to say:

Jessica: Ja, classic signs. But that was just the symptoms displayed that day, but it was a sequence of events over several months that led me to say, right, I've teed it up. I know where to get drugs now. Okay, so I know exactly where to go. I've got some time - two years ago - I'm living by myself now. In the back of my mind it was, maybe, I can get away with it. Ja, and just stopped talking about my feelings in terms of my addiction. You know, and not being in touch with that really.

Jessica's talk about the process leading to relapse has a medical tone which is interspersed with description of self-reflection. Her reflection about having "teed it up" is agentic in contrast with her description of how she became silent about her felt experiences. Indeed she links the avoidance of "talking about my feelings" to her thinking about herself and relapse as a loss of agency. Her comment about "just" stopping talking about her feelings points toward how she has minimized this element of personal dialogue. Jessica has a sick role described by disease and symptoms which are conflated with the affective states of mind Jessica experiences leaving little room for a psychological explanation of her narrative.

Cultivating the sick role in the addiction counselling context is potentially disastrous from the point of view of affect regulation and learning to manage particular mental states. It is particularly dilemmatic from the point of view of personal agency, as individuals adopting a sick role because of addiction-as-a-disease, do not actively promote psychological reflectivity of a mentalizing stance which might promote the capacity for down-regulation of emotionally charged states of mind (Fonagy & Target, 1997). This is a profound dilemma for clients who are particularly vulnerable to emotional dysregulation and possibly counsellors as well, when it comes to the expression and regulation of their affect – desire for "recovery" of "disease" during addictions counselling conversation (Koob & Le Moal, 2001).

Implicit in this dilemma, is that addiction counselling conversation constructs a set of positions about disease which would appear to conflate agency with addiction-as-a-disease in a counselling relationship. In attempting to describe how this is achieved, it is crucial to consider the construction of desire, wanting, health and illness as fundamental aspects of

the addiction counselling conversations at this research site. With this in mind, the next section explores the ideas of desire and psychic equivalence in the context of the discourse of the research participants.

The psychic equivalence of desire as illness: “I know the result will be jail, death or institution”

The ideas of mentalizing and non-mentalizing seen from a critical discursive point of view may be helpful to understand the conversations of addictions counselling and may clarify confusion between the diseased neurological map and the psychological territory of addiction. Mentalizing is a useful conceptual tool for understanding the potential psychological misunderstanding of addiction as a disease from a psychological point of view. How counsellors and clients come to understand one another and talk about addiction as a disease, is significantly reliant on each person’s capacity to mentalize – to hold minds in mind – and verbalise this as an experience. The notion of addiction as a disease suggests that the addict or counsellor does not need to mentalize the idea of the presence of a so-called illness and ought to accept it as a fait accompli.

The link between a failure in mentalizing capacity and substance abuse is made firmly by Allen and colleagues when they describe how “substance abuse is a clear example of failure to mentalize. ... They [drug users] are flying blind. In this instance, the erosion of mentalizing can be an unwitting consequence of substance abuse. Of course, substances also can be used intentionally to avoid mentalizing, that is, as a deliberate effort to obliterate painful mental states” (Allen et al., 2013, p. 6). The treatment environment and intervention that Allen et al. (2013) suggest that clients are in need of, is one in which they are able to exercise and develop their mentalizing ability so that they are no longer “flying

blind” (p. 6). This suggests that drug users tend to operate in psychic equivalence mode and require a mentalizing intervention to assist in their recovery.

In order to examine the mind-mindedness of the treatment intervention that is used to address the treatment of addiction as a disease at the research site, the concept of psychic equivalence needs some development from its definition in the literature review. Psychic equivalence is a description of the mental state of a person whose mental flexibility and imagination are replaced by concreteness of thought. Psychic equivalence is a pre-mentalistic mental mode in which the imagination of alternative psychological possibilities is substantially diminished or even absent in a person attempting to understand themselves or others. These are moments of “mind-blindness” where individuals struggle to attribute beliefs, desire and intentions to themselves and others because of a collapse to a psychic state of “flying blind.” It is a potentially threatening, “negative” or inflexible psychological position described by Allen (2006, p. 17) as a psychological “mode [which] collapses the differentiation between inner and outer, fantasy and reality, symbol and symbolized: mind = world”. Essentially, in psychic equivalence mode, individuals negate the possibility of the psychological - mind-mindedness - and rely on literal, face-value physical explanations for psychological phenomena. Statements such as Jane’s “realizing how strong my addiction was” point to a person relating in psychic equivalence mode. Psychic equivalence and how it relates to the research sample’s therapeutic conversations are discussed in detail below. The essential conceptual component of psychic equivalence is that the individual’s psychological view of themselves and others is lost.

One of the ways psychic equivalence can be seen is the construction of addiction-as-a-disease during counselling conversation. This construction presents a psychological

dilemma for the counsellor and client – the talk of states of mind in terms of a physical disease renders the interaction between client and counsellor in a sense, mindless. The experience of subjectivity and intersubjectivity during counselling is supplanted by an alien “re-introjection” of disease discourse (Holmes, 2006, p. 45). This presents a difficulty which is not one regarding the claim about addiction's origin (which is an entirely different problem) but rather of how to talk about addiction as a disease given what consequences this may have for mind-mindedness. In order to illustrate this point, four excerpts are examined below.

Jane : Jails, institutions and death

During my general interaction with staff and patients at the research site, I noticed that as part of their conversational repertoires, client and counsellors offered one another opinions about the outcome of the continued use of drugs. This itself was not particularly surprising until I listened more attentively to the content of the conversation. The content of these casual passageway conversations generally conveyed issues and experiences that related to desperation, upheaval and the “crisis-mode” of clients and their treatment issues. What happened was that these conversation regularly pointed toward a NA slogan – “jails institutions and death” and was used by clients and counsellors alike (Narcotics Anonymous World Services, Inc., 1989).

My sense of their statements was that this talk was an attempt by counsellors and clients to help them both understand the potential outcomes of the “disease” they had been admitted to treatment for. This rather stark set of ultimatums appeared to represent a means to talk about, from a twelve-step point of view, relapse and treatment outcome albeit via three stark consequences. Indeed, they appeared to be intended as markers for

the progression of a disease and were as much fatalistic as they were examples of impersonal treatment jargon. No addict or alcoholic would be spared from this trajectory, it seemed. This left me wondering how these statements impacted on the client and counsellor when they talked about recidivism and the outcome of their counselling time together. In particular, I wondered if they formed a psychological grid or scaffold within which the relapsing client's relapsing behaviour could be understood. It was with this in mind that I met with Jane .

The impressions I had been offered by treatment staff of Jane were of L'enfant terrible, master manipulator and frightened child. Her impact on the treatment team had been profound inasmuch as they struggled to know what to do with her in the context of behaviour she had exhibited in treatment that had broken the rules of the therapeutic community. She was, in their view, an international (not resident in South Africa) patient with an "adult-sized addiction" although she was indeed a young adult – recently turned nineteen years old. The conversation between myself and Jane was conducted amiably enough and my impression of her was one of a compliant, treatment weary and wise young woman. Our conversation focused on her experience of returning to treatment. What quickly emerged from our conversation was the notion of addiction as a disease that both supported and limited Jane's treatment dialogue. Indeed, her knowledge of the disease model lead her to believe that "picking up" drugs would irrevocably result in "jail, death and institution". I wanted to understand both the conviction with which she held this statement in mind and whether indeed the discourse was representative of a psychic equivalence mode Jane constructed by holding this position.

Jane described treatment was an educative experience inasmuch as “through this treatment centre I've learnt a lot of knowledge about the twelve steps that I didn't know about, which have actually been very helpful. A lot of the information I've learnt here about coping with cravings and the denial or not, I've done before, so it kind of consolidates my knowledge”. Yet, not much later in the interview, the notion of struggling to learn about addiction-as-a-disease emerged when Jane stated that:

“basically, I relapsed coming out of treatment; went back to actually work at the rehab centre, and then relapsed again. Going back again was just more a kind of realising how strong my addiction was, and I didn't really understand that. So learning about it was a struggle in a way. At first I didn't believe that it was a disease. There was like that resistance to it. It made it quite a struggle. I wasn't open-minded about things.”

From these two positions, some important issues emerged from this conversation related to the idea of addiction as a “strong” “disease” and the notion of psychic equivalence. Jane constructs the necessity of having to learn about the disease concept and the strength of the disease itself as central to the conviction she holds about her relapse. She foregrounds the acceptance of the belief about addiction as a disease as central to having a disease and her ability to think about herself as diseased - to be “open-minded”. Indeed, what Jane’s state of mind suggests is that the desire to use drugs and engage in treatment is indeed a powerful experience she struggled to negotiate successfully. Jane introduces the idea of addiction as a disease as being “helpful” knowledge that “consolidates” her learning through a “struggle” on her return to treatment. She notes not having had this “disease concept” information before and therefore constructs a common-

sense argument that it is likely that due to this lack of knowledge, that she has relapsed.

Jane says that “new” information is what she has needed in order for her to benefit from treatment. The new information that she is shown is that addiction is a disease:

Jane : “I find that this treatment centre compared to my last one, actually makes more sense to me.

Researcher (R): “How so?”

Jane : Just in the way they see it as a disease. I do believe that it's a disease.”

This interchange highlighted to me that Jane’s struggle regarding her “open-mindedness” hinged on her acceptance of the dominant disease discourse of the treatment setting and her acceptance of the sick role of diseased client. Her accommodation of the normative view of the treatment centre - addiction as a disease - allowed her to see herself as making more sense. Jane’s construction and accommodation of the sick, passive role where she develops a discursive position toward her drug use as a disease shows she had adopted the treatment idea of addiction “just in the way they see it as a disease.” It would appear that in coming to “believe” that her addiction is a disease, Jane is able to find the perfect “fit” between her experience, belief and a treatment belief that explained her relapse. Doing this, she accepted she has a disease and involving herself in treatment will prevent her from the scenario of “jail, death or institution” (Narcotics Anonymous, 1976). However, the notion of jail, institutions and death, borrowed from Narcotics Anonymous Literature, helps Jane achieve a discursive foreclosure on the complex task of her self-definition as a so-called diseased addict and does little to explain her relapse in psychological terms.

Jane reports that the treatment institution provided her with new learning about the disease of addiction that “makes more sense” – the foreclosure has clarified her position – but has it attended to the desire of how “strong” her addiction is? Her rhetorical model illustrates her acceptance of a “disease concept” and it appears to point, in particular, to a circular argument that will “achieve” her aim: new information about the disease I have, addresses the disease I have been told I have by the institution I am receiving treatment from, for the disease they say I have, which I believe to be true and will keep me from “jail, death and institution.”

At face value this circular logic is compelling in the light of the imagined scenario of using drugs again. However, Jane's thinking is reflective of psychic equivalence mode, by the nature of the "collapse" the of mental and semantic structure of her statement. Jane's statement of an imagined a scenario of using – a situation many addicts find themselves in – suggests the "daunting" possibility of drug use alongside the idea of being diseased:

R: What was difficult about accepting that it was a disease?

Jane: I just find it hard to accept that it won't be with me for the rest of my life.

R: And that's daunting because? Or hard to accept because?

Jane: Because I just look around and see ... being so young as well - being 19 - and all my other friends are out doing the whole partying thing, and knowing that I can't do that anymore, it's hard to accept that. If I do pick up again, you know, it will be ... I know the result will be jail, death or institution.

The possibilities Jane's reflective imagination initially suggest (“if I do pick up again”) then collapse to become the certain knowledge of the progression of her disease toward

“jail, death and institution.” This certainty is constructed by Jane using an institutional interpretative repertoire by expressing assimilated treatment jargon. To concretely labour the point, she cannot, with certainty, say anything beyond the imagined intoxicating effects of her drug of choice. The certainty with which Jane thinks about the likely consequences of a relapse suggests that her imagined future *is* her future. In this sense mind and world are equated as one. Given that Jane's collapsed narrative represents a given mental state at a point in time, her use of the interpretative repertoire achieves the unwavering claim that “If I do pick up again, you know, it will be ... I know the result will be jail, death or institution.” The psychic equivalence demonstrated in Jane's thinking is instructive inasmuch as it points to conversations that clients and counsellors have that are shaped by the jargon of treatment. This jargon, that Jane learns and uses, obviates a great deal of the range of psychological agency, flexibility and by extension, her responsibility for health by constructing her as a sick, diseased client. Jane's position is important to highlight not only because of how the interpretative repertoires of clients and counsellors embed their health positions within the dominant discourse but because they lose the reflective quality so valuable to a psychological narrative. Jane's achievement of accommodating the disease model is however ironically incomplete, with the *Freudian slip* of: “I just find it hard to accept that it won't be with me for the rest of my life.” This discursive turn points toward the idea that there is more to talking about addiction than framing it as an inevitable disease. Some additional excerpts of participant's dialogue develops the themes of non-mentalizing in counsellor/client discourse.

Aaron: Structure, or “doing the requirements”

Aaron was considered by the treatment staff who worked with him in largely pejorative terms. The label of “recidivist”, possibly disguised the concern and even

disapproval that several staff appeared to direct toward him. He had several treatment attempts and left staff with the impression of being a hopeless, malignant treatment candidate. In chapter five, I explore some of Aaron's dialogue in relation to desire and drug using. What follows is an analysis of Aaron's comments about how his relapse and return to treatment might be understood from the point of view of psychic equivalence. Aaron's conversation was guided by constructing the notion of "structure" on his conversation about treatment. I was curious about what this meant and what bearing it had on his thinking about treatment. In this excerpt, Aaron talks about completing and leaving treatment. He reports that his problem is one of not being able to stay without drugs after leaving treatment:

R³: What about getting out is the problem?

Aaron: Well, sticking to what I say I'll do on the inside.

R: Such as? Just as an example?

Aaron: Structure, or like a programme. No, just following a program, like I'm doing with the requirements here. I'll do the requirements the next one I'm going to [another program], and then when I get out, I don't do the requirements to stay clean.

It is tempting to naively see Aaron's commentary as a concise, straightforward treatment plan of action, which it is indeed, in part. However, the question remains as to how Aaron goes about constructing his plan and with what sense of agency he can put it into action. Aaron's dialogue points toward the construction of an idea about ownership

³ R is used as an abbreviation for researcher to maintain consistency with the labeling of participants Aaron and Walter etc.

through the use of phrases such as “doing with the requirements here.” Here Aaron references the treatment programme and the treatment of which he has been a participant, through the use of the word “requirements”. What this suggests is both a treatment imperative and structure closely allied with the notion of health, yet juxtaposed with the idea of “when I get out, I don’t do the requirements.” Indeed, the latter statement suggests the question I go on to ask:

R: Whose requirements?

Aaron: The requirements, ja, it’s a good question. It’s what is suggested. So the requirements of ... there are no other requirements – it’s just a suggestion. I have like a tango going on, in the sense of, I’ve got lots of friends who are addicts and who haven’t been clean through NA, or who have a manageable life now, that’s not through NA, and they still drink and they still ... because ** fucked up lifestyle. And that is where I struggle: I keep wanting to do it that way, because I keep on coming back here. In a sense, I wish I didn’t even know people like that. Because then I wouldn’t ... you know, this is the only way.”

Aaron’s earlier notion of “just following a programme” is one that minimizes his agentive capacity through the word “just” and limits and directs him toward constructing a single, reified possibility of following a programme, as if it were the programme that would provide him structure, direction, motivation. In particular, the statement “It’s just a suggestion” is a personal minimization of an ideological dilemma that he faces – taking personal responsibility for his choices and actions like his friends do, or following the “suggestions”. Aaron wanting to “do it that” way and the comparison of treatment “requirements”, his “friends” and their behaviour is a difficulty about how to engage a

disease treatment model he sees others doing without and staying "clean". Aaron relies on treatment ideology, "NA" and "structure" to formulate the notion that a "suggestion" for his recovery would be to follow the programme which he appears to reluctantly accept. Yet his evidence for the need to accept the treatment model is:

Aaron: "My circumstances or my digression ... like the spiral downwards. They say I will get worse every time. There's pretty good evidence for that."

Aaron's struggle is to construct and accept the seemingly benevolent hegemony of treatment structure in order to view his relapse as a failure of personal agency and triumph of treatment's clinical judgement. His occupying of a sick role and being ill constructs the discursive structure he needs as an alibi to distance himself from the responsibility of personal choice after treatment. His conclusion, from the point of view of psychic equivalence is that "It's like another no-choice situation really, because I'm an addict and because I've got addicted thinking – it's all these other things. I should just come down and listen; you get told what to do, in a sense." Aaron's construction of "evidence", wanting and "doing the requirements" position him as wishing for and accepting treatment structure *en passant* - a passive addict in a sick role, whose thinking is "addicted." Aaron's evidence of his own illness is shaped by the mental model he has of his experience, seen through what treatment construes to be valid, which he then makes his own. It is an invidious position to occupy and negotiate for client and also, as we will see below, when thinking about the counsellor.

Andrea: If the counsellor "fits" ... it's for your own good

The excerpts analysed so far point toward clients and counsellors negotiating health positions from a disease model point of view. This significantly impacts on their ability and

limits the flexibility to negotiate a range of psychological positions in relation to treatment. Particularly, adopting the sick role for clients appears to be a means of psychologically engaging the treatment they are experiencing whilst limiting their reflectivity. The acceptance of the utility of a sick role begs the question of how this is achieved. Andrea's view of how this negotiation occurs is instructive. Referring to another treatment peer, she describes how she and her counsellor came to "understand" one another:

Andrea: Also what I said to her is, [counsellor X] ... a lot of the patients are scared of [counsellor X] because it's 'oh, I don't want to get [X] as a counsellor.' Shjoe⁴, [counsellor X] looks ... but I actually explained to them, no, that's part of [the counsellor's] work. I came to understand, that is how it works here. They can't be softies⁵ with us. Not that they are mean with us – but you know the procedures. They have to do it for our own good. But afterwards, when I needed [counsellor], there was this "fit" that I got. I really ... I'll tell [counsellor X] anything."

Andrea's description of 'her' counsellor to a treatment peer, marks a style of interaction of which others have been "scared". Andrea's version of the counsellor's behaviour constructs the sense that treatment has an enduring style and method when she describes "I came to understand, that is how it works here." She constructs being "scared" of the counsellor as a normal yet unnecessary *rite de passage* as this is "part" of the counsellor's therapeutic work, justified by the treatment context. The notion offered here by Andrea is an implicit imperative that the peer who Andrea is reassuring, ought to accept

⁴ Afrikaans: expression or exclamation that is indicative of anticipation, surprise, admiration, exhaustion; phew –approximates this [English]. In this context, "shjoe" is likely to mean uncertain, anxious anticipation.

⁵ Colloquially meaning weak or not tough/strong enough for a task i.e. soft. Implying a lack of willpower, force; forceful resilience.

the status quo as far as therapeutic intervention goes in treatment. This furthers the notion that Andrea goes on to describe - that of the passive “addict” described earlier by Aaron who struggled with the “structure” of treatment, as one should who not be frightened of the counsellor. This is so because “they have to do it for our own good.”

This statement shows the disease model talk of clients and counsellors becomes both a means and method of moral instruction. So Andrea concludes that this psychological acquiescence to this way of treatment intervention means that she will “tell [counsellor] anything” and constructs a position beyond passivity, possibly best described as dependence. Andrea’s dependence appears to be not only limited to what she sees as a good “fit” between her and her counsellor but also a fit in the orthodoxy of the “procedure” of treatment.

