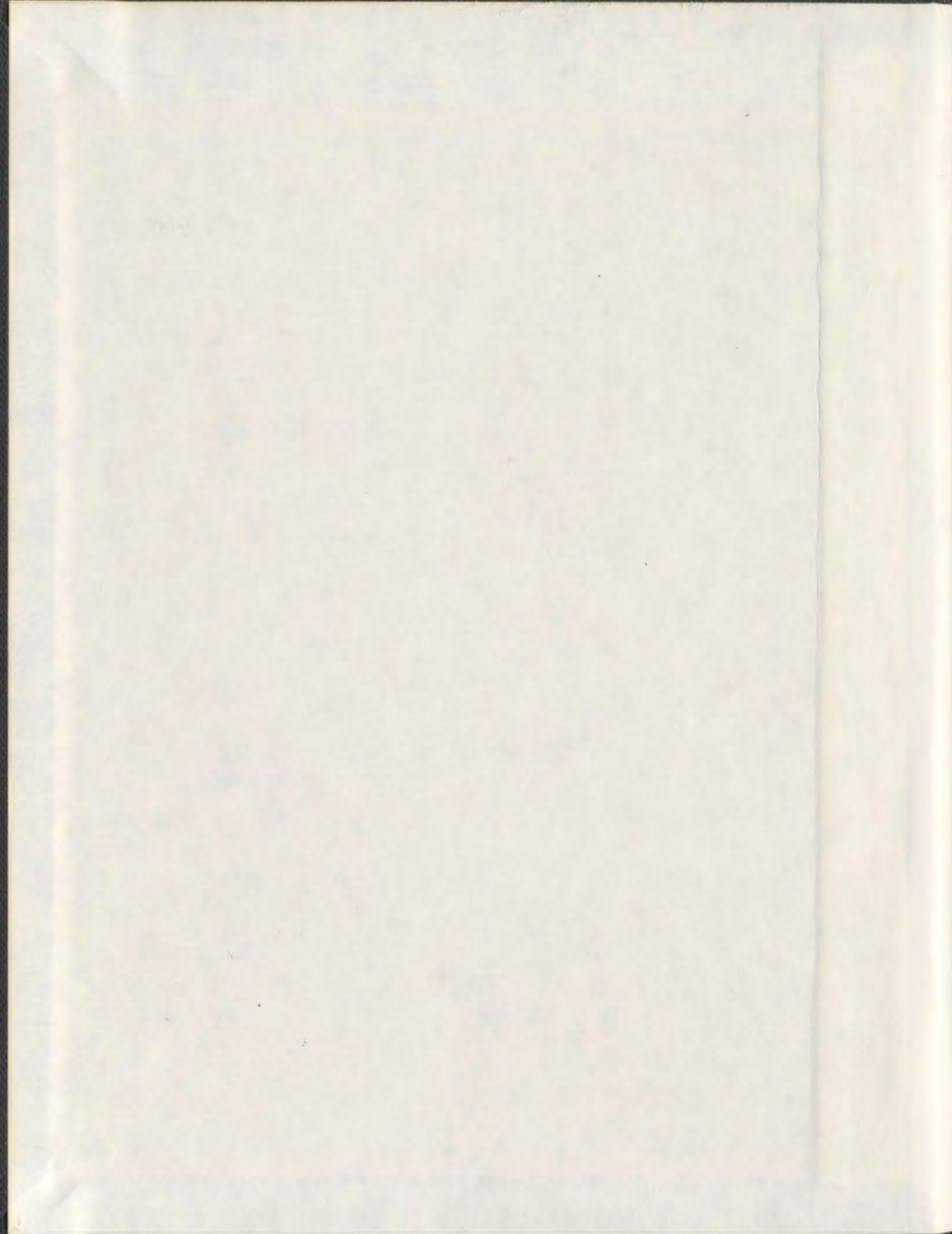


SELF-DETERMINATION MEANINGS IN CONCURRENT
DISORDERS TREATMENT AND RECOVERY
EXPERIENCES: A QUALITATIVE STUDY

JOHN FRANCIS OSTRANDER



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Self-Determination Meanings in Concurrent Disorders

Treatment and Recovery Experiences:

A Qualitative Study

by

© John Francis Ostrander MSW RSW

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ABSTRACT

Growing attention is being paid to co-occurring mental health and substance use disorders or concurrent disorders (CDs) in relation to treatment services and supports. A related theme is the mental health self-advocate vision of recovery that includes respecting peoples' subjective self-determination (SD) in treatment. Client SD is an important social work concept but its meaning and purpose remains unclear and it is typically defined from the professional perspective. Understanding SD meanings of people with CDs in relation to recovery may help social workers better assist people with CDs to achieve their recovery goals. This study explored the meanings of SD in CDs treatment and recovery experiences among five female and three male participants. Interview transcripts were analyzed using a qualitative grounded theory approach.