Given Andrea and Aaron’s ideas that addictions treatment therapeutic alliance holds nothing to be “scared” of and follows a “procedure” and an “evidence” trail, I was curious to find out if treatment had a central, guiding interpretative repertoire that reassured clients and counsellors of the validity of their experience and efforts in treatment.

Jerry: A disease like diabetes

Talking about treatment did not appear to come easily to Jerry, who seemed reluctant at times to engage in conversation. When we did speak, he reported his experience in a somewhat reticent and dogmatic manner. I came to understand this experience of him later during the interview, when Jerry described his feelings about a treatment rupture he had experienced. I held this as a partial explanation of his reluctance to engage me, a researcher and clinician at the same treatment centre.

Another aspect of his reluctance was to do more specifically with the treatment intervention. I asked Jerry what had been different in his experience of this, his second treatment more than a decade after his initial treatment. Jerry highlighted P&D (powerlessness and damages) groups as a significant feature. P&D groups are part of the therapeutic group intervention at the research site and are therapeutic groups oriented to direct patients toward step one of the twelve steps – “We admitted we were powerless over alcohol - that our lives had become unmanageable.” (Alcoholics Anonymous World Services, 2001, p. 59). “Powerlessness” in P&D groups loosely translates into loss of control and consequent “damages” and unmanageability of their behaviour caused by the individual whilst intoxicated, as Jerry indicates below:

Jerry: Specifically, the lecture structure that is similar. The ** house is what is known as the P&D groups (powerlessness and damages). And the essence of that is to come and share with the group, and the groups would give feedback on the damages it [drinking/drug using] causes in the process and the consequences of one's abuse. So you get the kind of feedback that one doesn't sort of constantly think of during an addicted period.

R: What's it like being in those groups?

Jerry: It's tough because they take you apart there.

R: Okay, so you get taken apart.

Jerry: Deconstruction, [counsellor] calls it.

R: That's interesting.

Jerry: Deconstruction.

Jerry's experience of treatment appeared to have "deconstruction" as a central theme. His experiences of P&D groups - played a particularly significant part in how he came to view treatment. The feedback Jerry received in those groups had the effect that he describes as having been taken apart. Indeed, during a poignant interchange Jerry reports, patients replace one interpretative repertoire for another in a painful play on words:

Jerry: Ja. I can't recall his name ... was it [?] ... he shared here last Friday night. And I think lots of the people in treatment here got the idea that they have made a mistake, and he actually told me It [the P&D groups] ** pain and destruction. It was very weird what he said, pain and destruction.

It is in this context that Jerry talks about being taken "apart". P&D groups are constructed in this excerpt with a bitter sense of how confrontational and directive these groups can be in order to "deconstruct" a client's talk about their drinking or drug use behaviour. When referencing this play on words, referring to the interpretative repertoire of P&D, I notice that Jerry smiles and mentions the difficulty he imagines his peer having had during those treatment groups. It would seem perhaps that having at least shared a similar difficulty makes the experience more tolerable. Whilst there are several points to consider about Jerry's dialogue, the one salient to the research question is what psychological treatment role "deconstruction" of Jerry's beliefs about his addiction plays in the therapeutic process. It would seem that treatment is not only about the deconstruction of the beliefs – or as Aaron earlier called it, challenging "addicted thinking" – it additionally suggests that a client holds an epistemologically incorrect belief about their addiction during P&D groups. Therefore, a second component that is implicit in P&D groups and treatment

discourse is to frame the client's behaviour with another more correct model for their behaviour:

R: Given that the approach here in treatment is orientated towards understanding alcohol dependence or alcoholism from a disease point of view, does that fit with how you are meaning, describing alcohol use as a bad habit? Or is that something different?

Jerry: I'm referring to those years when I had the relapse then. Now my understanding is different. Because I'm also a diabetic, so I've already got one disease under my belt.

R: That's what I was asking, in terms of seeing alcoholism or addiction as a disease, do you now consider yourself to have two diseases?

Jerry: Yes.

R: Now my curiosity then is how did you come to that conclusion?

Jerry: Look, the diabetic, my mom and dad were diabetic. But the theory that you teach here (the disease model), as addicts we have to admit that you have a disease or an illness.

Jerry faithfully, having experienced P&D groups, draws the conclusion that he has not one, but two diseases, given the "theory" he has been taught. He confirms this by equating his hereditary diabetes to conclude that he has two diseases, not one. Jerry derives the construction of the notion of having two diseases, particularly the disease of addiction, from what "they teach here".

Jerry's and the above excerpts point toward the development of an "habitual line of argument" in the approach toward patients, based on their reported evidence about their own behaviour with treatment intervention aiming to evaluate how well this does or does not fit the dominant discursive model in treatment (Wetherell, 1998, p. 22). Clients like Jerry are not likely to be attending treatment because they believe their life experience is acceptable or satisfactory - they are seeking expert opinion and intervention to address this difficulty. It would seem, however, that the manner in which this occurs is deeply problematic from the point of view of mind-mindedness. Constructing a psychological model that shows a client that s/he has a problem – drug use – that is known to be treated based on the evidence of a physical disease, seems psychologically spurious to say the least.

It would be inviting to conclude the analysis at this point: psychiatric jargon, reflective of psychic equivalence mode, positions clients in the non-reflective "sick role". However, the next section of this chapter analyses the discursive consequences that holding a disease-based treatment model position makes available to clients and counsellors and questions to what end they are viable in a treatment of addiction.

Self-will and Desire: Negotiating Addiction and Responsibility

In the previous section, I have suggested that in addiction treatment, the interpretative repertoires that develop in counselling discourse are reflective of both a dominant discourse of treatment at the research site and psychic equivalence mode as conceptualised by Fonagy and others (Bateman & Fonagy, 2010; Fonagy, et al., 2002). The interpretative repertoires that develop in talk about each individual's drug use, such as "disease", to construct the subject positions such as "addict", are reflective of a disease model discourse which is found in medical and twelve-step treatment generally and in this

research sample's dialogue. This dialogue constructs a psychological model and trajectory from which clients and counsellors develop a personal construction of addiction, relapse and conversation in order to be understood in disease model treatment terms.

Development of this account foregrounds the sick role of a client based on a “collapse” in thinking about alternative explanations for their behaviour. This state of affairs in the dialogue of research participants obviates to a large degree the self-defining narrative range and discursive activity they may wish to utilize in talk about the difficulties each experiences with substance use. In a sense, the sick role that is constructed in counselling discourse has consequences for the construction of and negotiation around “responsibility”, “action” and “desire.” It is not uncommon to hear counsellors at the research site say to clients, “Take responsibility!” In so doing, what mentalization theory calls psychic equivalence, is positioned in the foreground of this treatment hegemony.

Holding the two different theoretical models of mentalizing and discursive psychology with two of their key ideas - psychic equivalence and interpretative repertoires - alongside one another, constructs a theoretical lens through which it can be seen that participant's psychological modes construct and underpin the sick role in counselling dialogue about the disease of addiction. This is in stark contradiction to what might be considered to be the ideal state of affairs, at least from a mentalization-based view of psychotherapy. Allen and Fonagy (2002) quote several authors to suggest that “optimally,” from a mentalizing point of view “discourse in psychotherapy on the part of both therapist and patient integrates implicit and explicit mentalizing in a process of representational description (Karmiloff-Smith, 1992), explicating what has been implicit. ... But language also makes possible the development of a coherent narrative, a systematic way of understanding

that is unimaginable without it (Tomasello, 1999). The construction of a meaningful life story is the capstone of explicit mentalizing (Bruner, 1990), as reflected in the concept of autobiographical agency (Fonagy et al., 2002) for the individual (Allen & Fonagy, 2002).

Psychic equivalence and interpretative repertoires are part of a discursive environment – there is no complete way of thinking-feeling or verbalizing something – “different discourses give the subject different, and possibly contradictory, positions from which to speak.” (Jørgensen & Phillips, 2002, p. 17). One could expect, in any given context, to be "interpellated" in several different ways (Jørgensen & Phillips, 2002, p. 40). However, the interpretative repertoires present in counsellor and client discourse achieve the significant aim of positioning and limiting the manner in which addictive behaviour can be constructed, understood and hence talked about with reference to responsibility. In short, the sick role and the idea of the diseased patient limit the possible understanding one may have of individuals discursively positioned in that manner. The analysis that follows aims to look at some of the consequences of holding this position for the therapeutic alliance to address whether the counsellor and client can offer an agentic mind-minded autobiographical account of their relapse and treatment.

In the earlier excerpts above Jane, Aaron, Andrea and Jerry’s use of disease model discourse limited the manner in which each thought about addiction and treatment. Each gave accounts of health and illness that were consistent with the kind of care they were able to talk about in the treatment context and indeed expected or understood they were being offered by the treatment centre. It follows that if counsellors construct the client as ill with the disease of addiction, then the intervention that is required of the counsellor is a *curative* one in spite of no documented cure for addiction. This means that it is valuable and

necessary that clients see themselves as actually having a disease and being sick to construct a path “toward” cure with relapse probably an inevitable part. This positioning by the participants relative to one another as ill addict clients and healthy counsellors limits the scope and meaning of their interaction. Particularly, it limits the manner in which they can claim responsibility for their addiction in the therapeutic relationship and hence their agency and choice if the disease of addiction is indeed to be seen as a no-fault illness.

The choice to talk about drug use experience that each patient has and a recovery endeavour each hopes for, is therefore limited by the use of the use of the disease model by the treatment provider, counsellors and ultimately clients themselves. As Pickard and Pearce (2012, p. 16) point out “[i]n order for a piece of behaviour to count as an action, it must be subject to the capacity for choice and control. But that capacity comes in degrees: there can be a greater or lesser number of alternatives available, and it can be easier or harder to avail oneself of them”. The use of a disease model framework, which restricts the range of available topics during counselling talk during treatment, limits the construction of choice to explain relapse experiences. The client’s personal evidence of their addiction is often used as proof to substantiate its validity: loss of control, negative consequences, drug dependence and tolerance. All of these domains are clinically “true” for an addict and a counsellor and each talks about them with relative ease. However, from a psychological point of view, that they constitute a “disease” and thereby validating the necessity of participant’s interaction in psychic equivalence mode and a sick role is another matter. As such, treatment conversation between client and counsellor can largely only rely on or abide by “disease” located interpretative repertoires, if the notion of disease is to be upheld. It is this that has significant implication for how the client and counsellor can construct “responsibility” and “agency” during counselling.

Self-will as diseased

The following excerpts brings forward the notion of responsibility and psychological action, motivation and choice to this discussion. The excerpts are lengthier than others in order to give a snapshot of the narrative participants use to construct agentic aspects of their treatment experience. They are all elements that one might conventionally use to define agentic behaviour based on the notion of individual will (Pearce & Pickard, 2010). How these elements are conflated with the sick role of addiction treatment is explored via these excerpts. Jessica, in her conversation with me, had been talking about her experience of her admission to treatment, concluding: “so it's just the truth, people talking about the truth, and coming from different angles and from different people. That was different.” She reported that the teamwork of the counselling team had been an outstanding feature of treatment for her but goes on to highlight a struggle about honesty regarding motivation and its conflation with being sick:

Jessica: The teamwork. Definitely, the teamwork, and understanding as a team. But then going back to Friday, when having the counsellors, it was that I was not willing, after meeting with [counsellor], for a few days. I was really afraid to follow suggestions that they have made - and I was holding on. And, it is my self-will and my self-reliance that they were looking back at and trying to point out to me. And eventually, it got to a stage where I was wanting to do one out of the three things and I didn't want to do the rest. And it started with [team counsellor], who is not my counsellor, in group, and him saying, listen, let's talk about honesty, Jessica. What do you know about honesty? You can't be honest. And he drilled into me and he said, listen ... and he was quite open and honest about it ... well, not quite, he was very open and honest in terms of, I suggest ... I don't know what you're doing here. I

think you should go and get your bags and pack because we don't want to see you die. We have been to so many funerals, and we're tired of going to funerals. If you are not as serious about your recovery as we are, then please leave, and you can get up and go now and think about it. And I was like, shit, hang on a sec, what's just happened? And I just walked out of the room, thinking what's happened, and then they excluded me from lectures that afternoon. And then the rest of the counsellors had a conversation with me, and it wasn't [my counsellor] who was in the meeting, it came from another voice - it came from [team counsellor]. He said, listen, bud, what are you doing? How serious are you about this? What are you going to do differently? How are you going to do it differently? You've got to do it, and if you are not serious about it, there's the door."

There are many ways to view this excerpt, however the notion of "self-will" is most pertinent to this portion of the analysis. Broadly, Jessica talks about whether or not she is "honest" about his "self-will" and can therefore make the correct choice. She grapples with a course of action based on choices in a disease-model context. Notwithstanding that she has been exposed to significant psychological pressure to come to a conclusion about her decision to follow a treatment recommendation, her decision after a weekend of thought about her options follows a particular path:

R: So just that I'm sure I'm following you clearly, there were three treatment recommendations. You preferred to do one of them, and then there was a challenge to say that you need to, at the very least, follow our suggestions, otherwise you must leave the treatment centre.

Jessica: Ja, I need to surrender and let go and trust.

R: And that was Friday.

Jessica: That was Friday.

R: And how did that then unfold?

Jessica: I had a long weekend to think about it - a very long weekend to think about it, and I went up-and-down like a yo-yo. I did what they asked me to do in terms of writing letters to my business partner, and thinking about my life story and being open and honest to my family in terms of the true nature of my addiction. I found it a bit easier, but before Friday I was already willing to do it. I was dead against it. It was going against every grain of ... I can't even tell you ... it's just completely against my nature and my feelings, and I didn't want to do it. I did not want to do it. And I was thinking through the weekend, and I saw [counsellor] on Tuesday - and I did it. Don't ask me what made me do it, but I did it. I can't tell you why I did it, because I was thinking even before I saw [counsellor], I said, [counsellor], I'm not doing it. I'm not doing it. Even up to the door, I'm not doing this. I'm not doing this. And when I got in there [counsellor] sat me down and said, right, so we're going to phone your boss now. And as soon as she said that, I was just like, okay, I'm going to do what you're saying."

Jessica constructs through her notion of "self-will", a set of positions that describe conflicting choices – "I found it a bit easier, but before Friday I was already willing to do it. I was dead against it" - and a course of action she is to engage with as part of his current treatment – "And as soon as she said that, I was just like, okay, I'm going to do what you're saying." Jessica's choices about attending another treatment environment and how to go about this are met with a coercive pressure to comply with treatment recommendation. The implicit suggestion Jessica makes is that she

did not have a choice and explicitly states that "Don't ask me what made me do it." This statement, suggesting she does not know what motivated her to make this choice, appears to be made not because she does not know what motivated her but that she has constructed her forgetting. She constructs a position of passivity in order to "surrender and trust" the treatment intervention and turn from his own agency and will. The most likely reason for this would be is that her conversation "represses" the desire of her "self-will" in order to avoid the health position of a sick addict and rather be interpellated as a healthy client who has "surrendered" to a treatment directive (Billig, 1999, p. 168).

Similarly, Ariel experiences the same kind of pressure:

Ariel: Well, then they also just wanted me to go to secondary [follow-up residential care], which I agreed to. It was actually suggested for me to do a month of secondary⁶, and I was meant to go to [treatment A]. And I had just set my mind that I wanted to go to the [treatment A], which is a [competitors treatment centre] facility. And again, I suppose very much ... it wasn't really the old way of getting my way because I didn't manipulate, but I went to the director and I said, you know what, I'd really like to go to the [treatment A]. Is there any way that you could find a space for me? And she did, but that was on the ... this was actually coming up just before Christmas, and then also only a space like just before New Year. So they [Director of the treatment competitor] then proposed that I stayed a fourth week at [competitor's primary care], and then move onto secondary. And by this

⁶ Secondary - treatment jargon for an additional "step-down" treatment phase or intervention. Happens after a primary care treatment intervention. In The South African context it is typically 1-3 months in length.

time my self-will really set in, and I decided I've had enough time in primary [initial treatment phase]. You know, I had done three-and-a-half weeks before and I've done three weeks now, so I'm getting sick and tired of these sessions – all of this. And I decided, probably most important, it's Christmas and I want to be with my daughter. So I said I would like to go and spend Christmas with my family, and then come back and do the secondary.

And when I was told that they didn't think it was a good idea, I started making up arguments that weren't really necessarily true, like I said you're going to keep me here for another week, just as sort of storage over the Christmas period when there aren't counsellors here anyway. I'm going to pay a lot of money for it. You know, I paid actually a lot of money already for primary – and I was going into that kind of mode. I mean, I do have the money, so it wouldn't have been the main concern. But I suppose, I did manipulate my way, and it actually wasn't a very profound experience for me that I ... I sort of got myself into a situation with my counsellor where she said, yes, I see that's ... I don't exactly now remember how they put it, but it was like I thought I had the agreement that it was what I should do.

And then it came up in a community meeting that I was doing this against the counsellor's suggestions, and that set me off in such a state of fury and feeling wronged and thinking, this is something ... and it's happened here too ... it's particularly not having ... you know, in my own way, gotten what I believe is an agreement that we were going to do it my way, and then being told that actually, they are not in agreement with that, but I'm going to do it anyway. It's something that triggers off something in me that I still don't know what it is, but it's ... So I then

set in motion a big story about going to my counsellor and saying, but you said ba-ba-ba and ba-ba-ba.

And I got into ... I don't know what to call it ... but a conflict situation with her where she ended up saying, can't you see the kind of chaos you're creating around yourself? And she said, I've had enough with you now. Go on! And that feeling of rejection ... and I spoke to her later also, where I felt I had a very strong feeling of rejection from my counsellor. When we spoke about this a bit later in the day, I just really wanted to cry like a baby. It brought up some very strong feelings of trying to say something and not being heard, not being listened to and not being understood. And then having that's where I'm coming from, and then I use all my sort of adult, professional skills in trying to manipulate, really. (Laughs). But then when I don't get it, it goes back to ... it's really a little child who is trying and trying to be heard, and isn't.

Ariel has, like Jessica, also made a number of choices in order to negotiate her position in relation to treatment. She frames these as "manipulation" and as part of an "adult", "professional" persona that sets her "against the counsellor's suggestions". Met with therapeutic rupture, this conflict in turn precipitates "such a state of fury and feeling wronged." Ariel makes a claim about "really" being a "little child who is trying and trying to be heard, and isn't." Whilst the excerpt gives a sense of Ariel's reflective capacity, it is the manner in which she has had to negotiate her interaction with the treatment staff that suggests the dilemma she faces. Ariel reports her claims for responsibility of her "manipulation" clearly in order to construct the sense of the depth of feeling – helplessness, rage, hurt - she feels when her view is negated. Ariel is able to talk about the experience of

negation which “brought up some very strong feelings of trying to say something and not being heard, not being listened to and not being understood.” The idea of “manipulation” allows Ariel to “voice” feelings that are strong for her and yet constructs the notion of morality in her blameworthiness. Ariel’s deviance from a “true” account of her intentions, from the counsellor’s perspective, is seen as creating a situation of “chaos”. And thus, a bind exists: *Tell us what you want, choose and be negated for taking the choice and blamed for taking responsibility for a course of action.* Whether an attuned, mentalized treatment response would have altered her self-evaluation is a moot point. It is rather that Ariel sees herself as self-willed and therefore manipulative, deviant and ill that shows the limiting effects of a disease-based treatment hegemony.

Both Ariel and Jessica talk about their ability and desire to choose a direction in treatment they value in different ways. When they as treatment clients do this, they self-referentially and via the counsellor’s interpellation of them, construct their choices as a product of an addict’s *self-will*. This notion is held in a way that conveys that they are trying to control their treatment process beyond their station. In another instance a counsellor mentions that “wrestling” with the staff ensues in situations such as these. Negotiating treatment plans and directions is commonplace in many therapy modalities and “... negotiation of treatment is an inevitable response of clients who are trying to adapt to imperfect treatment conditions ...” (Holt, 2007). Negotiation of the range and type of choices clients make is not in question. Yet, as part of an acculturation to treatment, clients in this sample refer to themselves as having “self-will” as an extension of being in the sick role. This appears to be based on the logic that a client is seen as a person with an illness which has affected their ability to choose, performing a sick role and wanting treatment. It follows that there is then a degree of incapacity that they must have to make personal

decisions about their treatment. If the orthodoxy of the diseased irrational client is questioned, the notion of self-will is invoked to highlight their illness and irrationality of their choices.

The dilemma that is constructed from the positions that Ariel and Jessica hold, and that is implicit in the sick role that other participants in the sample have been shown to hold, is not that they are negotiating a treatment plan with the counsellors and treatment institution but are constructed as having a diseased “self-will” for doing so. Self-will in this instance is being circularly constructed as an aspect of the client’s illness – their ability to choose is influenced by the sick role that they occupy because they are seen as diseased. The meaning of this is that the treatment discourse they are party to, not only attempts to shape the means for their understanding of addiction-as-a-disease but has in so doing *fundamentally* limited their frame of reference to think of themselves as intentional, active psychological agents. This limits their capacity to consider alternatives to what they want and how they can be (held) responsible for their choices. So this also limits the range of agency each has, given the existing restrictions of the treatment environment, personal capacity and the degree of freedom of choice each can reasonably exercise. Each client in treatment will have the “final” choice of whether or not to use/relapse. The construction of diseased self-will removes an important dimension of agency from psychology of making such a choice.

This premise then serves to justify the use of the dominant twelve-step and disease model of addiction, as both are a means of necessarily limiting choice in both clients and emphasis the “good” of interventions that counsellors might offer. Seeing addiction as an illness of problematic and irrational choices coupled to faulty individual agency allows for

this singular ideological construction that enables the treatment of the symptom of self-will to be attributed to addiction-as-a-disease. It therefore follows that the counselling staff, according to this account, are “legitimately” concerned about the irrational conduct of the drug using client as they cannot see why the client would rationally choose drug use unless they were ill. The counselling approach to understand clients is to construct them as not only full of desire to use drugs but largely incapable of seeing their shortcomings without the assistance of a more correct alternative because of their diseased “self-will.” This perversely constructs the inherent moral demand that the counsellor do everything s/he can to make the clients see their disease as one that will kill them and possibly others. This consequently constructs treatment interventions as accountable and legitimately heroic; an engagement of the ill patient as battle of wills - health against irrational sickness, and deviance against compliance in order to uphold the broader “values and morals” of a “wider shared [treatment] reality” (Radley & Billig, 1996 p. 229). Thus, the ideological dilemma of a no-fault disease emerges from the construction of talk about addicts as diseased, in the context of the therapeutic relationship.

Concluding Observations

Given the above argument, the interpretation that can be offered regarding the mindedness or mentalization, of these positions that Jane, Aaron, Jerry, Andrea, Ariel and Jessica hold, is that they portray few of the principles of reflective discursive self-definition or mentalizing. Client participants, in their accounts, use interpretative repertoires they have learnt, located in disease model thinking to construct their health positions to the detriment of their range of choice and capacity for considering action and responsibility. Their counsellors, in order to sustain this narrative, pursue the portrayal of clients who are psychiatrically unwell and who cannot be trusted with their own minds and agentive

choices. Similarly, participants, having learnt their positions are intractable, struggle to maintain their desire for treatment and for this need to be held in mind for fear of being and becoming passive, a-libidinal addicts.

The next chapter, explores the challenge and ambiguity of mentalization in an addiction treatment context.

Chapter 5: A discursive analysis of the dilemma of desire in addiction treatment

talk

Context: Counselling session

Ludwig: "What we cannot speak about we must pass over in silence."

Otto: "One should indeed be silent, but not *about* anything."

Question: What might the mentalizing therapist say?

Adapted from *Great Lives: Ludwig Wittgenstein*, BBC Radio 4, 13 December 2011

Mentalization and curiosity as an ambiguous struggle in addiction treatment

In the preceding chapters I have made the argument that mental processes, positions and modes are discursively constructed in the context of the therapeutic counselling relationship. When talking and thinking about treatment, relapse and addiction, certain modes of discourse are prevalent in conversations between counsellors and clients. Chapter 4 points to this - treatment conversation reflective of psychic equivalence mode, suggests likely rupture and impasse in the therapeutic conversation and process. Mentalizing literature suggests this is "normal" – that no *perfect* psychological discursive mentalistic attunement can continuously occur in conversation – and that islands of psychic equivalence, pretence and mentalizing necessarily occur as conversations begin and end. It is in this sense that conversations are ongoing, punctuated, mental discursive processes within which rupture and misunderstanding can potentially be reflected upon and repaired.

However, treatment conversations dominated by modes of discourse such as psychic equivalence and pretence are likely to construct a range of adverse reactions in counselling

talk. Furthermore, these modes of discourse appear to mitigate against the imagining and development of a healthily agentic sense of self in treatment necessary for recovery. Understanding how individuals, as participants in the counselling dyad, generate misunderstanding and hence rupture in the therapeutic alliance when they consider relapse, particularly when occupying non-mentalistic mental modes of talk, is the core of this chapter's analysis. Additionally, in this chapter, I will further develop the idea that individuals construct mental positions and modes of discourse in counselling talk as a means of discursively deriving individual agency regarding their desires. This, in turn, permeates the process of self-definition and self-regulation of these desires in the context of addictions counselling.

Counselling has an explicit focus on mental states during sessions which brings into sharp focus client's and counsellor's abilities and frailties when they explicitly attempt to think, feel and talk about relapse. It is this talk about relapse – the talk about mental states and processes related to the mental positions that individuals occupy apropos their drug use – that is the focus of counselling and this discussion. In particular, the discursive construction and positioning of people – diseased addict, counsellor, sick or “in recovery” – are addressed with reference to self-definition and affect regulation. The following section introduces some theoretical constructs pertinent to this analysis and then following from this, a discussion of the discourse of counsellors and clients are focussed upon in detail in order to reflect their struggle to negotiate desire in addiction treatment.

Discursive self-definition in addiction treatment

It is a relatively well explored and accepted position in philosophy, psychology and psychodynamic literature that the self, as a constructed and subjective entity, cannot be objectively observed (Swartz, 2012). Indeed, it is also well articulated in psychoanalytic literature that the development of the nascent self is contingent on the understanding of an

attuned caregiver (Fonagy et al., 2002). This is important, as one of the capacities that children develop from attuned caregiving, is the enjoyment of their and others' minds. As language and the skill of representing and then meta-representing the psychological realm in words develops, so does the natural potential for discursive positioning, misrepresentation and misunderstanding. In this discursive sense, people's (or children's) psychological agency relies in part, on their capacity to formulate languaged representations of mental events, contingent on others, and to coherently construct and express these in the context of discourse. These self-constructed and self-defining processes are fundamental to the talk that the participants of this study rely on in the conversation of everyday counselling (Fonagy et al., 2002). Participant's use of their reflective ability to discursively construct and maintain a health related sense of themselves in treatment, and rely on their emergent capacity for mind-mindedness developed during childhood (Fonagy et al., 2002).

The abovementioned psychological capacity offers individuals, as adults, the opportunity to explore, through elements such as language and conversation, the understanding of misunderstanding in their and other's minds. This means that misunderstanding and rupture in psychological terms has the potential to be repaired. As such, counsellors and clients rely on utilizing this exploratory capacity, in their day-to-day counselling sessions, to construct and negotiate mental states, positions and roles in relation to relapse events. The efficacy with which they are able to construct robustly agentic positions for themselves is crucial, as this shapes how they are likely to act toward and reflect on relapse as a personal, psychological and health related experience. Clients and counsellors attending explicitly to being mind-minded during counselling, in this sense, implicitly rely on early learning alongside the cues gained from past and current relationships.

Psychological learning provided by caregivers that has been consolidated over time, as well as involvement in relationships such as those developed at a treatment institution, shapes the health discourse of each participant and how they reflect on their relapse and health in a treatment context. As such, the discourse that participants use to comment and reflect on their relapse and treatment experience offers unique dialogue about their sense of themselves as ill or healthy (Fonagy & Target, 1996; Radley & Billig, 1996). Participants' expression of the experience of agency come to rely not only on their ability to represent and meta-represent this but to mentalize, conceive of self-states and articulate these experiences through talk and other utterances (Fonagy & Target, 2006). Addiction treatment discourse therefore demands of individuals to negotiate and possibly hold several mental positions in mind at any given time during treatment in order to consider a sense of self that is both agentic and healthy. How these positions may conflict or be consonant with one another, given the context in which they occur, is likely to have an impact on how relapse is discursively marked during treatment. It was with this mind that I thought of the clients and counsellors in the research sample.

I started to question how clients and counsellors might consider what their (shared) ideas of how treatment might unfold, both in an ideal and pragmatic sense. I was particularly curious about how the ideology of disease model, embedded in their discourse and used as an assumed, consensual starting point, had impacted on their ability to have a helpful therapeutic conversation with one another. The particular anticipatory unease that I held in mind at this point, centred on the question of whether the means to construct a therapeutic alliance through conversation may have already been obviated for each participant for different reasons, stemming from an ideological dilemma about "having" a disease.

I was also concerned that the counsellor's use of a disease-based treatment model appeared fundamentally misattuned when addressing the client's treatment needs. Its use appeared to both generate and perpetuate misunderstanding in the addiction counselling relationship. Indeed, it left counsellors with the dilemma of developing a psychological relationship with clients whilst relying on the disease model used to frame interventions from a "physical stance" (Fonagy et al., 2002, p. 25). As such, it appeared that counsellor's interventions were based on needs to assert expert control over a client in denial of their disease. In counselling treatment one might reasonably expect counsellors who are explicitly tasked with attempting to assist clients, to mentalize their clients and their therapeutic ruptures by attempting to construct therapeutically helpful contexts. This is so that each person who may have not been able to hold difficult psychological material in mind before may become able to do with the help of another's mind. Clients and counsellors therefore engage one another in treatment talk that is helpful. More overtly stated, counsellors when tasked with engaging clients, do so in a context based on explicit reflection about treatment, addiction and relapse, in order to mentalize addicts and their addiction. Counsellors in this sense might offer their minds to clients – they work toward being able to mentalize the client – to repair rupture and reflectively collaborate in developing a health identity related to treatment goals. As such, the conversation of counselling relationships aims to construct reflective discourse that assists clients to claim and occupy a health-oriented, meaning-rich psychological landscape. Yet is it is here that clients however, during our research conversation, appear to have offered a commentary to counsellors that points to their treatment conundrum: Portrayed by Aaron who says of addiction and his treatment that it is "almost like the illness that I want." What follows is an analysis to reveal whether, through

counselling discourse of the disease model, the desire for self-definition in relation to this illness can indeed be “seen” by counsellors.

Discursive self-definition and the construction of regulated desire

Two important aspects about desire come to mind in order to address the research question: Firstly, how the participant’s discourse might signify their desire, and secondly, whether the use of the disease model shapes the construction of “non-mentalistic” subject positions each participant might occupy in the construction of their desire during treatment conversations. Desire, and in particular the representation of desire, are crucial elements of addiction counselling from a mentalizing point of view because being able to hold a reflective position or stance apropos desire during counselling offers individuals a position from which they can attempt to regulate, negotiate, express desire and construct discourse to narrate their experiences. Zellner and colleagues (2011), point to this as a crucial idea that requires differentiation from traditional notions of incentive salience that are typically used when describing “wanting” to include wanting attachment (Zellner et al., 2011, p. 2006).

Wanting, needing, aspiring, wishing, longing, craving and yearning are dimensions of desire that can be infused and even saturate talk and shape contexts. Desire and the expressions of wanting form part of the conversation that counsellors and clients have with one another about the use of drugs during treatment. In order to construct, tolerate and manage the affective aspects of experiences such as desire, counsellors and clients must accurately mark their desire as a construction of the reality they intend to express (Dennett, 1989; Fonagy et al., 2002). I wondered how the construction of drug (not)-wanting in conversation between participants was shaped by their possible reliance on the disease model. Specifically, I was curious about how other participants discursively marked their

positions and the consequent impact that this had on their ability to understand each other's desire alongside their involvement in disease model based treatment.

The analysis that follows aims to explore, as set out in the introduction, the discursive construction of psychic equivalence in counselling talk and its relationship to the expression of desire. What follows are vignettes from participant's conversation about their relationship to treatment, each other and the organization of the desire for drug-using. I aim to develop the point that desire is both problematic as well as ideologically dilemmatic from a psychological point of view when a dominant disease discourse is prevalent in treatment conversation. Desire is psychologically problematic from a disease model point of view of addiction as it does not overtly distinguish liking from wanting as incentive sensitization theory does (Robinson & Berridge, 1993). Ideologically, desire, from a disease model perspective, is also deeply paradoxical and problematic as clients come to treatment to cure their out of control want of drugs and therefore treatment should enable the desire of not wanting them.

It is through the analysis of these excerpts that I further aim to make clear that mentalization in the context of a disease model based counselling approach, creates a hegemony regarding the expression of desire and an ambiguity about how to construct health positions in which the client and counsellor can hold one another's minds in mind. I have started with Walter and Aaron's conversation and then move to others' to elaborate on the notion of misunderstood desire. It is Aaron's turn of phrase "the illness that I want" that he uses to describe his understanding of disease, want and his struggle to talk about desire which calls for analysis. The phrase is chosen for the reason that it locates the use of the interpretative repertoire of "illness" in both treatment discourse and disease-model ideology.

Furthermore there are two additional points this analysis aims to examine. The first is that referencing “illness” locates the idea of and talk about wanting within disease model discourse. This highlights the possibly difficult and ambiguous psychological position that the client and counsellor have to hold in mind, when trying to think about what recovery from addiction and relapse might mean. The second point this analysis aims to understand is the powerful effects of disease model language and how desire to use drugs becomes regulated by disease model discourse.

Walter & Aaron: “The illness that I want”

Aaron, at least as I remember him, was an impressive character to interview. His reputation had preceded him by the time we met – not uncommon for people who have had several treatment episodes. He was talked about by staff who had participated in his earlier treatment in ways that suggested his pathology was as enduring as the institution. In so doing, I thought of the Aaron’s story as forming part of the institution’s oral history and the oral tradition of clinical team. Their talk, constructed by the retelling of the story of their relationship with him, also established a treatment legacy I was curious to examine.

Turning to my conversation with Aaron and Walter, I wondered what understanding both participants would use to negotiate and clarify Aaron’s *desire* to use drugs again and again, given the emphasis that they had placed on the disease model to signify Aaron as an “addict.” The conversation about relapse that I had had with Aaron and Walter thus far had reached the point where Walter’s use of the disease model of addiction appeared to be of significant influence in generating misunderstanding and rupture in the counsellor-client relationship. This misunderstanding centred on the notion of being a person and addict in treatment and beyond and was constructed from non-mentalistic psychological positions. The conversations that Aaron and Walter had with one another construct significant

opportunity for misunderstanding: Walter sees Aaron as an “addict” with a “disease” and Aaron claims that this is like “the illness that I want”. A particularly potent element of this (actual) misunderstanding is that, having heard both Walter and Aaron’s accounts of their relationship and what they believed had contributed to relapse, there seemed to be an impasse that centred on desire in relation to drug use that is psychological. I wondered whether or not the reflective means to notice and attend to this rupture whilst attempting to treat Aaron’s wanting of his “illness” were also shaped by a disease discourse.

It consequently struck me as interesting that when I had asked Walter about the impact that Aaron’s behaviour in treatment had on him, Walter noted how he felt torn between the needs of the team and his manner of approaching and engaging Aaron in treatment conversation. Walter expressed his desire to try and understand Aaron as positioned in an impasse, stating that, “At first, I tried not to ... and I mean, having supervision around it – I had supervision that day, and immediately my reaction was, shit, I can’t do all of this, and now you are bombarding me with all the information. I don’t know this guy. I don’t know what he wants.” It is in these statements, an element of desperation emerges from Walter’s narrative in his need to understand Aaron and his problem – pulled between the input of the clinical team and his own sense of clinical initiative. Then Walter reflects and gathers himself, going on to say, “And then I took a stance of ... stepping aside from the team for a bit. You know, I hear all the information, and I’ll hold it, but now I need to sit with the patient, and I’ll try that it doesn’t affect me trying to build a rapport with him, in a ... I want to say negative way, but that it doesn’t influence me in such a way that I can’t look at him and build that rapport with him.” Walter’s ability to reflect on and mark his clinical needs as a counsellor – a desire to understand his client – allow him to mark this desire and construct a further position in order to consider himself in relation to the clinical team. Yet, Walter also

reflects on how he feels drawn to and influenced by the “information” he is “bombarded” with by the team, not wanting to be “negative” about it. However, Walter’s predicament of wanting to get to know Aaron relies on developing a set of ideas about Aaron’s drug use as well as who he is, in order to develop “rapport” with him as Walter does not know Aaron and “what he wants”.

Walter appears to be struggling here with how to relate to and imagine Aaron’s desire for using when thinking about his “wants” whilst relying on disease discourse. Additionally, Walter appears to be grappling with how disease discourse shapes how he knows Aaron, alongside how embedded he is within the treatment context he is describing. This is shown by how Walter is certain that Aaron has “got a disease of addiction” but in particular, notices that getting to know Aaron is problematic because: “... it wasn’t just my preconceived ideas – it was the whole team, because everybody has worked with him before and everybody knows Aaron.” He also notes that Aaron has heard about the disease of addiction “ad nauseum” and that he is a “complex case.” In so doing Walter’s narrative in relation to Aaron leaves him facing the dilemma of how to help and understand Aaron’s desire to use when Aaron holds the explicitly contradictory position of wanting his illness. The dilemma of personally getting to know Aaron or getting to know him based on his and other’s preconceived ideas is something he holds in mind and yet he also states that “With addiction, to be honest, it’s pretty straightforward black or white” but “Treating [Aaron] with the constraints of addiction focus, if that makes sense, and not really being able to venture too much outside of that” poses the risk of “not wanting to lose the focus myself while I’m working with him, but also for him not to lose complete focus of what’s the main reason for being here.” Walter postulating that addiction must form the primary focus for treatment, shaped by the notion of a required simple, “black or white” intervention, sabotages the possibility of potentially

understanding Aaron's position regarding his addiction and leaves Walter struggling to recognise how to approach Aaron beyond his and others' "preconceived ideas."

Walter's need for "straightforward" coherence to his understanding of his role in the team and the need to make a psychological connection at an individual and personal level with Aaron is deeply influenced by his use of the "preconceived" ideas located in the dominant disease discourse. He reflects on his and the team's desire to use "preconceived" ideas about Aaron to understand him and yet notes his discomfort with this approach given that these preconceived ideas contradict the notion of personal rapport that he hopes to develop with Aaron. His belief that an initial "one-on-one" counselling encounter would have been "easier" seems to be constructed because of the powerful impact that the clinical disease discourse has had on his thinking about how to approach Aaron. It is Walter's particular reliance on the notion that "with addiction, to be honest, it's pretty straightforward black or white" combined with the idea that Aaron was a complicated patient to consider, contrasted against the clinical team's differing approach to his left him in this position:

R: It sounds like there's, on the one hand the team's needs, and on the other hand the client's needs.