SD meanings hinged on the subjective "sense of self" of participants within their ecosystem. Three interrelated SD meaning components were identified: key *standpoint* elements (beliefs and values, attitudes towards self and ecosystem, sense of control, and aspirations), a power or force (associated with *being determined*) and *determining* processes (knowledge building and decision making). A primary sense of self and a later more "nuanced" sense of self in CDs recovery were distinguishable within participants' descriptions and meanings. The more nuanced sense of self reflected more situationally relative, compatible, and discerning meanings of the self, SD, the ecosystem, mental health, addiction, and CDs recovery. Hermeneutic knowledge building is interpreted as facilitating the

trend towards a more nuanced sense of self over time. One practice implication involves the role and importance of SD in relation to regulating the relative stability of the sense of self simultaneously with growth and change associated with CDs recovery.

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LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
CDs	Co-occurring mental health and substance use disorders or concurrent disorders.
CSD	Client self-determination in social work
CASW	Canadian Association of Social Workers
DSM-III	Diagnostic and Statistical Manual of Mental Health Disorders, 3 rd Edition.
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Health Disorders – text revised, 4 th Edition.
NASW	National Association of Social Workers
SCI	Structured Clinical Interview
SD	Self-determination
SDT	Self-determination theory in motivational psychology

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CHAPTER ONE

Introduction

One recent trend in the field of mental health involves persons with mental illness demanding greater self-determination (SD) in their interactions with treatment and rehabilitation systems, programs, and professionals (Ralph, 2000; Stroman, 2003). Contextually, client self-determination (CSD) has been an important concept in social work for the past eighty years (Taylor, 2006). The term “client” is typically used to refer to people who are receiving services that involve social workers although it is critiqued as being potentially de-personalizing and disempowering (Fook & Askeland, 2007).

The meaning and purpose of CSD in social work are disputed (Reamer, 2006) and there is a paucity of research focusing on it. The small number of published studies over the last thirty years typically deduced meanings or definitions of CSD in order to explore workers’ attitudes and behaviors towards it in different practice settings or hypothetical contexts. I found no published social work studies that focused solely on what SD means to people who have received treatment and rehabilitation services for mental health issues or mental illness. A greater understanding of the meaning(s) of SD from the experiential point of view of people living with and recovering from mental illness, and how they may relate to social work’s concept of CSD, is an area of research that could enhance current social work practice knowledge. Research in this area could augment social

workers' ability to assist individuals with mental health challenges to achieve their recovery goals.

Another intersecting trend in mental health is the growing recognition of the need to integrate assistance for substance use disorders into mental health treatment and rehabilitation (Health Canada, 2001; Meuser, Noordsy, Drake & Fox, 2003). The calls for greater integration stem from mental health treatment systems, programs, and practitioners not typically addressing substance use disorders directly (Osher & Drake, 1996; Health Canada, 2001). Similarly, substance abuse or addiction treatment programs have not traditionally dealt with co-occurring but relatively independent symptoms of mental illness (Center for Substance Abuse Treatment; 2006a). Studies suggest that people living with both addiction and mental illness are at a greater risk of harming themselves and being socially marginalized (Health Canada, 2001). The traditional sequential or uncoordinated parallel treatment approaches may not best help most people challenged by both issues (Grella, Gil-Rivas & Cooper, 2004). Finally, a high prevalence of substance use problems being found among people with mental illness has also led to calls for people dealing with both issues to be seen as typical rather than atypical in treatment (Minkoff, 2001; Gil-Rivas & Grella, 2005). Consequently, this study of the meanings of SD focuses on people with co-occurring mental health and substance use disorders or concurrent disorders (CDs).