Walter: Yes. Which, nobody knew what the client's needs were. Everybody had a preconceived idea, you know, being at the work and having sex with somebody, knowing his HIV status with no protection. I mean, that's what the team ... they all wanted to work around that, and nobody has actually started really building rapport with [Aaron].

Indeed this influential sequence of non-mentalistic positions emphasises the "physical stance" consonant with the disease model discourse that is demanded of Walter (Fonagy et

al., 2002, p. 25). In a sense Walter appears to want to construct a naive helper position for himself in relation to Aaron, where there are no “preconceived” ideas and that they can develop “rapport” freely, and yet he is convinced that Aaron’s relapse is grounded in his denial – evidence of the disease – and that he can control his drug taking behaviour. As a consequence, I wondered how effective a disease model stance will be, given the assumptions it appears to be based on – that rapport will develop from disease discourse assumptions – and whether the discursive ground for a mentalized understanding of Aaron’s desire to use drugs exists. Particularly, it would seem from these participants that desire in the context of recovery from the disease of addiction becomes an unthinkable impasse in counselling conversation and around which counsellor and clients develop one another in a symmetrical struggle about misunderstanding when using disease model language. As such, I was curious to see if disease model talk in other counselling relationships similarly constructed desire as a counselling impasse. Indeed the following extract is chosen as its analysis draws on the interpretative repertoire of disease model and 12 step ideas of alcoholic ‘powerlessness’ and the inevitable ‘progression’ of the illness of addiction.

Donna and Andrea: “This could only get worse”

Andrea was someone who struck me as ordentelik⁷ to use her mother tongue – proper – in both her conversational style and manner and in truth, had I closed my eyes, I would not have imagined her to be a client of a residential substance dependence treatment programme. What struck me about our conversation was the intensity with which she held her view of her addiction which was shaped by both her religious beliefs and her firm observation that treatment without the twelve steps, was a “disaster.” In particular, her sense

⁷ Afrikaans - translates as well mannered, proper, reasonable and decent yet possibly officious

of what had brought her to treatment interested me. She put it like this to me: “I had that year of sobriety. I knew the promises came true. And that being absolutely clean, that was wonderful. And then when I picked up again, just how quickly it went. ... I crashed so quickly, and if I look back at my whole life, I did realise how ** disease this is.” Andrea talked to me about feeling “foolish” and “embarrassed” about her relapse and how her over-committed involvement in starting a twelve-step meeting during the time after a residential treatment episode had left her with a sense of being burdened which she believed set her up for using again. She impressed upon me during our conversation a sense of being at odds with herself – a person whose clear-mindedness accounted for a relapse using a well-defined frame of reference – and yet who seemed simultaneously ashamed of her desire to use drugs beyond what that frame of reference might be able to account for.

The manner in which she talked about her relationship with her counsellor pointed to the notion that she had come to rely on both her counsellor – “[Donna] ... She helped me through this” – and the disease model of addiction as a means of understanding her behaviour. Her fear was the idea that beyond relapse, her disease would develop to a point where “I will do something extreme like kill someone or run someone over by accident – or driving drunk or whatever. This could only get worse.” Andrea’s almost fatalistic belief in the notion that she carried a progressive disease also seemed to have made an impression on her counsellor.

Donna shared the sentiment of how Andrea’s disease would progress if left unchecked. She extrapolated this notion to include the idea of being addicted to relationships, when she said to me that “I reckon, in terms of her disease, for me, that shows the level of the illness, I will choose a drug that’s not mine but yours, in order to have something between

you and me. If you want to do cocaine, I'll do cocaine with you. For me, that's quite ill." Understandably, the counsellor's concern that Andrea may come to depend on substances and relationships in order to derive satisfaction and meaning in her life is constructed as troublesome and worthy of clinical attention. I notice again the non-mentalistic (psychic equivalent) processes evident in their construction of Andrea's illness that are to be the focus of the counselling relationship. This further contributes to the idea of Andrea's "illness" and her "obsessive" behaviour that are used to draw the conclusion about Andrea's behaviour being that of a diseased addict, scuppering an exploration of this significant area.

This seems to be the case as Donna ends up constructing a position where she says to me that "I actually in the end started thinking, I wonder if she's got some strong borderline qualities that have never been diagnosed or discussed with her, or would have helped her understand herself a bit better. So is that the missing piece? Is that what has been missed?" The direction that Donna and Andrea's conversation has taken them is toward a disease model explanation of the behaviour of the client and yet Donna reveals her concern to me that "it's almost like a carbon copy of the process: the last time she was here, she had come off the back of a relationship that she had started in treatment." Donna's reflection on the gap in her understanding of Andrea's behaviour appears to be constrained by the permissible limits of the disease model discourse and as a consequence, seems unable to explore the "missing link" in Andrea's recidivism. As such, the only reasonable conclusion that she and Andrea can draw about her relapse is that it is because of her "borderline qualities" or illness. Consequently Donna assumes there is the likely progression of her disease toward relationships and that without the acceptance of the danger of this position her disease will get "worse", "quickly".

This example is chosen for analysis because of the of the psychiatric and disease model interpretative repertoires which become a discursive 'blind-spot' that precludes the exploration of other psychological alternatives for relationship rupture. The analysis of the counselling talk premised on these notions aims to show the reification of psychiatric concepts and how powerfully the therapeutic alliance can be skewed by the construction of the addict or patient from this premise. This point is taken up with and analysis of an excerpt of Desiree and Jane's conversation.

Desiree & Jane: "But we didn't become friends"

Desiree's and Jane's therapeutic relationship seemed to, at least from the point of view of the counsellor, to have all the ingredients for a helpful collaboration. Desiree saw Jane as an "unusual" client who had "exactly the profile I like to work with." As an overseas client she was allocated to treatment as "a four-weeker" but as that time drew to a close Desiree saw treatment as an "artificial environment" where "you know, I was being pretty ineffective in terms of touching her. (Sighs)." The inaccessibility of Jane constructed by Desiree is mirrored by Jane's view of her own motivation. Jane saw her own motives as hard to understand, reflecting on her relapse saying: "It's like I just had the knowledge, but didn't put it into play."

Jane attributes her struggle with motivation in treatment to the fact that her session times with Desiree were "very short, and I thought they would be longer" and that she struggled to "trust" others, particularly those in her therapeutic community. Further, the issue of "trust" is strongly reflected when Jane says: "I think it was more of a, if I want to get better, I've got to let go and trust the counsellors and listen to what they say, instead of fighting it ... that definitely affected or had some effect to why I relapsed." This is indeed a

point of “ambivalence” that Desiree believes they “never got past.” What seems to be constructed by this position is the desire for a helpful, trusting relationship held alongside the ambivalence to develop one.

As Desiree told me her thinking about Jane developed in a way that “...for quite some time, say, about the first week of her process she was almost too good to be true, in a sense. And I was wondering ... because Dr X had told me that she was intensely borderline ... and I was wondering what on earth it was that he was talking about.” Desiree goes on to say in what appears to be a strongly self-fulfilling prophecy, that “Later in her process it emerged that she'd been fraternising with one of the patients here, which kind of put every bit of her work and what she told me in therapy here under a big question mark. So I doubted her sincerity of everything that we'd done previously. So it was like we had to start all over again.” The absolute confirmation of Jane's borderline pathology – another psychiatrically constructed disease model notion - and untrustworthiness comes to define their relationship and as Desiree later comments: “Yes, definitely it still sits with me.”

The point might be well made that disease saturated interpretative repertoires of pathology-based language which are located in psychiatric and psychoanalytic formulations of disease not only obscure desire but also impede the development of a therapeutic relationship. The argument may even be made that not only does this language obscure desire but is also confusing for client and clinicians alike given that “literally, there are 256 permutations of the criteria set for which the diagnosis can be achieved” (Sanislow, Marcus, & Reagan, 2012, p. 55) In the next instance the client and counsellor struggle around the idea of his seriousness toward his disease and managing his feelings about drinking. This excerpt is chosen because it relies on the interpretative repertoire that alcoholics are in denial about

the extent of how powerful their disease is seen to be. Indeed the analysis focusses on how in this context desire to drink confirms the interpretative repertoire.

Jeff & Jerry: "The conversation got the better of me"

I had anticipated that my interview with Jerry was going to be a complicated conversation to have inasmuch as I had heard Jerry was initially quite disappointed and angry toward the clinic about the fact that he had had a change of counsellor during his treatment process. I had been concerned that this context would unduly impact on both his willingness to engage in the research interview and shape his responses toward his counsellors. Whilst he did use some of our conversation to share his unhappiness about the rupture of his counselling relationship and he participated somewhat reticently at times in conversation, Jerry put forward an account of his relapse and engaged me in a frank account of why he had begun drinking again: "I was off the booze for about two-and-a-quarter years. Then my sister had a party with the new millennium, and that must have been the 31st of December 1999, and I think I got caught up in that fever."

Jerry then accounts for why the "fever" had gripped him: "... I went along with my wife, and I felt sort of awkward and uncomfortable and I left. ... And I went home and I got bored sitting there by myself." Jerry's narration of the events that lead up to his relapse event foregrounds an emotional state that he has found difficult to contain and process. What Jerry shares positions him as isolated from others in his need to abstain from alcohol and having to negotiate this uncomfortable experience from which he ultimately turns to drink. Jerry does not fully venture toward describing what the experience of this personal struggle is like for him and prefers to turn toward that he had in fact returned to the party " ... And they eventually had a glass for me, but I said, no, I'm off the booze. I've been in rehab. Have a

glass of this? No. Eventually, I ended up having a glass with them. ... We started chatting about the old days and the drinking days, and the conversation got the better of me.”

The notion that both he and his counsellor have about Jerry’s return to drinking is that some kind of disease process was at play causing Jerry’s relapse - an infectious party “fever” or an “illness” is identified as influencing him to drink. Jeff believes Jerry “didn’t quite see the seriousness of illness.” Consequently, Jeff constructs Jerry’s isolated position as a justificatory denial when he states that “...he still shared in a way that justified his illness and the blaming of others. His denial was in the sense that it's always somebody else's fault.” Jeff interprets Jerry’s “blaming” of the party fever as Jerry dislocating his belief about having a disease in favour of an explanation that others influenced him to drink. Put another way, Jeff seems to be suggesting that an alcoholic who takes their sobriety seriously, ought not to put themselves in such a precarious social position.

Jerry appears to turn away from personalizing his responsibility in disease model language in Jeff’s eyes whilst Jerry notes that the “conversation got the better of me.” The psychological demands of the “party” construct a position from which Jerry can reference a “fever” that influences his decision to return to drinking. Whilst Jerry’s languaging, ostensibly does not directly reference a disease model discourse, it points to the idea that a psychological process influenced his behaviour. Indeed, something profoundly psychological - interpersonal and personal - is at play in the decision Jerry takes to begin his relapse. The interpersonal pressure and emotions he feels - the desire to drink got “the better of him” and this is what he and Jeff struggle to hold in mind from a disease model point of view: wanting to drink is evidence of desire rather than evidence of a drinking related illness. Conversely, it would seem unlikely that thinking of his desire as evidence of an active disease would have

assisted Jerry in dealing with the discomfort associated with the very same set of feelings. His initial refusal of alcohol and comment about having attended “rehab” support this notion. What appears to have changed his mind, is the *minds* or talk of the friends who are drinking, not the existence of his professed illness.

Whilst taking treatment and affect seriously are important, when misunderstanding develops, the consequences can be catastrophic for the therapeutic relationship as Gina and Aubrey demonstrate. The excerpt that follows was chosen for analyses because of the manner in which the interpretative repertoire of the disease model concept of loss-of-control was used to negotiate compliance and adherence in the therapeutic alliance. The analysis shows how this develops into a symmetrical struggle.

Gina and Aubrey: “it was almost like a fight, mostly, actually ...”

Aubrey and his counsellor Gina’s interviews struck me as an exercise in reconciling opposites – Aubrey presented himself as a bullish, underdeveloped, needy and irascible person who appeared to have had a long history of exposure to invalidating environments and drug use. Conversely, Gina struck me as acutely sensitive, professional and responsive person. She appeared to be attuned to and reported feeling responsible for her clients treatment needs as their counsellor. She had also reported to me, within a work context, that she had felt invalidated by working with addicts from a disease model point of view. This was because her professional training in clinical psychology appeared to be at odds with how treatment at the research site was thought about. I was thus curious to see how this would affect the participant’s conversations and how two quite different people would find common therapeutic ground with one another.

It emerged that the disease model discourse was indeed the place that was a common difficulty for them, established though their conversation, where Gina initially reported that Aubrey had no “understanding” of the “disease model concept” which his current treatment process had exposed him to. I was curious to know how Gina had negotiated this with him – the acceptance of the disease discourse. Gina explained to me: “Well, just looking at where he was when he went in the first time, and how things had been and how did he get to where he was now, and through information really helping him to try and see that it's not about the drug - it's about addiction. And whatever he chooses, he's not going to have that control. I mean, I don't know if I'm answering your question, but kind of just through information”.

Gina, in showing me that giving Aubrey the information he needed to deduce that he had the disease of “addiction”, suggested to me that using disease discourse might be an expedient means of dealing with a client whose (drug using) needs may be hard to conceptualise or respond to without this template. Gina acknowledged that as her difficulty: “I mean, it was frustrating. But I also felt like the more he dug his heels in, if I kind of challenged him, it just didn't work. So then he would just dig his heels in further, like we were butting heads, you know. So I kind of had to try and look at different ways of getting him to the same in-point. But I kind of didn't get there, anyway. But I mean, ja, it was frustrating, and I guess I kept questioning am I doing wrong. What could I be doing differently? Because on the one hand I think he would have been quite nice to work with, but on the other hand I kept being frustrated because he just wasn't where we all wanted him to be.”

The assurance that Gina appears to have in the disease model informing her client, appears to be the thing that obscures her from reflecting on the notion that the disease discourse that she uses and offers to her client, is the likely obstruction to their understanding

of what may have been useful therapeutic grist in the relationship. Ultimately, Gina comes to the conclusion that: "I mean, it was a lot of this kind of ... it was almost like a fight, mostly, actually, interspersed with some quite useful sessions. But again, that was when I wasn't being too challenging or insistent about certain things." The position that Gina constructs for herself is one of helplessness in the face of the will of her client and his disease of addiction.

Aubrey's sense of his relapse on alcohol and then his drug of choice was that "I suppose, it put me out of control. I'm looking for a bigger high than just the alcohol. And I now know, it's euphoric recall - which I've just learnt here, without thinking about the consequences." Whilst Aubrey's use of disease model language - "out of control" - here reflects his assimilation of this paradigm and his belief in its utility, his construction of his relapse sequence is based on the social notion of peer pressure where "because they want to have a drink on me. Actually, I got ** about going with them. I had my doubts and then eventually I said, ja, okay, let's just go and have one or two beers - and then I'd go with them." The social and psychological need to be with friends drinking alcohol is therefore misunderstood and underemphasised by both the client and the counsellor through their reliance and use of the disease model and the notion of inevitable loss of control. Gina's position is one of informing Aubrey that these are pieces of information about the progression of his disease. Aubrey implies that had he known he had had a disease, this information would have helped him avoid his relapse. Neither Gina nor Aubrey holds in mind the psychological experience that accompanies the initial refusal Aubrey offers his friends. Neither does it develop the notion of how powerfully his friend's requests to join them affected him psychologically, nor how he was convinced to have "one or two beers." Aubrey's desire to drink and turning from thinking about how to negotiate this desire is absent both in his and Gina's conversation about his relapse.

The above vignettes point toward the conclusion that the experience of desire, (not) wanting to drink or drug, is not fully accounted for by conversations that are premised on disease model discourse. Indeed, the curiosity one might consider important when talking about drug using, and the therapeutic alliance and relapse appears to be almost entirely absent.

Holding desire in mind as a discursive dilemma

Misunderstanding is a highly aversive experience in psychotherapy. Bateman (2012), when describing the need for mind-mindedness in (mentalization-based) therapy, often emphasises the reflective role that the counsellor needs to play in psychotherapy, if the therapy is to be effective. He cites the work of authors such as Lambert (2002) which strongly suggests that counsellors who are able to give clients “feedback information [which] indicates whether the client is making the expected amount of progress necessary to finish therapy with a clinically meaningful outcome” is indeed reflective of the therapy outcome and hence the importance of “understanding misunderstanding” in session (Bateman, 2012). This point can be made differently by noting that clients receiving counselling treatment wish for counsellors who demonstrate an “accepting and understanding stance” toward them (Littauer, 2005, p. 28). Whether one takes “understanding” to mean empathy or mentalizing, a high degree of active reflectivity is needed to understand the dilemma facing clients such as Aaron and his struggle with the disease model during treatment: “It’s so entwined with my life, that it is difficult not to want part of that illness. There, that’s it: I want part of that illness. Not the illness, because I haven’t made peace with it, but I want part of what I’ve done in my illness. You know, I’ve done good ... no, it’s not good things ... I’ve had fun. I’ve had fun with my illness. And I want to hold onto those parts, but I don’t want to hold onto other parts.” One might read this excerpt as a client wanting an “accepting and understanding” counsellor

who can talk about addiction without the actual and implicit limits of the disease model in order to repair misunderstanding in their conversations (Littauer, 2005, p. 28).

Yet, there are no perfect counselling situations and counsellors and clients misunderstand one another fairly regularly. These misunderstandings form part of the grist of psychotherapy when an attempt to understand these “errors” is made by counsellors and clients. The aim of understanding and repair rests on the ability of the client but particularly the counsellor, to reflect on and express this misunderstanding and to work on resolving the misunderstanding that has occurred (Ackerman, 2003). These examples of the impact of misunderstanding in therapeutic relationship are highlighted by this counsellor: “I can’t remember specifics ... but he would throw things at me, like trying to tell me I’m doing a kak⁸ job. Not saying it outrightly, not in that many words, but he would ... I can’t remember what ... but it created that feeling.” Another instance shows how misunderstanding damages the therapeutic relationship such as Desiree’s conversations with Jane, where Desiree sees her as being “almost too good to be true” given that their relationship developed to a point where from Desiree’s point of view “I felt like she didn't trust me, and I certainly didn't trust her.”

That misunderstanding occurs is not in question but rather what misunderstanding occurs and how it impacts the therapeutic relationships that are under scrutiny in this analysis. Ultimately, misunderstanding can be iatrogenic if perpetuated as treatment intervention and this point is developed further with reference to Walter, Aaron and their desire to communicate with one another to draw this chapter to its conclusion.

⁸ Afrikaans vernacular: vulgar slang that directly translates as *shit/crap*. Also meaning very poorly done; badly done.

Aaron notes what the impact of feeling misunderstood had had on his "... one-on-one sessions maybe, I didn't feel comfortable talking to [Counsellor] about it" and that as a consequence of the counsellor pursuing a particular therapeutic agenda he felt "... like I have been totally stripped of it [privacy]. Totally stripped." And so indeed the crux of the dilemma that clients and counsellors face when they attempt to understand and discuss the reasons for relapse seem to centre on the struggle to accommodate the idea of desire within conversation premised from a disease model perspective. Furthermore, the positions that clients occupy are constructed in order to be understood from a disease model point of view – consenting, passively ill patients in a sick role is taken as given, enabling the non-mentalistic construction of their relapse. This is deeply unsatisfactory for client and counsellor as is noted by a counsellor Walter constructing himself as a "policeman" when asked about his role in the therapeutic relationship.