1.1 Defining CDs

Many terms may refer to CDs in North America. *Co-morbidity* is common (Schuckit, 2006). In the United States, *dual diagnosis* and *dual disorders* may be used separately or interchangeably (Meuser et al, 2003). *Co-occurring disorders* is gaining popularity in the literature (Center for Substance Abuse Treatment, 2006b). The Canadian term, *concurrent disorders* (CDs), is used in this dissertation (Health Canada, 2001; Centre for Addiction & Mental Health, 2004).

Researchers and service delivery providers may arbitrarily define CDs differently (Todd et al., 2004). For example, definitions may be limited by severity and/or differential diagnosis (Meuser, Drake, & Wallach, 1998). The general definition used in this dissertation is: “a *combination* of mental/emotional/psychiatric problems with the abuse of alcohol and/or other psychoactive drugs” (Health Canada, 2001, p. v).

1.2 Significance of the Problem

Despite the strong push for more integrated and coordinated service delivery for people with CDs there is not yet a strong base of research and practice knowledge to support evidence-based treatment guidelines in this area (Watkins, Hunter, Burnam, Pincus, & Nicholson, 2005; McHugo et al., 2006). Consequently, people with CDs face treatment programs and practitioners, including social workers, who typically do not have extensive CDs training, experience, or who can refer confidently to a proven body of ethical and effective treatment guidelines (Gil-Rivas & Grella, 2005; Smith, 2007). As mentioned

above, there is a simultaneous call for mental health treatment and rehabilitation reforms to include greater SD within a person-based, rather than expert-based, vision of recovery (Stroman, 2003). However, mental health self-advocates do not usually refer to addiction issues in recovery and the addiction self-help movement tends to keep professional services at arms length. The need to better understand, respect, and integrate whenever possible meanings of SD in individuals' vision of recovery could be argued to be even more critical for people with CDs because of the limited current knowledge and experience to guide integrated services and supports that have a likelihood of helping and not doing more harm.

1.3 Purpose of the Study

The purpose of this study is to begin the systematic process of developing empirical knowledge and practice-related theory that builds on an understanding of the meanings of SD for persons facing the challenges associated with CDs. This study also hopes to shed some light on how participants' meanings of SD in treatment and recovery experiences associated with CDs might relate to: (a) current social work conceptualizations of CSD; and (b) its optimization in social work practice in the area of mental health and addiction.

1.4 The Research Question

How are meanings of SD defined and perceived, among a sample of persons who self-identify as having CDs, within the context of their treatment and recovery experiences?

1.5 Rationale for Study

Exploring the research question may contribute to the initiation of the systematic development of integrated practice knowledge for CDs that is inclusive of client meanings of SD. The systematic development of integrated social work CDs practice knowledge needs to begin with inductively exploring understandings that are grounded in client experiences and SD meanings because:

- CDs are being seen as a major risk for the majority of people with mental illness living in the community (Center for Substance Abuse Treatment, 2006c).
- People with CDs face mental health systems, programs, theories, and practices that historically were developed and evaluated separately from those that focused on substance use disorders (Health Canada, 2001; Blakely & Dziadosz, 2007).
- Mental health self-advocates are calling for reforms to mental health treatment and rehabilitation services and supports that include greater SD (Stroman, 2003); however, SD is not commonly mentioned by self-advocates vis-à-vis addictions.
- Studies suggest that people with CDs are more at risk than persons with mental health or substance use issues alone to abandon treatment, to be marginalized by treatment providers, to be victimized in society, to relapse

in recovery, to commit suicide, and to experience an increased array of employment, housing, and relationship difficulties (Health Canada, 2001; Gil-Rivas & Grella, 2005).

- CDs are being recognized as an important practice issue in current mental health social work (Kimberley & Osmond, 2003; Smith, 2007).
- This author found no published research in social work that studied peoples' meanings of SD or focused on CSD in relation to CDs.

Given the nature of the issues that confront clients with CDs and the paucity of social work research that focuses on the client's perspective on SD, this dissertation study is exploratory in nature and employs a qualitative grounded theory methodology. Consistent with this methodology, professional and disciplinary literature is not used to pre-determine what key problems should surface or what key theoretical concepts should emerge (Strauss & Corbin, 1998). Prior to presenting the methodology, Chapter Two provides a literature review that is designed to orient the reader to: (a) conceptualizations of the self and SD in philosophy, psychology, social work, and the mental health self-help movement; and (b) social work theory and practice in the fields of mental health, addictions, and CDs. Within the context of the review, I will clarify my own position on the issues that are discussed. Chapter Three discusses the methodology and the methods used in this study, Chapter Four presents the inductively developed grounded theory, Chapter Five discusses the findings, and Chapter Six is a brief conclusion.