The examples used thus far point toward the idea that clients and counsellors are in a positions where, as reflected in their conversation, a struggle to hold one another in mind ensues. Clients construct counsellors as benevolent, experienced teachers whilst also powerful, scary and important guardians of the treatment processes. For the counsellors it would appear that clients need "information", intervention or even policing in order to stop the client from "keeping therapy at bay." Additionally, clients whose behaviour cannot be accounted for in conventional disease model terms, are seen as attitudinally problematic and holding "that I-don't-give-a-fuck attitude" or "borderline." Counsellors construct clients as people whom they expect to behave in a responsible manner in relation to the requirements of treatment once they see the proposed rationale of having a disease. This positioning of the client, their "attitude" or psychiatric diagnosis suggests a set of dismissive expectations in relation to the client's sense of narrative, agency and investment in treatment. Indeed, it is

as if the client's moral compass is frustratingly faulty: good patients ought to respond to invested counsellors appropriately. Clients, who cannot direct their behaviour, need more direction not less; to stick with the structure and instruction of treatment.

This analysis suggests that several points constellate around the notion that disease model discourse orients clients and counsellors to engage one another in non-mentalistic modes of thinking and talking about desire and relapse. The constructed misunderstandings which have been shown in the excerpts above, suggest that expressing psychological desire is possible but not understandable as a feature of disease model based counselling conversations of this sample. It is in this context that holding desire in mind becomes untenable from a disease model perspective. It is this point of view that constructs the discursive therapeutic collapse of understanding desire. Aaron's statement "It's almost like the illness that I want", is an expression of intentional desire in relation to several things – self, illness, counsellor, treatment, family, drugs that the disease model does not fully accommodate. Talking about "relapse ... as almost like the illness that I want" is an attempt at self-regulatory action in the sense that the discursive construction of "almost" represents a wished for but not acted upon desire to return to drug taking. Aaron's drug taking is thus represented as aversive from the point of view of illness and the participant's desirous intent is mentalized.

Aaron's attempt to mentalize himself – to reflect on and consider the relative values he holds, the mental positions he occupies in relation to his drug using, and the desires related to the two puts forward both the ambiguity of having been substance dependent and the desire to no longer be so. This construction is at once reflective and agentic, powerfully narrating a complex set of self-experiences. Yet, the notion of illness that Aaron puts forward

is self-limiting inasmuch as it is a concrete expression of the complex desire that Aaron holds in mind, necessarily translated into the dominant discourse of treatment.

A treatment modality that relies so fully on disease discourse and its application to understanding the unique desire of individuals' return to drug use from the point of view of hegemony, is positioned to both powerfully and non-mentalistically shape and limit desire in the minds of clients and counsellors. Aaron's dilemma when describing his desire appears to be how to construct a discursive position from which he can best understand himself and be understood, in both a research but in particular, a treatment context. Aaron having an "illness" legitimates several aspects of himself in the context of treatment – his desire for drugs, treatment, "fun." Not wanting the "other parts" suggests that he notices he is expected to be responsible for both pleasurable and unpleasant consequences of drug taking and yet constructs a reluctance to accept this as a whole. Therapeutically, this complexity and dilemma might be a useful position from which to explore a range of alternative experiences and perspectives that Aaron may not have considered before. However, in order to do this, counselling Aaron using the disease model, suggests Aaron's illness needs to be reconciled with the idea of treatment and "fun". This means that Aaron's illness is marked as the primary explanatory principle that he ought to use to understand his drug using experience and desire and in that sense trumps all other "fun" alternatives. The dilemma remains that for Aaron to psychologically reconcile the responsibility of "illness" with having "fun." This can only be done by accepting the disease discourse of treatment. In this sense he needs to show he believes that he has the illness of addiction first.

Concluding Observations

The circular logic of establishing evidence for having a disease to treat clients who are seen as having a disease positions both clients and counsellors in psychic equivalence mode. It is in this context that the desire for and exploration of aspects of self is collapsed into a singular disease model treatment narrative. Counsellors search for illness and consequently aim to teach clients to live with his/her disease. Willing clients learn about their disease to reach recovery.

Rather poignantly, Walter makes this statement which, in spite of its reflective qualities is bitterly ironic given his and the above commentary of other counsellors: "Hence, "I mean, again, what keeps on coming to mind is the complexity of it all ... With addiction, to be honest, it's pretty straightforward black or white, but with some patients we do allow them to break certain boundaries because of the patient's profile. Because with Aaron, it wasn't just clear-cut. So I do believe he needs therapy. He needs a lot more therapy." It is this context that single-mindedness can be equated with disease model interventions and the sick, a-libidinal construction of desire dislocated from the individual. In contrast, mind-mindedness is curiosity located in counselling conversation about the desire to use drugs and gain recovery.

Therefore, the "physical stance", illness based, disease model approach it must be concluded, is the antithesis of the mentalizing approach and indeed reveals a deep incompatibility with notions of curiosity, complexity and mind-mindedness needed to approach personal desire, relapse and an effectual addictions counselling conversation (Fonagy et al., 2002, p. 25).

Chapter 6: Conclusions and Recommendations

“Fantasy, it turns out, comes with a lot of infrastructure” (Grossman, 2013, p. 42).

“Whilst it is comforting, and perhaps even necessary to seek refuge in essentialist ideas about ourselves – enunciated in pronouncements like, ‘My name is Stephen and I am an addict’, such statements offer an explicitly one-dimensional account of the self.”

(Bamber, 2010, p. 30).

Introduction

There are many ways to address and conceptualize treating relapse, some of which are evidence-based, medical, motivational, based on moralistic judgement, or put an emphasis on the appreciation of natural consequences of drug use or sustained abstinence. All of these rely on talk about mental states in some significant way, and all have struggled to address relapse. This chapter provides a discussion of the conclusions that can be drawn from this research. It also shows the conclusions in light of the aims of the research: to discover whether clients and counsellors mentalize the notion of relapse in the counselling dyad. The chapter also provides recommendations based on these conclusions.

These conclusions examine a layer of counselling conversation and show that the construction of jargonised disease-model discursive talk turns people toward and from the topic of relapse and hinders the treatment of this complex condition. Indeed, there are very few scenarios in which talk is not deeply influenced by disease model thinking when individuals engaged in counselling respond to relapse. The analysis of counselling talk, the method of analysis itself and context constructed by current literature on the topic of

relapse and addiction counselling, all suggest that there are several areas that need attention when thinking about the issue of how relapse treatment is talked about. The conclusions that follow, are aimed at offering clear positions about the notion of institutional jargon and how people talk about relapse in addiction treatment during counselling sessions.

Conclusions

The following conclusions are presented from the analysis of the research material.

Talk is a primary means to understand individual and institutional non-mentalizing when delivering addiction counselling treatments

Talk, in its various forms, is a substantial part of the addiction treatment endeavour. Undeniably present, talk is often considered a silent fact of treatment when it has such a fundamental role to play in elements of treatment such as counselling. This research took the position that the analysis of talk is a primary means of achieving psychological understanding about how relapse is constructed in the counselling dyad. This positions it in contrast to the disease model of addiction which primarily offers physical explanations for addiction. These explanations are often translated into pseudo-psychological notions and treatment interventions to address addiction and relapse.

This analysis of counselling discourse within a residential addiction treatment context, showed that during counselling conversation, talk was used in specific non-mentalistic ways when considering relapse and its consequences. This occurred at two levels. Firstly, a specific way in which this was evidenced, was by the individual participants of the study (not dissimilarly from many addiction treatment programmes nationally and internationally) who predominantly relied on describing addiction as a “disease”. The

second was that this interpretative repertoire was consonant with that of the research site and other treatment institutions. These institutions typically define their treatment programme as being based on the notion of addiction as a disease because this is an evidence-based way of treating addiction. Following from this, the individuals in this sample primarily constructed relapse as a reified personal symptom of the “disease” of addiction. Reliance on the disease concept meant that participants constructed conversations about health-illness using the interpretative repertoires available in institutional discourse. This allowed them to maintain consonance within the addiction discourse of the institution and maintain a disease model hegemony. Using disease model talk had substantial consequences for the mental model used to construct addiction and represents a necessary use of dominant discourse which is characterised by psychic equivalence. The evidence from the analysis of individual participants’ mode of treatment talk also indicates that the institutional hegemony of the disease model limited the participants’ range of expression of ideas and feelings about addiction and relapse. One of the experiences that the disease model hegemony had a substantial effect on was the talk that constructed the expression of desire.

Institutional talk about *disease* suggests it is used as a discursive means to limit the expression of desire

Co-constructed counselling talk that went in “search” of the “disease” inside the individual, turned participants either from novel ideas about personal relapse experiences or towards protective, self-fulfilling evidence for its existence. The conclusion that can be drawn from this is that institutional addiction treatment talk that relies on pre-formulated notions of addiction as a disease creates treatment contexts which limit the degree to which

addiction and relapse can be thought, felt and talked about during counselling. This conclusion contains an additional element.

The addiction counselling talk of the participants in this sample constructed their wanting of drugs as a “disease” of desire. Consequently, participants’ talk about relapse was constructed as a diseased failure of managing their desire for drug taking adequately, whilst not wanting recovery enough. This had the ill-fated consequence of positioning participants in a dilemma of how to talk about their efforts and desires to access treatment; how to consider their efforts complete in the context of disease and relapse and what recidivism might eventually mean. Indeed, creating the position of addiction as an internal psychological disease constructs a situation where more treatment and making more effort directed participants toward a scenario that would be repetitious, unhelpful and possibly harmful. Diseased desire, in this context, meant that clients were constructed as perverse in their desire for drug taking and needed to be constructed as alibidinal in their pursuit of recovery. It is from this disease model perspective that the contentious position of consent and responsibility as regards engaging treatment is constructed in a psychologically sterile and singular manner.

Counselling talk about relapse – an intricate and negotiated endeavour – framed by institutional repertoires about disease, substantially limited participants’ access to a range of complex psychological factors associated with relapse. Indeed, the constructed hegemony of a range of disease model approaches, which dominate much of addiction treatment, suggests that this is a routine way in which institutions and participants tolerate the often unbearable states of *mind* present in addiction treatment and counselling. Those who receive treatment for addiction remain diseased, full stop. Yet there is a substantial body of evidence that suggests the disease model has limitations – this is positioned and

phrased in many ways that point toward recovery: spontaneous remission, maturing out, “self change” or “natural recovery” (Klingemann et al., 2010, p. 1510). In short, disease model approaches allow for this psychological *defence* against ambiguous, anxiety provoking personal narratives of addiction and relapse.

Additionally, this means that counselling relationships, particularly in time-limited, profit driven settings, are limited by the avoidance of the psychological complexity of relapse to accommodate this contextual reality. However, it does not mean that state funded drug treatment initiatives are free of this simplification. Irrespective of treatment setting, the capacity to talk about relapse and particularly to talk about the desire to use drugs again, is corroded and oversimplified through the use of interpretative repertoires like “disease” and as such, remains sub-textual and in a sense silent. Here the discussion comes to another conclusion about counselling talk which is the negotiation of complexity of desire for a return to drug use, alongside agency.

Singular disease narratives erode individual agency when relapse treatment is negotiated

Participants from this sample used institutional disease model talk that limited the range of conversation about their desire for drug use and recovery. This also indicated that the manner in which participants thought about their treatment experiences was limited. This was achieved by the use of disease model discourse that impacted on both the subject positions participants might occupy as well as how flexibly they may redefine these positions. Disease in this sense became an *idea* or *model* that was used as a psychological mechanism that limited the expression of desire in relation to talk about drug use. Participants who engaged in a institutionally prompted process of projection (you have a disease) and introjection (I have a disease) of non-psychological disease model ideas and

ideology achieved this by the use of disease model talk. Participants in this way achieved a position of health in relation to the treatment programme expectations and perhaps became “good” “healthy” “patients”. This was done in ways that pathologically accommodated the dominant discourse of treatment. Individuals were thought about and hence constructed as “sick”, “other” or “in/out of recovery” in a pathologized discourse about a diseased individuals whose “self-will” was diseased. During the relative crisis of admission and treatment provision, treatment participants’ talk revealed that they “might accentuate the use of defences such as projection and a less complex understanding of social relationships” (Shahar et al., 2010, p. 957). This meant that the notions that they had about desire for drug use and relapse were repressed by discursive turns from complexity in conversation to simplified disease narratives.

This defensive use of simplification – addiction as a disease – by the institution and the participants, engendered a psychological state that mentalization theory describes as psychic equivalence and can be “seen” in the talk of participants, in the activity of projection. Participants, in different ways, spoke of the despair and desperation that their relapse had caused, but struggled to construct a range of alternatives, largely because they used the institutional disease model answer provided for them and projected “into” them: “You have a disease”. This projection constructed clients as sick, resistant, diseased and the counsellors as implicitly well, experts in recovery and health. This discursive practice created a context in which choice and the freedom to choose are presented and constructed as limited by “disease”.

Sadly, in the relative crisis that treatment represents, clients and counsellors believed disease model jargon to be self-evident and true and this curtailed talk about choice, action and responsibility regarding drug use substantially. Holding the disease model

belief in mind, participants sacrificed a degree of personal freedom, choice and ultimately psychological agency in their treatment experience. This enabled the entrenchment of disease model talk and perpetuated non-psychological formulations about relapse in the counselling dyad.

Synthesis

It would be tempting to end the conclusion here. However, there is another layer to these concluding remarks which introduces the recommendations of this study. This study deals with some of the paradoxes inherent in treatment communication and the psychological means that people use to tolerate and react to these ambiguous positions constructed in counselling talk. With no clear answer to the addiction treatment conundrum – a singular cure – clients and counsellors live with a psychological ambiguity that is rarely named: that the disease model, in part, psychologically protects them from unthinkable and unbearable states of mind that repeated drug use and treatment exposure produces. Indeed, diseases like addiction are constructed as legitimately acute or chronic, treatable or incurable whilst being undeniably real. A range of evidence-based models of addiction attests to this but this type of evidence has limits. Relapse without the explanatory power of the disease model is harder to explain and justify. The argument that “genetics or dopamine made me do it” are deeply psychologically unsatisfactory. However, the need to find answers that reflect a psychological dimension and talk about the collapse that relapse represents, may well need to be avoided because in face-to-face counselling talk they are difficult and painful. Those conversations are often fraught with a range of questions – why do you do it, what were you thinking – that can only be answered with personal evidence. It is in this sense, expedient – both clinically and personally – to think about addiction as a no-fault, no-choice illness than one derived from the deep-seated

unknown thoughts and feelings, complex systemic psychological interactions for which there might be little hope of respite.

The model of addiction as a disease limits, relegates or even negates the mind in many ways; in treatment this is necessarily so. This stance allows counsellors to tolerate their client's projection of varied dependencies into them and enables them to assign the experience to their client's illness. It allows for clients' de-stigmatization of their responsibility for their drug use and to allocate this to the disease. It is in this context that the use of the disease model suggests that it is risky to offer choice and agency to clients and counsellors. Indeed, it is because it opens a plethora of questions of how a counselling process might be mind-centred, responsible and active. However, in high demand environments such as the treatment centre in this study, the quicker the lingo is learned and the rules are followed, the better.

Yet, people repeatedly come to and offer treatment for some level of restitution – to please family members, to work at saving their jobs or marriages, to be employed or find respite from the personal cost of addiction or to continue their using path. The disease model says this path is inevitable. The relapsing illness marches on. Perhaps however, there is a psychological alternative. Mentalization theory and critical discourse theory each suggest in different ways that mental states are opaque and motivations often unclear and yet in the observable efforts of talk, counsellors may have access to and tolerate their clients' dependence differently. It is in the specific arena of talk in the counselling relationship in which psychological evidence for relapse is located: where contingent, marked, mirrored interaction may assist in gathering and clarifying the intentions of a drug user and their counsellor (Fonagy et al., 2002). Counsellors may come to accept and acknowledge their treatment limitations, be curious about failure and success as

representative of their ability to have promoted critical, reflective therapeutic talk about mental states related to drug use. Specifically, they may become able to symbolically and symbiotically be a psychological safe drug substitute for their clients even though the clients may not overtly know this – a secure base from which to deal with feelings of otherness and alien difference. In doing this, the ambiguity of the dependence dynamic may be used to scaffold the beginning of psychological independence and relational interdependence. Interestingly, participants of this study showed evidence of their mentalistic capacity by engaging in talk about their relapses and treatment programme. Conducting the research interviews themselves was a psychological and (at times) mentalistic effort that hinged on the participants' mentalistic functioning. The counsellors and clients had moments of mentalizing that were of varying reflective quality during these interviews that suggests the natural flow of conversation. However, the predominant *mode* from which participants talked about relapse and addiction was non-mentalistic and appeared to be a fallback position when responding to questions of a complex emotional, psychological nature. Overall, it appeared that the participants had been shepherded toward an institutionally primed, non-mentalistic stance.

Recommendations

Talk represents an undervalued resource in addiction counselling and also an undervalued means to foreground the powerful psychological factors present in counselling relationships. Future studies about how addiction counselling discourse and addiction treatment talk are utilised as clinical interventions may open up ways to reflect on the successes and failures of addiction treatment through exploration of psychological dilemmas.

These future studies are needed because currently counselling talk is predominantly taken to be a vehicle to access internal diseased thinking – “addictive thinking” and feeling about drugs. This research suggests an alternative to this view and that there are further directions for research, based in critical thinking about counselling talk, not only at a clinical level but at a theoretical level as well. Future research should explore the notion of how mental states are reflected in treatment talk and how these are included in addiction counselling discourse. This would point toward the development of critical theory about how addiction is constructed and thought about in clinical settings, particularly those that have strongly behaviourally focussed interventions.

As such, when people treating recidivism talk to addicts, they need to consider the following recommendations that are both organizational and individual. The evidence from this research suggests that mentalization-based therapy (MBT) has a substantial role to play in clinical settings where addiction is treated and this is a substantial direction for future studies about addiction treatment talk and theory about addiction counselling discourse. MBT is not, however, a panacea. In this context, the first recommendation is crucial: that treatment providers, clients and counsellors talking about addiction and relapse consider these problems in a manner that reflects the complex systemic – and hence relational – issues directly present in counselling talk. In this way, addiction and relapse can be thought and talked about from a psychological point of view. This foregrounds how addiction is talked about and constructed at both individual and institutional levels. Approaching addiction psychologically has implications for clinical interaction at organizational and interpersonal levels.

Organizations that undertake relapse prevention interventions and addiction treatment should consider investing in research that locates mentalization-based therapy as

central to their broad clinical efforts in order to promote mind-minded constructions of treatment. A second aspect of this recommendation is that the research endeavour should focus on and determine mentalization-based therapy's utility and impact on treatment outcome at both qualitative and quantitative research levels. This would require training and use of mentalization-based therapy as part of an organizational and clinical stance in treating addiction. Given that mentalization-based therapy has been manualized for the treatment of Borderline Personality Disorder, it is a likely future challenge that manualized treatment is specifically developed for application in the context of addiction treatment and relapse. A manualized mentalization-based intervention for addiction treatment is itself not novel (Suchman et al., 2010). However, a manualized treatment that is explicitly focused on mental states which will require that clients and counsellors revisit their disease-based conceptualization, formulation and intervention activities to address relapse, is new.

In order to achieve this, institutions which offer treatment for addiction and relapse will need to audit, reflect on and challenge their treatment assumptions, skills and practices in a systematic manner on a regular basis to promote training in psychological therapies. This would ideally be initiated by internal institutional processes or alternatively, held as a requirement of statutory regulatory bodies of hospitals and professional staff.

Mentalization-based therapy in this context is likely to be a potentially helpful method in which staff might be trained. One important cautionary comment is attached to this recommendation. Training in mentalization-based therapy and manualizing treatment for addiction treatment offerings runs the risk of becoming non-reflective itself if it neglects to examine its own discursive construction in context, when applied to an organizational or individual change process. As such, the essence of this recommendation is not to create a false dichotomy in which mentalization-based treatment is offered as a solution to disease

model treatment. Rather the recommendation is for individuals and organizations to actively promote critical evaluation of practices and promote psychological interventions in the addiction treatment context.

Second, individual staff members and groups of staff of addiction treatment institutions should be encouraged and supported to actively engage in reflection on the psychological treatment context and discourse which they participate in constructing. Research strongly suggests supervision is a critical component of addiction treatment and therefore future research about the therapeutic impact of counsellors talk about treatment models they use to construct addiction treatment would have significant value (Knudsen, Ducharme, & Roman, 2008). Collaborative supervision and reflection on the cohesiveness of clinical interventions would mean a commitment of time and other institutional resources to create regular staff “events”, workshops, group staff planning and facilitated discussion about what best (psychological) practice in the treatment initiatives offered at institutions might be/become. These interactions would be used to identify, discuss and reflect on clinical, institutional and staff-patient narratives to highlight and address impasses that draw on pre-mentalistic modes of psychological functioning which occur from time to time. Pragmatically, they may centre on programme evaluation, maintenance and optimization of client-staff interaction so that staff and clients see treatment as a “seamless system” of “opportunity not a punishment” (Taxman, 1998). This would be part of an ongoing endeavour to create a culture of psychologically reflective and critical thinking and activity about clinical practice rather than to root out “bad practice”. Facilitators who have experience and understanding of the practice and theory of mentalization would be able to contribute toward achieving this aim. This, alongside training in mentalization-based therapy, would require the inclusion of staff supervision, knowledge sharing and discussion

about best treatment practice. At the level of counselling talk, mentalization theory and therapy suggests curiosity, not knowing and active participation as positions in therapy sessions. The following suggestions appear to be apt considerations in the addiction treatment context and are interwoven with some of Bateman, Fonagy and Skårderud's thoughts on mentalization-based interventions counselling (Bateman & Fonagy, 2003, p. 195; Skårderud, 2007, pp. 331-336):

1. Minding the body and making a "shift from body to embodiment" in order to include the notion of subjectivity and intersubjectivity (Skårderud, 2007, p. 335). This is particularly pertinent to drug use and the struggle to hold drug use and the body in mind. This is often where psychic equivalence is most potent for addicts and counsellors, and disease model thinking creates a struggle to represent feelings fully. Shame-reactions regarding the body and emotional states are all too common in addiction treatment.
2. Psycho-education should be offered to client and counsellors in order to create a context in which they become empowered by expertise and information about the physical as well as the psychological dimensions of drug use.
3. Counsellors should have the skill to develop clarity of purpose and agreed upon therapeutic expectations between themselves and the client. Some of this discussion may centre on the notion of the functions that a symptom possesses for the client. In this sense the notion of so-called "cross-addiction", can overwhelm and confuse clients and counsellors by attempting to deal with the breadth of addictive appetite. Contracting to realistic therapeutic agreements that are sustainable between treatment provider and client is essential in this context.

4. Interventions should be offered to the client which are based on a consideration of the stability of the client's self-structure and their ability to tolerate interventions. In this context a willingness to engage clients in discussions about unspoken, difficult topics that may have elements that are non-negotiable are important e.g. abstaining from drug use; amount of drug used in harm reduction intervention. This relates to point 3 inasmuch as symptoms can point toward mental frailties that are longstanding and that need careful psychological attention e.g. personality disorders.
5. Mental closeness by the therapist should be by marked and contingent interaction. This is based on a mentalizing stance which is "an ability on the therapist's part to question continually what mental states both within the patient and within themselves can explain what is happening" in their interaction with one another (Skårderud, 2007, p. 333). It is in this context that treatment compliance, psychic equivalence and pretend mode need addressing in an attuned, clear manner. This is in order to look at issues of secondary gain, compensatory psychological defensiveness and over-simplification alongside the treatment of drug use. Acceptance of and understanding psychological phenomena such as projection that are present in conversation, coupled with the ability to negotiate this effectively in a clinical setting, is crucial for addiction treatment.
6. Related to point 5, addiction counsellors who are able to flexibly and curiously talk about psychological states, like projection, in a sense free themselves from persistently being trapped by pre-mentalistic modes of thinking. Additionally, counsellors who are able to model curiosity, "live with" and reflect on these experiences (in session) offer clients a mental experience that can be learnt from in vivo.

7. Therefore, following from point 6, counsellors that offer therapeutic statements that flexibly allow for here-and-now talk to assist in clients' representation of mental states to allow for mentalizing discourse to develop.

These suggestions derive, in large part, from the notion of the opacity of mental states and offer a set of principles to guide client-counsellor interaction rather than a formula for therapy. This essentially suggests that promoting mentalization becomes part of a treatment intervention and psychological component of addiction treatment process that individual staff members and organizations offer. It ought to be said here that a list of principles does not suggest that a useful psychotherapy or counselling recipe exists. Yet, the ideas suggested here have relevance to drug users inasmuch as they can represent a substantial attempt to promote psychological thinking about a syndrome and treatment process often saturated by talk reflective of psychic equivalence mode.

Third, individuals directly offering treatment interventions should be provided access to supervision and training that encourages reflectivity about institutional treatment positions and practices and the importance of institutional and individual mind-mindedness. Treating addiction can be draining clinical work, where all too often clients' needs, demands and wants are dismissed because they are seen as primitive, petulant or entitled. In this context, those who work in the addiction field need substantial support, supervision and training. This of course requires institutions and practitioners to invest in a longer term view of addiction treatment service provision given the cost that training and supervision represent. There are of course novel ways to access information, share resources and collaborate with the use of technology that are already available to many treatment centres. What is perhaps needed is the framework within which to establish support for addiction treatment counsellors and professionals which is viable and acceptable. The

Professionals in Crisis programme of the Menninger Clinic is a good example of a cohesive attempt to care for the psychological wellbeing of health care providers from a mentalization point of view (Bleiberg, 2003).

Fourth, it is recommended that professionally accredited staff and staff who are not formally qualified collaborate in defining treatment methods, goals, processes and programmes in a way that is led by local and international evidence about addiction and relapse treatment. This would be to identify and select interventions based on their value to particular treatment programmes from the point of view of current evidence as well as their psychological valence. This would require the discussion about and use of mentalization-based principles to structure treatment interventions and planning so that a cohesive treatment intervention narrative might be developed. In this context, mentalization-based therapy principles might be used effectively to foreground psychological mindedness in treatment processes and interventions.

These recommendations suggest that there is a substantial effort required of organisations and individuals to understand the potency of psychological elements of their treatment offerings regarding relapse and addiction. There is likely to be some significant effort required to promote the idea that talk about mental states has a substantial role to play in treatment of relapse alongside biomedical and behavioural interventions. The challenge ahead for treatment organizations, counselling staff and clients remains: to construct and engage in mind-minded interventions to treat addiction that embody a spirit of curiosity, flexibility and critical awareness.

References

- Ackerman, S. H. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, 1–33.
- Agrawal, A., Wetherill, L., Bucholz, K., Kramer, J., Kuperman, S., Lynskey, M., . . . Bierut, L. (2013). Genetic influences on craving for alcohol. *Addictive behaviors*, 38(2), 1501-1508.
- Alcoholics Anonymous World Services. (2001). *Alcoholics Anonymous: The story of how many men and women have recovered from alcoholism* (4th ed.). New York: Alcoholics Anonymous World Services.
- Allen, J. (2003). Mentalizing. *Bulletin of the Menninger Clinic*, 67(2: Special Issue), 91-112.
- Allen, J. G. (2006). Mentalizing in practice. In P. A. Fonagy (Ed.), *The handbook of mentalization-based treatment* (pp. 3-30). Chichester: John Wiley & Sons.
- Allen, J., & Fonagy, P. (2002). *The development of mentalizing and its role in psychopathology and psychotherapy. (Technical Report No. 02-0048.)*. Research Department. Topeka, KS: The Menninger Clinic.
- Allen, J., Bleiberg, E., & Haslam-Hopwood, T. (2013, December 10). Understanding mentalizing: Mentalizing as a compass for treatment. Houston, Texas, U.S.: The Menninger Clinic. Retrieved from <http://www.menningerclinic.com/education/clinical-resources/mentalizing>
- Allen, J., Fonagy, P., & Bateman, A. (2008). *Mentalizing in clinical practice*. Arlington: American Psychiatric Publishing.
- Allen, J., Stein, H., Fonagy, P., Fultz, J., & Target, M. (2005). Rethinking adult attachment: a study of expert consensus. *Bulletin of the Menninger Clinic*, 69(1), 59-80.

Althusser, L. (2006). Ideology and ideological state apparatuses (notes towards an investigation). In A. Sharma, & A. Gupta (Eds.), *The anthropology of the state: A reader* (pp. 86-111). Malden, MA: Blackwell.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (Text Revision ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Arlington, VA: American Psychiatric Association.

American Psychiatric Association. (2013, July 29). *Substance-related and addictive disorders fact sheet*. Retrieved from www.dsm5.org:

<http://www.dsm5.org/Documents/Substance%20Use%20Disorder%20Fact%20Sheet.pdf>

American Society of Addiction Medicine. (2013, August 1). *American Society of Addiction Medicine - For the Public*. Retrieved from American Society of Addiction Medicine:

<http://www.asam.org/for-the-public/definition-of-addiction>

Annis, H., Schober, R., & Kelly, E. (1996). Matching Addiction Outpatient Counseling to Client Readiness for Change: The Role of Structured Relapse Prevention Counseling. *Experimental and Clinical Psychopharmacology*, 4(1), 37-45.

Antaki, C., Billig, M., Edwards, D., & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *Discourse Analysis Online*, 1(1), 1-12. Retrieved from <http://www.shu.ac.uk/daol/previous/v1/n1/index.htm>

Aronson, J. (1994). A pragmatic view of thematic analysis. *The Qualitative Report*, 2(1), 1-3.

Bailey, L. (2005). Control and desire: The issue of identity in popular discourses of addiction. *Addiction Research and Theory*, 13(6), 535-543.

- Baker, H., & Baker, M. (1987). Heinz Kohut's self psychology: An overview. *American Journal of Psychiatry*, 1-9.
- Bamber, S. (2010). *Recovery writing volume one: 2009-2010*. Manchester: The Art of Life Itself.
- Banai, E., Mikulincer, M., & Shaver, P. (2005). "Selfobject" needs in Kohut's self psychology: Links with attachment, self-cohesion, affect regulation, and adjustment. *Psychoanalytic Psychology*, 22(2), 224.
- Bateman, A. (2012). *Introduction to mentalizing*. London:
<http://www.ucl.ac.uk/psychoanalysis/unitstaff/>.
- Bateman, A., & Fonagy, P. (2003). The development of an attachment-based treatment program for borderline personality disorder. *Bulletin of the Menninger Clinic*, 187-211., 67(3: Special Issue), 187-211.
- Bateman, A., & Fonagy, P. (2009). Borderline personality disorder. In A. W. Bateman, & P. Fonagy (Eds.), *Handbook of mentalizing in mental health practice* (pp. 757-779). Arlington: American Psychiatric Publishing.
- Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry*, 9(1), 11-15.
- Baumeister, R. (2002). Ego depletion and self-control failure: An energy model of the self's executive function. *Self and Identity*, 1(2), 129-136.
- Baumeister, R., Bratslavsky, E., Muraven, M., & Tice, D. (1998). Ego depletion: Is the active self a limited resource? *Journal of Personality and Social Psychology*, 74(5), 1252-1264.
- Benford, R., & Gough, B. (2006). Defining and defending 'unhealthy' practices : A discourse analysis of chocolate 'addicts' accounts. *Journal of Health Psychology*, 11, 427-440.

- Berridge, K., & Robinson, T. (1998). What is the role of dopamine in reward: hedonic impact, reward learning, or incentive salience? *Brain Research Review*, 28, 309–369.
- Berridge, K., & Robinson, T. E. (2011). Drug addiction as incentive sensitization. In J. Poland, & G. Graham (Eds.), *Addiction and Responsibility* (pp. 21-53). London: The MIT Press.
- Berridge, K., Robinson, T., & Aldridge, J. (2009). Dissecting components of reward: 'liking', 'wanting', and learning. *Current opinion in pharmacology*, 9(1), 65-73.
- Beutler, L., Harwood, T., Kimpara, S., Verdirame, D., & Blau, K. (2011). Coping style. *Journal of Clinical Psychology*, 67(2), 176–183.
- Beutler, L., Harwood, T., Michelson, A., Song, X., & Holman, J. (2011). Resistance/reactance Level. *Journal of Clinical Psychology*, 67(2), 133–142.
- Billig, M. (1999). *Freudian repression: conversation creating the unconscious*. Cambridge, UK.: Cambridge University Press.
- Billig, M. (2001). Discursive approaches to studying conscious and unconscious thoughts. In D. Tolman, & M. Brydon-Miller (Eds.), *From Subjects to Subjectivities* (pp. 290-303). New York: New York University Press.
- Billig, M. (2003). Critical discourse analysis and the rhetoric of critique. In G. Weiss, & R. Wodak (Eds.), *Critical discourse analysis: theory and interdisciplinarity* (pp. 35-46). New York: Palgrave Macmillan Ltd.
- Billig, M. (2006). A psychoanalytic discursive psychology: From consciousness to unconsciousness. *Discourse Studies*, 8(1), 17-24.
- Bleiberg, E. (2003). Treating professionals in crisis: a framework focused on promoting mentalizing. *Bulletin of the Menninger Clinic*, 67(3: Special Issue), 212-226.

- Blum, K., Chen, A., Giordano, J., Borsten, J., Chen, T., Hauser, M., . . . Barh, D. (2012). The addictive brain: all roads lead to dopamine. *Journal of psychoactive drugs*, *44*(2), 134-143.
- Borkman, T., Kaskutas, L., & Owen, P. (2007). Contrasting and converging philosophies of three models of alcohol/other drugs treatment: Minnesota model, social model, and addiction therapeutic communities. *Alcoholism Treatment Quarterly*, *25*(3), 21-38.
- Bossert, J., Stern, A., Theberge, F., Marchant, N., Wang, H., Morales, M., & Shaham, Y. (2012). Role of projections from ventral medial prefrontal cortex to nucleus accumbens shell in context-induced reinstatement of heroin seeking. *The Journal of Neuroscience*, *14*, 4982-4991.
- Bowen, S., Chawla, N., & Marlatt, G. (2011). *Mindfulness-based relapse prevention for addictive behaviours: A clinician's guide*. New York: Guilford Press.
- Bowles, S., Louw, J., & Myers, B. (2011). Perceptions of organizational functioning in substance abuse treatment facilities in South Africa. *International Journal of Mental Health and Addiction*, *9*(3), 308-319.
- Brewer, J. (2003). Interviews. In R. Miller, & J. Brewer (Eds.), *The AZ of social research: a dictionary of key social science research concepts* (pp. 166-170). London: Sage Publications.
- Buckland, H. T., & Cunningham, S. (2013). Addiction & the brain: What's stress got to do with it? *The American Biology Teacher*, *75*(2), 136-137.
- Butler, S. (2011). Addiction counsellors in the Republic of Ireland: Exploring the emergence of a new profession. *Drugs: Education, Prevention & Policy*, *18*(4), 295-302.
- Cardinal, R., & Everitt, B. (2004). Neural and psychological mechanisms underlying appetitive learning: links to drug addiction. *Current Opinion in Neurobiology*, *14*(2), 156-162.

- Carter, R., Johnson, S., Exline, J., Post, S., & Pagano, M. (2012). Addiction and “generation me”: narcissistic and prosocial behaviors of adolescents with substance dependency disorder in comparison to normative adolescents. *Alcoholism Treatment Quarterly*, 30(2), 163-178.
- Chouliaraki, L., & Fairclough, N. (2010). Critical discourse analysis in organizational studies: Towards an integrationist methodology. *Journal of Management Studies*, 47(6), 1213-1218.
- Connors, G., DiClemente, C., Velasquez, M., & Donovan, D. (2013). *Substance abuse treatment and the stages of change: selecting and planning interventions* (2nd ed.). New York: Guilford Press.
- Constantino, M. J., Arnkoff, D. B., Glass, C. R., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. *Journal of Clinical Psychology*, 67(2), 184–192.
- Cook, C. (1988). The minnesota model in the management of drug and alcohol dependency: miracle, method or myth? Part I. The philosophy and the programme. *British Journal of Addiction*, 83, 625-634.
- Cromby, J. (2007). Integrating social science with neuroscience: Potentials and problems. *BioSocieties*, 2, 149–169.
- Cromby, J. (2012). The affective turn and qualitative health research. *International Journal of Work Organisation and Emotion*, 5(2), 145-158.
- Cromby, J., Newton, T., & Williams, S. J. (2011). Neuroscience and subjectivity. *Subjectivity*, 4(3), 215-226.
- Davies, B., & Harré, R. (1990). Positioning: the discursive production of selves. *Journal for the Theory of Social Behavior*, 20(1), 43–63.
- Davies, J. (1997). *Drugspeak: The analysis of drug discourse*. Amsterdam: Harwood Academic Publishers.

- Dennett, D. (1989). *The intentional stance*. Massachusetts, USA: MIT Press.
- Di Nucci, E. (2013). Addiction, Compulsion, and Agency. *Neuroethics*, 1-3.
- DiClemente, C., Holmgren, M., & Rounsaville, D. (2011). Relapse prevention and recycling in addiction. *Addiction Medicine*, 765-782.
- DiClemente, C., Schlundt, D., & Gemmell, L. (2004). Readiness and stages of change in addiction treatment. *The American Journal on Addictions*, 13, 103–119.
- Dingel, M. J., Hammer, R., Ostergren, J. E., McCormick, J. B., & Koenig, B. A. (2012). Chronic addiction, compulsion, and the empirical evidence. *AJOB Neuroscience*, 3(2), 58-59.
- Donmall, M., Jones, A., Weston, S., Davies, L., & Hayhurst, K. P. (2012). The drug treatment outcomes research study (DTORS): Research design and baseline data. *Open Addiction Journal*, 5, 1-11.
- Edley, N. (2001). Analysing masculinity: Interpretative repertoires, ideological dilemmas and subject positions. In M. T. Wetherell, & S. Yates, *Discourse as data: A guide to analysis* (pp. 189-228). London: Sage Publications Ltd.
- Eliot, T. (1963). *Collected poems 1909-1962*. Suffolk: Faber & Faber.
- Everitt, B., & Robbins, T. (2005). Neural systems of reinforcement for drug addiction: from actions to habits to compulsion. *Nature Neuroscience*, 8(11), 1481-1489.
- Fairclough, N. (1989). *Language and Power*. New York: Longman.
- Fairclough, N. (2000). Discourse, social theory, and social research: The discourse of welfare reform. *Journal of Sociolinguistics*, 4(2), 163-195.
- Fairclough, N. (2001). Critical discourse analysis as a method in social scientific research. In R. Wodak, & M. Meyer (Eds.), *Methods of Critical Discourse Analysis* (pp. 121-138). London: Sage.