1.6 Researcher's Statement

Transparency and reflexivity of a researcher's background, values, and interests that may inform or bias the research process contributes to a qualitative research study's degree of rigor and the reader's judgment of the study's trustworthiness (Sandelowski & Barroso, 2002). Professionally, I have worked as a CDs specialist outside of Ottawa, Ontario since 2001. I have joint appointments with a publicly-funded out-patient addiction services agency and community-based mental health services agency. My position is adjunct to the mental health agency's crisis program. My primary role has been to provide comprehensive functional assessments and coordinated treatment planning for people seeking assistance for CDs. Previously, I was an addiction counselor in a different addiction treatment agency. In this position, I found I was an agent of, and experienced first-hand, the forced "run-around" of people seeking help for CDs. The runaround was, I believe, due to a number of factors, including agencies and practitioners exercising powers to arbitrarily limit or withhold assistance. Such actions appeared to be based on, at least partly, different personal and/or theoretical perspectives underlying unproven assumptions as to the causes and solutions vis-à-vis CDs-related symptoms and relapses.

Personally, I did see a counselor on my own initiative for a brief but useful time in my twenties. However, I have not been diagnosed with a mental health disorder nor experienced being a patient or client in relation to an addiction. Working with people who have struggled in these areas has certainly led me to

reflect on my own substance use and misuse in my teens and early twenties. This has led me to decide that a key factor in my life has been “luck” in terms of not becoming a system client at some point. For example, drinking and driving was “normal” in the rural area of British Columbia where I grew up in the seventies. I could have easily been charged with impaired any number of times, which could have set up interactions with authorities and medical experts that led to me being a formal (potentially non-compliant) client. I have also reflected on difficult interactions I have had with others but none that were significantly traumatic or abusive. Finally, I have had many struggles managing my emotions or moods. My belief is that we all have the capacity to struggle with mental health issues, substance use problems, and their “treatments.”

Overall, I have come to believe in the relevance of self-efficacy and SD in the recovery from mental illness and/or addiction. I believe that understanding meanings of SD for people living with and recovering from the many potential challenges associated with CDs may be critical for evolving clinical social work practice in ways that are congruent with: social work’s professional values; the risks and obstacles that people with CDs face; and the needs, rights, and strengths of people seeking assistance.

CHAPTER TWO

Literature Review

2.1 Introduction

The role of the literature review in qualitative grounded theory methodology is different than in studies using a quantitative approach (Strauss & Corbin, 1998; Charmaz, 2006). The difference lies with the qualitative methodology's goal of identifying naturally arising meanings among participants rather than defining and operationalizing meanings of key concepts prior to the sampling in order to test a hypothesis.

This literature review provides background to orient the reader to: (a) conceptualizations of self and SD in philosophy, psychology, social work, and the mental health consumer/survivor movement; and (b) social work theory and practice in the fields of mental health, addiction, and CDs. The review also highlights my perspective vis-à-vis the area of inquiry and sets the stage for the presentation of the analysis of the findings and discussion. Elaboration on my own perspective on the issues discussed serves to make the inquiry more transparent and underlies the choice to employ qualitative grounded theory research methodology to address the research question. One main theme underlies my perspective: meanings of self and/or SD are highly contested and highly confusing within and between the fields of philosophy, psychology, and social work. Consequently, exploring the subjective meanings of SD in treatment and recovery experiences among people recovering from CDs is both necessary and

appropriate because of the potential contribution to the well-being of people who are challenged by CDs. This inquiry also looks to contribute to a better understanding of the discussion of CSD within social work and other fields of study and practice.

2.2 Self and SD in Philosophy and Psychology

The *Oxford English Dictionary* (Murray, 1933) stated that the etymology of *self* is unclear. The general meaning involved a person's essential being, nature, or personality. The use of *self* in combination with other words began around the middle of the 16th Century and expanded in the 17th Century when new words appeared in theological and philosophical texts. From a reflexive verbal phrase such as "to determine oneself," a series of related words arose such as SD, self-determining, and self-determined (9: p. 409). The definition of determination included: "the definite direction of the mind or will toward an object or end, by some motive, regarded as an external force" (3: p. 269).

The 1933 edition listed one definition for *self-determination*: "determination of one's mind or will by itself towards an object" (9: 418). Metaphysics was the field of usage. The dictionary's second edition (Simpson & Weiner, 1989) added a second meaning for SD in the area of politics: "the action of a people in deciding its own form of government, free determination of statehood, postulated as a right" (14: p. 919).

2.2.1 Philosophy and the Self

How people may be uniquely free, unpredictable, and self-determining and yet simultaneously subject to, or limited by, a battery of pre-determining or deterministic biological, physical, psychological, social, structural, political, and/or divine forces has long been the subject of debate in Western philosophy. The debate is often framed in terms of free will versus determinism (Reamer, 1983). Compatibilists argue that free will and deterministic forces, powers, or influences may simultaneously occur. Incompatibilists argue that individual free will or else some other factor, force, or power (e.g., divine, biological, environmental) will determine the other (Flew & Priest, 2002).

Arguably, free will-determinism debates hinge on competing philosophical definitions of the self. Jerrold Seigal (2005) suggested that: “more than any other world culture, the modern West has made the debate about individuality and selfhood a central question – perhaps the central question – of its collective attempts at self-definition” (p. 4). Western philosophical understandings of the “modern self” typically cite historical influences and comparisons that begin with Ancient Greek philosophers such as Plato, Socrates, and Aristotle. Often cited are Plato’s (429-347 BC) concept of the immaterial soul or psyche, and the soul’s three elements: reason, desire, and spirit (Taylor, 1989; Seigal, 2005). Plato’s organization of these elements promoted the idea that reason needed to be the self’s “ringleader” in order to find moral good. Moral

good was gained through the element of reason making use of the spirit while minimizing the influence of desire.

2.2.1.1 The modern self.

Charles Taylor (1989) argued that John Locke (1632-1704) strongly influenced the dualistic view of the modern Western self. This view of the self is characterized by a disengagement from the external, natural world, the objectifying of it, and also disengaging one's reason from one's self. Taylor referred to this development as a "radical first-person stance" (p. 176). He suggested that Locke's "first-person stance" jammed the door open to modern Western culture's emphasis on the ideal of individual freedom or independence over communitarian aspects of the self.

Taylor argued that the modern self was at risk of moral disorientation in the modern milieu of Cartesian dualism and individualism because people searched for moral meanings in the inner world of individual selves and lives and marginalized sources of moral meanings in a shared social world. Taylor's critique of radical individuality in Western culture is echoed in some social work debates over the meaning and purpose of SD and autonomy (e.g., Falk, 1988).

In contrast to Taylor, Jerrold Seigal (2005) suggested that the modern Western self is more accurately characterized as balancing individualism, introspection, and communitarianism. He arrived at his thesis of the modern self via analysis using three dimensions of the self: the "bodily or material, the relational, and the reflective" (p. 5). The bodily/material dimension "involves the

physical, corporeal existence of individuals, the things about our nature that makes us palpable creatures driven by needs, urges, and inclinations, and that give us particular constitutions or temperaments” (p. 5). The relational dimension “arises from social and cultural interaction, the common connections and involvements that give us collective identities and shared orientations and values” (p. 5). Seigal described the third, reflective dimension as:

The human capacity to make both the world and our own existence objects of our active regard, to turn a kind of mirror not only on phenomena in the world, including our own bodies and our social relations, but on our consciousness too, putting ourselves at a distance from our own being so as to examine, judge, and sometimes regulate or revise it (p. 5).

Seigal argued that a useful way of discerning between various perspectives on the modern self is to determine which views argue for only one of his three dimensions to be defining versus those that have a more integrated bi-dimensional or multi-dimensional view. He noted that one-dimensional views of the self will often acknowledge the other two dimensions; however, only one dimension is said to be primary or defining (e.g., Plato’s reason being not only preferred but also capable of being the ringleader of the soul). The disparate viewpoints that Seigal and Taylor represent are exemplars of the challenges and complexities inherent in attempts to understand meanings of the self and, in turn, SD.

John Locke was the first significant philosopher to use the English term, *self-determination* (Murray, 1933). Locke referred to SD in *An Essay Concerning Human Understanding* (1690 [1829]). He referred to it in his critique of English Scholastic propositions, which concluded that people have the freedom, liberty, or

free will to choose to sin or not while also, simultaneously, being absolutely subject to divine predestination or determinism (Stillingfleet, 1662). Locke argued that the Scholastic view was incoherent. Consequently, he conceptualized SD as a *de facto* power based on people having the capacity for non-predetermined free will to choose to sin or not. Locke's work stands as a nexus linking meanings of the modern self in philosophy, later meanings of the self in psychology and psychiatry, and meanings of SD.