- Fairclough, N. (2001). The discourse of new labour: Critical discourse analysis. In M. Wetherell, S. Taylor, & S. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 229-266). London: Sage Publications.
- Fairclough, N. (2012). Critical discourse analysis. *International Advances in Engineering and Technology (IAET)*, 452-487.
- Fairclough, N., & Wodak, R. (1997). Critical discourse analysis. In T. van Dijk, *Discourse Studies. A Multidisciplinary Introduction* (pp. 258 - 284). London: Routledge.
- Fecteau, S., Fregni, F., Boggio, P. C., & Pascual-Leone, A. (2010). Neuromodulation of decision-making in the addictive brain. *Substance Use & Misuse*, 45(11), 1766-1786.
- Feltenstein, M., & See, R. (2013). Systems level neuroplasticity in drug addiction. *Cold Spring Harbour Perspectives in Medicine*, 3(7), 1-19.
- Flores, P. (2004). *Addiction as an attachment disorder*. Oxford: Jason Aronson.
- Foddy, B. (2010). Addiction and its sciences - philosophy. *Addiction*, 106, 25-31.
- Fonagy, P. (1991). Thinking about thinking: Some clinical and theoretical considerations in the treatment of a borderline patient. *International Journal of Psychoanalysis*, 72(639), 639-654.
- Fonagy, P., & Bateman, A. (2007). Mentalizing and borderline personality disorder. *Journal of Mental Health*, 83-101.
- Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and Psychopathology*, 21(4), 1355-1381.
- Fonagy, P., & Target, M. (1996). Playing With Reality: I. Theory Of Mind And The Normal Development Of Psychic Reality. *International Journal of Psycho-Analysis*, 77, 217-233.

- Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology, 9*, 679-700.
- Fonagy, P., & Target, M. (2006). The mentalization-focussed approach to self pathology. *Journal of Personality Disorders, 544-576*.
- Fonagy, P., Gergley, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization and the development of the self*. New York: Other Press.
- Fonagy, P., Steele, M., Moran, G., Steele, H., & Higgitt, A. (1993). Measuring the ghost in the nursery: An empirical study of the relation between parents' mental representations of childhood experiences and their security of attachment. *Journal of the American Psychoanalytic Association, 41* (4), 957-989.
- Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective-functioning manual, version 5.0, for application to adult attachment interviews*. London: University College London.
- Gergley, G., & Watson, J. (1996). The social biofeedback theory of parental affect-mirroring: The development of emotional self-awareness and self-control in infancy. *International Journal of Psychoanalysis, 77*, 1181-1212.
- Gibson, B., Acquah, S., & Robinson, P. (2004). Entangled identities and psychotropic substance use. *Sociology of Health & Illness, 26*(5), 597–616.
- Gillham, B. (2005). *Research Interviewing*. New York: Open University Press.
- Gorski, T. (2000). *The CENAPS model of relapse prevention therapy (CMRPT). Approaches to Drug Abuse Counselling (NIH Publication No. 00-4151)*. Bethesda, MD: National Institute on Drug Abuse.
- Gorski, T. (2009). *Passages through recovery: An action plan for preventing relapse*. Minnesota: Hazelden Publishing.

- Gossop, M., Marsden, J., Stewart, D., & Treacy, S. (2001). Outcomes after methadone maintenance and methadone reduction treatments: two-year follow-up results from the National Treatment Outcome Research Study. *Drug and alcohol dependence, 62*(3), 255-264.
- Grossman, L. (2013, December). Where the magic happens. *Time, 182*(25).
- Hammersley, R., & Reid, M. (2002). Why the pervasive addiction myth is still believed. *Addiction Research & Theory, 10*(1), 7-30.
- Hasin, D., Hatzenbuehler, M., Keyes, K., & Ogburn, E. (2006). Substance use disorders: Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV) and International Classification of Diseases, (ICD-10). *Addiction, 101*(s1), 59-75.
- Haviland, M., Hendryx, M., Shaw, D., & Henry, J. (1994). Alexithymia in women and men hospitalized for psychoactive substance dependence. *Comprehensive Psychiatry, 35*(2), 124–128.
- Hayes, S. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35*(4), 639-665.
- Hayes, S., Luoma, J., Bond, F., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy, 44*(1), 1-25.
- Hettema, J., Steele, J., & Miller, W. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1*, 91–111.
- Holmes, J. (2006). Mentalization from a psychoanalytic perspective: What's new? In J. G. Allen, & P. Fonagy (Eds.), *Handbook of mentalization-based treatment* (pp. 31-51). Chichester: John Wiley & Sons Ltd.
- Holt, M. (2007). Agency and dependency within treatment: Drug treatment clients negotiating methadone and antidepressants. *Social Science & Medicine, 64*(9), 1937-1947.

- Hutchison, K. (2000). Toward bridging the gap between biological, psychobiological and psychosocial models of alcohol craving. *Addiction, 95*(2), S229-S236.
- Hyman, S. (2010). The diagnosis of mental disorders: the problem of reification. *Annual Review of Clinical Psychology, 6*, 155-179.
- Johnson, B. (2003). Commentary on " understanding addictive vulnerability". *Neuropsychanalysis: An Interdisciplinary Journal for Psychoanalysis and the Neurosciences, 5*(1), 29-34.
- Jørgensen, M., & Phillips, L. (2002). *Discourse analysis as theory and method*. London: SAGE Publications.
- Jurist, E. (2005). Mentalized affectivity. *Psychoanalytic Psychology, 22*(3), 426–444.
- Kalivas, P., & Brady, K. (2012). Getting to the core of addiction: Hatching the addiction egg. *Nature Medicine, 18*(4), 502-503.
- Kalivas, P., & Volkow, N. (2005). The neural basis of addiction: A pathology of motivation and choice. *The American Journal of Psychiatry, 162*(8), 1403-1413.
- Karasaki, M., Fraser, S., Moore, D., & Dietze, P. (2013). The place of volition in addiction: Differing approaches and their implications for policy and service provision. *Drug and Alcohol Review, 32*, 195–204.
- Keane, H. (2002). *What's wrong with addiction?*. Victoria: Melbourne University Press.
- Keane, H. (2004). Disorders of desire: Addiction and problems of intimacy. *Journal of Medical Humanities, 25*(3), 189-204.
- Kemp, R. (2012). The symbolic constitution of addiction: Language, alienation, ambivalence. *Health, 16*(4), 434-447.
- Khantzian, E. (1997). The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. *Harvard Review of Psychiatry, 4*(5), 231-44.

- Khantzian, E. (2003). Understanding addictive vulnerability: An evolving psychodynamic perspective. *Neuro-Psychoanalysis, 2003, 5 (1), 5(1), 5-56.*
- Khantzian, E., Mack, J., & Schatzberg, A. (1974). Heroin use as an attempt to cope: Clinical observations. *The American Journal of Psychiatry, 131(2), 160-164.*
- Kirby, K., Petry, N., & Bickel, W. (1999). Heroin addicts have higher discount rates for delayed rewards than non-drug-using controls. *Journal of Experimental Psychology: General, 128(1), 78.*
- Kissen, M. (2006). Increasing executive and “self-soothing” capacities in the treatment of addictive disorders. *Bulletin of the Menninger Clinic, 70(3), 202-209.*
- Klingemann, H., Sobell, M., & Sobell, L. (2010). Continuities and changes in self-change research. *Addiction, 105(9), 1510-1518.*
- Knudsen, H., Ducharme, L., & Roman, P. (2008). Clinical supervision, emotional exhaustion, and turnover intention: A study of substance abuse treatment counselors in the Clinical Trials Network of the National Institute on Drug Abuse. *Journal of Substance Abuse Treatment, 35(4), 387-395.*
- Kohut, H. (1977). *Preface in J.D. Blaine & A.D. Julius (Eds.). Public Health Service: Alcohol, Drug Abuse and Mental Health Administration, Health, Education and Welfare . Washington, DC: NIDA Publication No. ADM 77- 470.*
- Koob, G. F. (2008). A role for brain stress systems in addiction. *Neuron, 59, 11-33.*
- Koob, G. F., & Le Moal, M. (2001). Drug addiction, dysregulation of reward, and allostasis. *Neuropsychopharmacology, 24(2), 97-129.*
- Koob, G., & Kreek, M. (2007). Stress, dysregulation of drug reward pathways, and the transition to drug dependence. *The American Journal of Psychiatry, 164(8), 1149-1159.*

- Koob, G., & Le Moal, M. (1997). Drug abuse: hedonic homeostatic dysregulation. *Science*, 278(5335), 52-58.
- Koob, G., & Simon, E. (2009). The neurobiology of addiction: Where we have been and where we are going. *Journal of Drug Issues*, 39(1), 115–132.
- Koob, G., Rocio, M., Carrera, A., Gold, L., Heyser, C., Maldonado-Irizarry, C., . . . Weiss, F. (1998). Substance dependence as a compulsive behavior. *Journal of Psychopharmacology*, 12(1), 39-48., 12(1), 39-48.
- Kunce, J. T., & Newton, R. M. (1989). Normal and psychopathological personality characteristics of individuals in alcohol rehabilitation. *Journal of Counseling Psychology*, 36(3), 308.
- Kurtz, E. (1979). *Not-God: A history of alcoholics anonymous*. Center City, MN: Hazelden Educational Services.
- Larkin, M., & Griffiths, M. (2002). Experiences of addiction and recovery: the case for subjective accounts. *Addiction Research and Theory*, 10(3), 281-311.
- Leshner. (1997). Addiction is a brain disease, and it matters. *Science*, 278(5335), 45-47.
- Leshner, A. (1999). Science-based views on drug addiction and its treatment. *Journal of the American Medical Association*, 282(14), 1314-1316.
- Leshner, A., & Koob, G. (1999). Drugs of abuse and the brain. *Proceedings of the Association of American Physicians*, 111(2), 99-108.
- Levy, D., & Truman, S. (2002). Reflective functioning as mediator between drug use, parenting stress and child behavior. *Paper presented at the College of Problems of Drug Dependence*. Quebec City, Quebec.
- Levy, K., Ellison, W., Scott, L. N., & Bernecker, S. L. (2011). Attachment style. *Journal of Clinical Psychology*, 67(2), 193–203.

- Levy, N. (2011). Addiction, responsibility and ego depletion. In J. Poland, & G. Graham (Eds.), *Addiction and responsibility* (pp. 89-111). London: The MIT Press.
- Littauer, H. S. (2005). Qualities clients wish for in their therapists. *Scandinavian Journal of Caring Sciences*, 28-31.
- Lundahl, B., & Burke, B. (2009). The effectiveness and applicability of motivational interviewing: A practice-friendly review of four meta-analyses. *Journal of Clinical Psychology*, 65(11), 1232-1245.
- Lyvers, M. (2000). " Loss of control" in alcoholism and drug addiction: a neuroscientific interpretation. *Experimental and Clinical Psychopharmacology*, 8(2), 225-282.
- Marlatt, G., & Gordon, J. (Eds.). (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behavior*. New York: Guilford Press.
- Martino, S. (2010). Strategies for training counselors in evidence-based treatments. *Addiction Science and Clinical Practice*, 5(2), 30–39.
- McCarty, D., McConnell, K., & Schmidt, L. (2010). Priorities for policy research on treatments for alcohol and drug use disorders. *Journal of Substance Abuse Treatment*, 39(2), 87-95.
- McLaughlin, J. (2009). Discourse or cognition: An introduction to discursive psychology. *Journal of Systemic Therapies*, 50–61.
- McLellan, A., Lewis, D., O'Brien, C., & Kleber, H. (2000). Drug dependence, a chronic medical illness. *JAMA: The Journal of the American Medical Association*, 284(13), 1689-1695.
- Meier, P., Donmall, M., Barrowclough, C., McElduff, P., & Heller, R. (2005). Predicting the early therapeutic alliance in the treatment of drug misuse. *Addiction*, 100(4), 500-511.

- Meier, P., Donmall, M., McElduff, P., Barrowclough, C., & Heller, R. (2006). The role of the early therapeutic alliance in predicting drug treatment dropout. *Drug and Alcohol Dependence*, 83(1), 57-64.
- Mein, E., & Fernyhough, C. (1999). Linguistic acquisitional style and mentalising development: The role of maternal mind-mindedness. *Cognitive Development*, 14, 363–380.
- Merriam-Webster. (2004). *Merriam-Webster's collegiate dictionary* (11 ed.). Springfield, Mass.: Merriam-Webster Inc.
- Meyer, M. (2001). Between theory, method, and politics: positioning of the approaches to the CDA. In R. Wodak, & M. Meyer (Eds.), *Methods of Critical Discourse Analysis*. London: Sage.
- Meyer, R. (1996). The disease called addiction: emerging evidence in a 200-year debate. *Lancet*, 347(8995), 162-166.
- Michels, R. (2008). Epilogue thinking about mentalization. In P. Fonagy, & J. G. Allen (Eds.), *Handbook of Mentalization-Based Treatment* (pp. 327-333). Chichester, UK: John Wiley & Sons, Ltd.
- Miller, W., & Carroll, K. (2006). *Rethinking substance abuse: What the science shows, and what we should do about it*. New York: Guilford Press.
- Moeller, F. (2012). Sex, stress, and drug cues in addiction. *American Journal of Psychiatry*, 169(4), 351-353.
- Mohammadpoorasl A, F. A. (2012). Addiction relapse and its predictors: A prospective study. *Addiction Research & Therapy*, 3(1), 1-3.
- Moore, M. (2005). The transtheoretical model of the stages of change and the phases of transformative learning comparing two theories of transformational change. *Journal of Transformative Education*, 4, 394-415.

- Myers, B., Fakier, N., & Louw, J. (2009). Stigma, treatment beliefs, and substance abuse treatment use in historically disadvantaged communities. *African Journal of Psychiatry, 12*(3), 218-222.
- Myers, B., Louw, J., & Fakier, N. (2008). Alcohol and drug abuse: removing structural barriers to treatment for historically disadvantaged communities in Cape Town. *International Journal of Social Welfare, 17*(2), 156-165.
- Myers, B., Parry, C., & Plüddemann, A. (2004). Indicators of substance abuse treatment demand in Cape Town, South Africa (1997–2001). *Curationis, 27*-31.
- Najavits, L., & Weiss, R. (1994). Variations in therapist effectiveness in the treatment of patients with substance use disorders: an empirical review. *Addiction, 89*(6), 679-688.
- Narcotics Anonymous. (1976). *Who, What, How, and Why*. Narcotics Anonymous World Services, Inc.
- Narcotics Anonymous World Services, Inc. (1989). *Who, What, How, and Why*. Narcotics Anonymous World Services, Inc.
- National Institute on Drug Abuse. (2009). *Principles of drug addiction treatment: A research-based guide*. USA: National Institutes of Health.
- National Institute on Drug Abuse. (2013, August 9). *DrugFacts: Treatment approaches for drug addiction*. Retrieved from National Institute on Drug Abuse:
<http://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>
- National Institute on Drug Abuse. (2013, July 12). *The science of drug abuse and addiction*. Retrieved from National Institute on Drug Abuse: <http://www.drugabuse.gov/>
- Neuman, W. (2000). *Social research methods: Qualitative and quantitative approaches*. Boston: Allyn and Bacon.

- Noël, X., Brevers, D., & Bechara, A. (2013). A neurocognitive approach to understanding the neurobiology of addiction. *Current Opinion in Neurobiology*, 23(4), 632–638.
- O'Malley, P., & Valverde, M. (2004). Pleasure, Freedom and Drugs The Uses of 'Pleasure' in Liberal Governance of Drug and Alcohol Consumption. *Sociology*, 38(1), 25-42.
- O'Brien, C., Childress, A., Ehrman, R., & Robbins, S. (1998). Conditioning factors in drug abuse: can they explain compulsion? *Journal of Psychopharmacology*, 12(1), 15-22.
- O'Brien, C., Childress, A., McLellan, A., & Ehrman, R. (1992). A learning model of addiction. In C. O'Brien, & J. Jaffe (Eds.), *Addictive states* (pp. 157-177). New York, NY , US: Raven Press.
- Ostler, T., Bahar, O., & Jessee, A. (2010). Mentalization in children exposed to parental methamphetamine abuse: relations to children's mental health and behavioral outcomes. *Attachment and Human Development*, 12(3), 193–207.
- Panksepp, J. (2003). Neuro-psychoanalysis. *Neuro*, 5(1), 21-29.
- Panksepp, J. (2005). Affective consciousness: Core emotional feelings in animals and humans. *Consciousness and cognition*, 14(1), 30-80.
- Panksepp, J., Knutson, B., & Burgdorf, J. (2002). The role of brain emotional systems in addictions: a neuro-evolutionary perspective and new 'self-report' animal model. *Addiction*, 97(4), 459-469.
- Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: a global public-health challenge. *The Lancet*, 369(9569), 1302-1313.
- Pearce, S., & Pickard, H. (2010). Finding the will to recover: philosophical perspectives on agency and the sick role. *Journal of Medical Ethics*, 36(12), 831-833.
- Peele, S. (2000). What addiction is and is not: The impact of mistaken notions of addiction. *Addiction Research & Theory*, 8(6).

- Pickard, H. (2012). The purpose in chronic addiction. *AJOB Neuroscience*, 3(2), 40–49.
- Pickard, H., & Pearce, S. (2012). Addiction in context: Philosophical lessons from a personality disorder clinic. In N. Levy (Ed.), *Addiction and Self-control* (pp. 1-25). Oxford University Press (in press).
- Pickersgill, M. (2013). The social life of the brain: Neuroscience in Society. *Current Sociology*, 61(3), 322-340.
- Pinker, S. (2009). *Language learnability and language development*. Cambridge: Harvard University Press.
- Potenza, M., Hong, K., Lacadie, C., Fulbright, R., Tuit, K., & Sinha, R. (2012). Neural correlates of stress-induced and cue-induced drug craving: influences of sex and cocaine dependence. *American Journal of Psychiatry*, 406-414.
- Potter, J. (1996). Discourse analysis and constructionist approaches: Theoretical background. In J. Richardson (Ed.), *Handbook of qualitative research methods for psychology and the social sciences* (pp. 125-140). Leicester, UK: BPS Books.
- Potter, J. (2012). Re-reading discourse and social psychology: Transforming social psychology. *British Journal of Social Psychology*, 51(3), 436-455.
- Prochaska, J., & DiClemente, C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice*, 19(3), 276.
- Quinion, M. (2013, December 26). *Addiction*. Retrieved from World Wide Words: <http://www.worldwidewords.org/topicalwords/tw-add1.htm>
- Radley, A., & Billig, M. (1996). Accounts of health and illness: Dilemmas and representations. *Sociology of Health & Illness*, 18(2), 220-240.