Since Locke, utilitarian (e.g., John Stuart Mill), existential (e.g. Søren Kierkegaard), and many postmodern perspectives (e.g., Jean Paul Sartre) argue that a *relativist* view best reflected the meaning(s) of the modern Western self and freedom individually and collectively. Immanuel Kant, Charles Taylor and others, including proponents of many religions, argue, instead, that some degree of universal *absolutism* best reflects the true meaning of the self and freedom individually and collectively.

Charles Peirce, George Herbert Mead, John Dewey, and William James are associated with the anti-positivistic *pragmatic* philosophical movement. Mead (1863-1931) is also credited with being one of the founders of *symbolic interactionism* in social psychology and sociology. Mead saw the self as arising and evolving through communication within social relationships. He wrote:

Thus the child can think about his conduct as good or bad only as he reacts to his own acts in the remembered words of his parents. Until this process has been developed into the abstract process of thought, self-consciousness remains dramatic, and the self which is a fusion of the remembered actor and this accompanying chorus is somewhat loosely organized and very clearly social. Later the inner stage changes into the

forum and workshop of thought. The features and intonations of the *dramatis personae* fade out and the emphasis falls upon the meaning of the inner speech, the imagery becomes merely the barely necessary cues. But the mechanism remains social, and at any moment the process may become personal (1913, p. 377).

2.2.1.3 The postmodern self. Generally, the postmodern movement is associated with critiques of the modern Western moral self, its promoted core beliefs and values (e.g., social norms, non-reflexive confidence in “progress”, individualism, rational processes of the mind, and logical positivism’s promotion of universal truths), its influence on peoples’ individual and collective behaviors (e.g., colonization, the Holocaust, global warming), and its expressions through hierarchical social structures (e.g., holding up notions of objectivity and social norms to disguise or validate entrenched patterns of the use of power and authority by some to support or perpetuate asymmetrically unfair limitations, prejudices, or oppression on others). Relativism, indeterminism, and the valuing of subjective knowledge are commonly associated more with postmodern perspectives while absolutism, scientific determinism, and the promotion of objective knowledge are more associated with modern ones (Flew & Priest, 2002; Blackburn, 2005). Pauline Rosenau (1991) distinguished between postmodern perspectives in terms of where they fall along an extreme to moderate continuum and across a cynical/skeptical to more positive/affirmative continuum.

A central debate or discourse associated with postmodern critiques of modern notions of the self revolve around the capacity of the individual to be self-organizing or not (i.e., self-constructing or self-producing) and to act

idiosyncratically to some effective degree (i.e., human agency) upon an external world (Gubrium & Holstein, 1995; Broad, 2002). For example, Jaber Gubrium and James Holstein (1995) appeared to be challenging extreme postmodern perspectives of the self when they argued that some postmodern views can render the self as being both “empty” or having no real substance and at the same time being “overly saturated” with dispersed meanings embedded within language and culture (p. 556). They argued for a postmodern perspective of the self that is not only subjectively constructing self-awareness individually and collectively but also potentially reconstructing it, because the self has individual agency to assign subjective interpretive meanings to relational experiences.

Michel Foucault (1926-1984) avoided aligning himself with any philosophical movement. Nevertheless, his historical-philosophical critiques of the Western mental health system, the penal system, and sexuality are often linked with postmodernism. Foucault argued that all social interrelations, notions of freedom, and interconnectedness or systems are fundamentally about relationships of power and knowledge. He stated that power is like an energy and “covers a whole series of particular mechanisms, definable and defined, which seem likely to induce behaviors or discourses” (2007, p. 60). Foucault spoke of the importance of describing meanings and social systems in relation to their particular knowledge-power “nexus.” He thought that an accepted “truth” is not given legitimacy by any “originally existing right” (p. 54). Instead, its knowledge-power nexus had to be “described so that we can grasp what constitutes the

acceptability of a system, be it the mental health system, the penal system, delinquency, sexuality, etc.” (p. 54). However, Jurgen Habermas famously differed with Foucault’s perception of power and truth (Kelly, 1994). Habermas was more of an inter-subjective idealist than Foucault’s non-committal view of the legitimacy of any particular upheld truth, in relation to the human “subject.” Habermas is associated with furthering notions and applications of *critical social theory*, such as in relation to feminist theory, liberation theology, postcolonial theory, critical race theory and anti-oppression theories.

Michael Kelly (1994) compared and contrasted Foucault and Habermas’ writings about power. In contrast to Foucault, Habermas argued that while power is clearly related to notions of truth and freedom; nevertheless, consensual meanings of these concepts can be contextually agreed upon in terms of designating legitimate or good and illegitimate or bad uses of power to, for instance, further or limit truth and freedom. Habermas argued that Foucault’s historical critiques implied that there can be no real awareness of self outside of strategic power-infused relationships with others. Consequently, there was no real hope for objective progress to occur in terms of self-emancipation for people collectively through self-awareness from being agents of, and/or suffering with, forms of oppression.

For Habermas and other critical theorists, the use of power can be legitimate or illegitimate and it does not just permeate personal relationships but also social structures and their institutions. These structural features can include

pre-figuring and/or asymmetrically concentrating forms and uses of power that oppress some people in communities but not others (Webb, 2000). Critical theory seeks to understand and address morally illegitimate uses of power through the strategic expression of morally legitimate ones.

2.2.1.3 Summary. Absolutism refers to: “The opposite of ‘relativism’, and hence infected with all the same ambiguity and indeterminacy” (Flew & Priest, 2002, p. 2). Debates associated with relativism, individualism, communitarian, and absolutism are in no way restricted to issues of morality and the self. For example, a relativist position towards knowledge argues that there is no universal objective knowledge or truth of the real world independent of the knower. Relativist views of SD would be consistent with compatibilist views of free will and determinism, while absolutist SD positions would argue that either free will or determinism always “trumps” the other. Parsing the positions illustrates the enduring paradoxical nature and complexity of these debates – is a firm relativist view of free will absolutist?

Relativism-absolutism debates in virtually all philosophical areas concerning the “self” show no signs of abating, including those concerning notions of SD, freedom, truth, autonomy, power, and will. Instead, philosophical debates or discourses appear to be growing in ambiguity and indeterminacy with the advancing of critical social theories, the advent of postmodern perspectives and critiques, a greater respect for cultural diversities, and multiple methodologies used in scientific research activities. This trend suggests that an applied discipline

such as social work accepts at its own peril historical and traditional philosophical assumptions of the meaning(s) of the self or SD to inform and improve practice.

2.2.2 Psychology and the Self

David Murray (1988) suggested that John Locke helped give credence to the notion first attributed to Thomas Hobbes (1588-1679) that all thought is made up of two processes – sensation and reflection:

By sensation the mind receives data from the external world. The sensations vanish, but memories are left. We can observe these memories with our minds and by reflecting on them can lay down further memories, and, moreover, give ourselves certain concepts by the process of mental abstraction. A single word symbolizing a unit of content of the mind at any time is 'idea' (p. 97-98).

Murray attributed Locke with the notion that the meaning of self is ultimately acquired by individuals through sensations, reflections (memory) and abstractions rather than being somehow innate. Through conscious memories, one has an ongoing sense of self or identity. However, Locke acknowledged that we can act without conscious awareness (e.g., sleepwalking).

Murray also highlighted Locke's role in furthering an "association of ideas" conceptualization of how the human mind works that influenced early psychologists. It suggested that the mind's activity involves a "flow" of connected memories that are "laid down" by sensations into a coherent and continuous sense of identity or self. How these memories are processed is learned.

2.2.2.1 Overview. Psychology emerged and grew in the latter half of the nineteenth century. Tracing the meanings of self in psychology is a thesis unto itself. However, using Seigal's dimensional framework for analyzing different

views of the Western self – the bodily or material, the relational, and the reflective – is a rough but useful tool for comparing and contrasting different psychological views of the self in relation to meanings of SD. It also overlaps with social work's traditional biological/physical, psychological, and social (i.e., "bio-psycho-social") perspective (Kimberley, 2000).