- Reinarman, C. (2005). Addiction as accomplishment: The discursive construction of disease. *Addiction Research & Theory, 13*(4), 307-320.
- Reynolds, J., & Wetherell, M. (2003). The discursive climate of singleness: The consequences for women's negotiation of a single identity. *Feminism & Psychology, 13*(4), 489-510.
- Reynolds, J., Wetherell, M., & Taylor, S. (2007). Choice and chance: negotiating agency in narratives of singleness. *The Sociological Review, 55*(2), 331-351.
- Robbins, T., Everitt, B., & Nutt, D. (2008). Introduction. The neurobiology of drug addiction: new vistas. *Philosophical Transactions of the Royal Society: Biological Sciences, 363*, 3109–3111.
- Robinson, T., & Berridge, K. (1993). The neural basis of drug craving: an incentive-sensitization theory of addiction. *Brain Research Reviews, 18*, 247-291.
- Sanislow, C., Marcus, K., & Reagan, E. (2012). Sanislow, C. A., Marcus, K. L., & Reagan, E. M. (2012). Long-term outcomes in borderline psychopathology: old assumptions, current findings, and new directions. *Current psychiatry reports, 14*(1), 54-61. *Current psychiatry reports, 14*(1), 54-61.
- Savov, S., & Atanassov, N. (2013). Deficits of affect mentalization in patients with drug addiction: Theoretical and clinical aspects. *ISRN Addiction, 1*-6.
- Scholz, R., & Tietje, O. (2002). *Embedded case study methods: integrating quantitative and qualitative knowledge*. Thousand Oaks: Sage Publications.
- Shaffer, H., LaPlante, D., LaBrie, R., Kidman, R., Donato, A., & Stanton, M. (2004). Toward a syndrome model of addiction: Multiple expressions, common etiology. *Harvard Review of Psychiatry, 12*(6), 367-374.
- Shahar, G., Porcerelli, J., Kamoo, R., Epperson, C., Czarkowski, K. A., Magriples, U., & Mayes, L. (2010). Defensive projection, superimposed on simplistic object relations, erodes patient-

- provider relationships in high-risk pregnancy: An empirical investigation. *Journal of the American Psychoanalytic Association*, 58(5), 953-974.
- Sharp, C., Fonagy, P., & Goodyer, I. (2006). Imagining your child's mind: Psychosocial adjustment and mothers' ability to predict their children's attributional response styles. *British Journal of Developmental Psychology*, 24, 197–214.
- Shumway, S. B., Harris, K., & Baker, A. (2013). Important factors of early addiction recovery and inpatient treatment. *Alcoholism Treatment Quarterly*, 31(1), 3-24.
- Sinha, R. (2011). New findings on biological factors predicting addiction relapse vulnerability. *Current Psychiatry Reports*, 13(5), 398-405.
- Skårderud, F. (2007). Eating one's words, Part I: 'Concretised metaphors' and reflective function in anorexia nervosa - An interview study. *European Eating Disorders Review*, 15, 163-174.
- Skårderud, F. (2007). Eating one's words: Part III. Mentalisation-based psychotherapy for anorexia nervosa—an outline for a treatment and training manual. *European Eating Disorders Review*, 15(5), 323-339.
- Skårderud, F. (2011). Two minds in the text: A commentary to Sebastian Simonsen, Nana Lund Nørgaard, Kirsten Aaskov Larsen and Kraka Ingeborg Bjørnholm: Mentalization-inspired case formulation: Minding the difficult patient. *Personality and Mental Health*, 5(1), 80-84.
- Skodol, A. E., Oldham, J., & Gallaher, P. (1999). Axis II comorbidity of substance use disorders among patients referred for treatment of personality disorders. Skodol, A. E., Oldham, J. M., & Gallaher, P. E. (1999). Axis II comorbidity of substAmerican Journal of Psychiatry, 156(5), 733-738.
- Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development*, 7(3), 269-281.

- Slade, A. (2006). Reflective parenting programs: Theory and development. *Psychoanalytic Inquiry*, 26, 640-657.
- Slade, A., Grienenberger, J., Bernbach, E., Levy, D., & Locker, A. (2005). Maternal reflective functioning, attachment, and the transmission gap: A preliminary study. *Attachment & Human Development*, 283 – 298.
- Smith, J., & Osborne, M. (2008). Interpretative phenomenological analysis. In J. Smith (Ed.), *Qualitative psychology: a practical guide to research methods* (pp. 53-80). London: Sage Publishers.
- Söderström, K., & Skårderud, F. (2009). Mentalization-based treatment in families with parental substance use disorder: Theoretical framework. *Nordic Psychology*, 61(3), 47-65.
- Stake, R. (1995). *The art of case study research*. Thousand Oaks, CA: SAGE Publications Inc.
- Suchman, N., DeCoste, C., Castiglioni, N., McMahon, T., Rounsaville, B., & Mayes, L. (2010). The mothers and toddlers program, an attachment-based parenting intervention for substance using women: Posttreatment results from a randomized clinical pilot. *Attachment & Human Development*, 12(5), 483-504.
- Sussman, S., & Sussman, A. (2011). Considering the definition of addiction. *International Journal of Environmental Research and Public Health*, 8(10), 4025-4038.
- Swartz, S. (2012). The broken mirror: Difference and shame in South African psychotherapy. *International Journal of Psychoanalytic Self Psychology*, 196-212.
- Taxman, F. (1998). *Reducing recidivism through a seamless system of care: Components of effective treatment, supervision, and transition services in the community*. Office of National Drug Control Policy. Greenbelt, Maryland: Bureau of Governmental Research.
- Tellis, W. (1997). Application of a case study methodology. *The Qualitative Report*, 3(3), 1-17.

- Tiffany, S. (1990). A cognitive model of drug urges and drug-use behavior: Role of automatic and nonautomatic processes. *Psychological review*, 97(2), 147-168.
- Twohig, M., Shoenberger, D., & Hayes, S. (2007). A preliminary investigation of acceptance and commitment therapy as a treatment for marijuana dependence in adults. *Journal of Applied Behavior Analysis*, 40(4), 619-632.
- Tzelepis, F., Paul, C., Wiggers, J., Walsh, R., Knight, J., Duncan, S., . . . Daly, J. (2011). A randomised controlled trial of proactive telephone counselling on cold-called smokers' cessation rates. *Tobacco Control*, 20(1), 40-46.
- Ulman, R., & Paul, H. (2006). *The self psychology of addiction and its treatment: Narcissus in wonderland*. New York: Routledge.
- Valverde, M. (1997). 'Slavery from within': The invention of alcoholism and the question of free will. *Social History*, 22(3), 251-268.
- Van Dijk, T. (1993). Principles of critical discourse analysis. *Discourse & society*, 4(2), 249-283.
- Volkow, N. (2013, July 12). *The Brain: Understanding neurobiology through the study of addiction*. Retrieved from National Institute on Drug Abuse:
<http://science.education.nih.gov/supplements/nih2/addiction/guide/pdfs/Entire.pdf>
- Volkow, N. D., Chandler, R., & Fletcher, B. (2009). Drug addiction as a brain disorder or disease - Reply. *JAMA: The Journal of the American Medical Association*, 301(18), 1881-1882.
- Volkow, N., & Fowler, J. (2000). Addiction, a disease of compulsion and drive: Involvement of the orbitofrontal cortex. *Cerebral Cortex*, 10, 318-325.
- Volkow, N., & Li, T. (2004). Drug addiction: the neurobiology of behaviour gone awry. *Nature Reviews Neuroscience*, 5(12), 963-970.

Volkow, N., Fowler, J., & Wang, G. (2003). The addicted human brain: Insights from imaging studies. *Journal of Clinical Investigation*, 111(10), 1444-1451.

Volkow, N., Wang, G., Tomasi, D., & Baler, R. (2013). Unbalanced neuronal circuits in addiction. *Current opinion in neurobiology*, 23(4), 639-648.

Vygotsky, L. (1966). Play and its role in the mental development of the child. *Voprosy psikhologii*, 1-18. Retrieved from <http://www.marxists.org/archive/vygotsky/works/1933/play.htm>

Wallin, D. (2007). *Attachment in psychotherapy*. New York: Guilford Press.

Waters, K., Holttum, S., & Perrin, I. (2013). Narrative and attachment in the process of recovery from substance misuse. *Psychology and Psychotherapy: Theory, Research and Practice*, 1-15.

Weegmann, M. (2002). Motivational interviewing and addiction-A psychodynamic appreciation. *Psychodynamic Practice*, 8(2), 179-195.

Weinberg, D. (2000). "Out There": The ecology of addiction in drug abuse treatment discourse. *Social Problems*, 47(4), 606-621.

West, R. (2001). Theories of addiction. *Addiction*, 96(1), 3-13.

Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse and Society*, 9(3), 387-412.

Wetherell, M., Taylor, S., & Yates, S. (2001). *Discourse as data: A guide for analysis*. London: Sage Publications.

Williamson, J., Buckland, H., & Cunningham, S. (2013). Addiction & the brain: What is an "addiction memory"? *The American Biology Teacher*, 75(1), 61-62.

Witkiewitz, K., & Marlatt, G. (2004). Relapse prevention for alcohol and drug problems: That was Zen, this is Tao. *American Psychologist*, 59(4), 224-235.

- Wodak, R. (2001). What CDA is about - a summary of its history, important concepts and developments. In R. Wodak, & M. Meyer (Eds.), *Methods of Critical Discourse Analysis* (pp. 1-13). London: Sage.
- World Health Organization. (2013, August 01). *Lexicon of alcohol and drug terms published by the World Health Organization*. Retrieved from World Health Organization: http://www.who.int/substance_abuse/terminology/who_lexicon/en/
- Wurmser, L. (1977). Mr. Pecksniff's horse? In J. Blaine, & D. Julius (Eds.), *Psychodynamics in compulsive drug use: Research monograph series 12* (pp. 36-72). Rockville, Maryland: National Institute on Drug Abuse.
- Young, L. (2011). Joe Sixpack: Normality, deviance, and the disease model of alcoholism. *Culture & Psychology, 17*(3), 378–397.
- Yücel, M., Lubman, D., Solowij, N., & Brewer, W. (2007). Understanding drug addiction: A neuropsychological perspective. *Australasian Psychiatry, 41*(12), 957-968.
- Zellner, M., Watt, D., Solms, M., & Panksepp, J. (2011). Affective neuroscientific and neuropsychanalytic approaches to two intractable psychiatric problems: Why depression feels so bad and what addicts really want. *Neuroscience and Biobehavioral Reviews, 35*, 2000–2008.

APPENDICES

Appendix A

Consent Form

University of Cape Town / Clinic⁹

Consent to participate in a research study

Dear Clinic Staff Member,

Formal Title: Holding relapse in mind – relating mentalizing and addictive behaviour

Study Purpose

You are being invited to participate in a research study being conducted by researchers from the University of Cape Town. The purpose of this study is to examine the treatment experiences of patients who have had two or more treatment episodes for their substance misuse. This will be in order to gain an understanding about how treatment impacts the relapse process. You have been asked to participate in this study because you fulfil the study criteria.

Study Procedures

If you decide to participate in this study, you will be interviewed for approximately 1 hour within one week of your patient's discharge from treatment. The interview may be as short as 45 minutes or as long as 1 ½ hours.

That interview will include questions about the treatment process for substance misuse, your experience of the treatment intervention, your experience of your treatment

⁹ Name of clinic withheld for reasons of confidentiality

relationship with your client and related feelings and behaviours. All information will be kept strictly confidential. The personal content of the interview will be held confidentially by the researcher and not be divulged to anyone, and ultimately will be destroyed.

The researcher will also need to access your treatment notes/ information from the clinic files from the current treatment episode. If your client had a previous treatment episode at the Clinic, that information will need to be requested from their archived treatment file.

After the interview is completed there is no further commitment that you have to fulfil in relation to the study and your work at the Clinic will continue uninterrupted. No information will be given back to you directly about your participation in the research.

Possible Risks

The interview that you participate in may bring you in touch with feelings or thoughts that you prefer to avoid or may have been unaware of up to that point. You may feel some initial embarrassment or worry about certain topics that are included in the interview. The time (1 hour) that you spend in the interview will also mean that there may be a potential conflict with time spent in your work commitments. Every effort will be made to ensure that the interview times do not distract you from your work experience.

Possible Benefits

There will be no direct benefit to you through participating in this study. However, we hope that information gained from this study will assist in developing treatment interventions for those who relapse after receiving treatment.

Alternatives

You can choose not to participate in this study. This choice will not in any way affect your relationship with the clinic or work environment.

Voluntary Participation

Participation in the study is completely voluntary and you are free to refuse participation in it. Similarly, you are free to refuse to answer any question that the researcher may ask of you. Refusal to answer research questions will in no way affect your relationship with the clinic. If you do decide to participate in the study, you are free to change your mind and discontinue participation at any time without this decision affecting your relationship with the clinic.

Confidentiality

Information obtained about you in this study will be kept confidential. Your name and other identifying information will not be kept with the interview information. It and this consent form will be kept separately in locked file cabinets and there will be no link between the consent form and the interview. The information obtained from the interview will not become a part of your employment record in any way, nor will it be made available to anyone else. Any reports or publications about the study will not identify you or any other study participant.

Questions

Any study related questions, problems or emergencies should be directed to the following sources. In the first instance to:

Mr Alex Carter: 021 7634501

Or, in the second instance to:

Dr Catherine Ward: 021 650 3422

If you are dissatisfied with any aspect of how this study has been conducted, please contact the UCT Department of Psychology: 021-650 3435

I have read the above and am satisfied with my understanding of the study, its possible benefits and risks and alternatives. My questions about the study have been

answered. I hereby voluntarily consent to participation in the research study as described. I have been offered copies of this three-page consent form.

Date

Signature of the participant

Name of participant (printed)

Transcription

In the interview that is to be conducted with the researcher, the conversation may be recorded. This is in order for the researcher and his supervisor to have an accurate record of the session. This session will be transcribed by a professional transcriber, who will also be bound to the confidentiality of this agreement. Until they listen to it, it will be stored on a password protected computer or a locked filing cabinet. After they have listened to it, it will be destroyed.

Date

Signature of the participant

Name of participant (printed)

Access to medical records

In the study to be conducted, access to information from your client's clinic file will be needed as data to be used in the study. Information such as biographical records and treatment notes will be accessed from the file. Any material copied from the file will be kept confidential. Electronically sourced material will be stored on a password protected computer and written documents in a locked filing cabinet. After it has been used, the documentation will be destroyed.

Date

Signature of the participant

Name of participant (printed)

Witness

Appendix B

Consent Form

University of Cape Town / Clinic¹⁰

Consent to participate in a research study: Holding relapse in mind – relating mentalizing and addictive behaviour

Dear Patient,

Study Purpose

You are being invited to participate in a research study being conducted by researchers from the University of Cape Town. The purpose of this study is to examine the treatment experiences of patients who have had two or more treatment episodes for their substance misuse. This will be in order to gain an understanding about how treatment impacts the relapse process. You have been asked to participate in this study because you fulfil the study criteria.

Study Procedures

If you decide to participate in this study, you will be interviewed for approximately 1 hour within three (3) days before your discharge from treatment. The interview may be as short as 45 minutes or as long as 1 ½ hours.

That interview will include questions about previous treatment for substance misuse, your using again after a treatment intervention, your experience of your current treatment episode and related feelings and behaviours. All information will be kept strictly confidential. The police will not be informed of any of your drug using behaviour. The personal content of the interview will be held confidentially by the researcher and not be divulged to anyone, and ultimately will be destroyed.

¹⁰ Name of clinic withheld for reasons of confidentiality

The researcher will also need to access your treatment information for the clinic files from the current treatment episode. If you had a previous treatment episode at the Clinic, that information will need to be requested from your archived treatment file.

After the interview is completed there is no further commitment that you have to fulfil in relation to the study and your discharge process at the Clinic will continue uninterrupted. No information will be given back to you directly about your participation in the research.

Possible Risks

The interview that you participate in may bring you in touch with feelings or thoughts that you prefer to avoid or may have been unaware of up to that point. You may feel some initial embarrassment or worry about certain topics that are included in the interview.

The time (1 hour) that you spend in the interview will also mean that there may be a potential conflict with time spent in your residential treatment. Every effort will be made to ensure that the interview times do not distract you from your treatment experience.

Possible Benefits

There will be no direct benefit to you through participating in this study. However, we hope that information gained from this study will assist in developing treatment interventions for those who relapse after receiving treatment.

Alternatives

You can choose not to participate in this study. This choice will not in any way affect your treatment, relationship with your counsellor, the clinic or possible readmission to the clinic.

Voluntary Participation

Participation in the study is completely voluntary and you are free to refuse participation in it. Similarly, you are free to refuse to answer any question that the researcher

may ask of you. Refusal to answers research questions will in no way affect your treatment process or further access to treatment at this clinic. If you do decide to participate in the study, you are free to change your mind and discontinue participation at any time without this decision affecting your treatment (or possible subsequent treatment) process.

Confidentiality

Information obtained about you in this study will be kept confidential. Your name and other identifying information will not be kept with the interview information. It and this consent form will be kept separately in locked file cabinets and there will be no link between the consent form and the interview. The information obtained from the interview will not become a part of your medical record in any way, nor will it be made available to anyone else. Any reports or publications about the study will not identify you or any other study participant.

Questions

Any study related questions, problems or emergencies should be directed to the following sources. In the first instance to:

Mr Alex Carter: 021-763 4501

Or, in the second instance to:

Dr Catherine Ward: 021 650 3422

If you are dissatisfied with any aspect of how this study has been conducted, please contact the UCT Department of Psychology: 021-650 3435

I have read the above and am satisfied with my understanding of the study, its possible benefits and risks and alternatives. My questions about the study have been

answered. I hereby voluntarily consent to participation in the research study as described. I have been offered copies of this three-page consent form.

Date

Signature of the participant

Name of participant (printed)

Transcription

In the interview that is to be conducted with the researcher, the conversation may be recorded. This is in order for the researcher and his supervisor to have an accurate record of the session. This session will be transcribed by a professional transcriber, who will also be bound to the confidentiality of this agreement. Until they listen to it, it will be stored on a password protected computer or a locked filing cabinet. After they have listened to it, it will be destroyed.

Date

Signature of the participant

Name of participant (printed)

Access to medical records

In the study to be conducted, access to information from your clinic file will be needed as data to be used in the study. Information such as biographical records and treatment notes will be accessed from the file. Any material copied from the file will be kept confidential. Electronically sourced material will be stored on a password protected computer and written documents in a locked filing cabinet. After it has been used, the documentation will be destroyed.

Date

Signature of the participant

Name of participant (printed)

Witness

Appendix C

Interview introduction and sample questions

I'm going to be interviewing you about your experiences of relapse (as a client) or treating relapse (as counsellor), and how those experiences may have been affected by how you think about yourself and your treatment. So, I'd like to ask you about your treatment and relationship with your client/counsellor, and what you think about the way it might have affected you. We'll focus mainly on treatment and relapse and we'll also get on to what brought you back into treatment. This interview takes about an hour to complete.

Interview:

1.1. What was your experience of the therapy sessions you had during treatment?

Prompt: Describe the flow of the session

Prompt: Describe what helped you make sense of the sessions

Prompt: Describe the structure or shape of the sessions

1.2. Describe what thoughts and feelings occurred to you in sessions with your patient / counsellor.

Prompt: What "popped" into your mind?

Did some thoughts recur more than others - what were they?

Prompt: Did you remember aspects of your sessions and not others – what were those aspects?

1.3. Did your conversations about relapse differ from other therapeutic conversations?

Prompt: How do you understand this?

Prompt: What meaning does relapse hold in your mind?

1.4. Describe moments in your therapeutic conversations that might have been difficult to relate your thinking to.

Prompt: Were there moments of “stuckness” and why?