Early psychological views of the self tended to emphasize one of Seigal's bodily/material, relational, or reflective dimensions. Competing theories emphasized one dimension as more important than the other two. Different views of the self have waxed and waned within and between various proponents of psychological and psychiatric schools of theory and practice (Alexander & Selesnick, 1966; Murray, 1988). For example, organic psychiatry's view of the self, mental health, mental illness, and addiction that is located in human physiology (especially the brain) sits firmly in Seigal's bodily/material dimension. This medical perspective gained dominance in the late 1800's, waned through the first half of the twentieth century, and has re-emerged with vigor in association with technological advances aiding the study of the human body and new psychotropic medications (Clarke, 1973; Murray, 1988).

2.2.2.2 Psychoanalytic/psychodynamic views. Sigmund Freud's (1856-1939) psychoanalytical theories are situated primarily (but not exclusively) in Seigal's bodily or material dimension associated with the human "mind" (rather than organic psychiatry's emphasis on the physical processes of the human brain).

Despite Freud's acknowledgement of a social dimension of the self and the importance of social processes in the inner workings of the id, ego, and superego; nevertheless, his early psychoanalytical writings focused primarily on the innate drives, internal conflicts, and fantasies of the individual's mind (Fromm, 1965 [1941]). Freud's work in the early twentieth century gained credibility and allegiance among many medical and mental health professionals, including social workers, until the latter half of the century (Clarke, 1973; Murray, 1988).

Many of Freud's early collaborators and students, and later "psychodynamic" theorists, developed their own distinct views of the self that diverged and competed for credibility and influence with Freud until his death, and subsequently with each other (Alexander & Selesnick, 1966). Otto Rank (1884-1939) was particularly influential in early psychiatric social work theory and practice associated with the *functional school* that is discussed below. After breaking from Freud, Rank focused on the bodily dimension in terms of an internal, innately creative, but not necessarily always constructive or positive force that he referred to as "will" (1945).

Other subsequent psychoanalytic/psychodynamic views turned to emphasizing more of the relational and/or reflective dimensions of Seigal's framework than Freud. Leading examples include the work of Alfred Adler (1870-1937), Erich Fromm (1900-1980), and Heinz Kohut (1913-1981), and, more recently, Carol Gilligan.

2.2.2.3 *Behavioral views.* Behaviorism is another one-dimensional view of the psychoanalytic sense of self. It is located primarily in Seigal's relational dimension. This view of the self challenged the psychoanalytic tradition in psychology through much of the first half of the twentieth century. This incompatible or "hard" deterministic view suggested that SD or free will was an illusion and that the behavior of the self was determined by environmental conditions and consequences (e.g., Skinner, 1971).

The classic behavioral view of the self has been challenged from within its field by more multi-dimensional views of the self. One example is *social learning theory* (Bandura, 1977). It integrated cognitions and memory (the bodily/material dimension) with social modeling processes and conditioned responses to environmental stimuli (the relational). The important concept of "self-efficacy" is associated with social learning theory. It refers to a person's assessment of his or her ability or competency to perform tasks.

2.2.2.4 *Humanist views.* Humanism is yet another distinct one-dimensional view of the self that arose in the mid-twentieth century. It is located in Seigal's reflective dimension. Murray (1988) suggested that humanism emerged in association with existential philosophy, discontent with the psychoanalytical school's theoretical emphasis on intra-psychic or internal impulse-driven forces and processes, and dissatisfaction with behaviorism's belief in deterministic environmental forces and processes (p. 415). Humanism sees the individual self in terms of not just surviving but "becoming" as the innate primary goal in life,

needing a positive attitude to his or her self (e.g., Rogers, 1961), and needing to pursue finding and expressing the “best” of his or her self (e.g., Maslow, 1962). These beliefs and values coalesced around ideas such as “self-development” and “self-actualization” (Murray, p. 416-417). The existential humanist view of the self in social work sees a person’s subjective perceptions of reality, regardless of the degree they are considered to be shared or dysfunctional, as key to understanding and helping the person (e.g., Krill, 1996).

2.2.2.5 Cognitive and social constructivist views. Cognitive theory (e.g., Beck, 1976) is another important psychological view of the self that is primarily concerned with informational processing of the mind (i.e., Seigal’s bodily/material dimension). It is often matched with behavioral approaches in practice (i.e., *cognitive-behavioral therapy*) to create a more multi-dimensional view of the self. Albert Ellis (1913-2007) integrated rational or cognitive processes with emotion-stimulating external events, situations, and/or experiences with other people (i.e., *rational-emotive therapy*). Behavioral, cognitive, and rational-emotive therapies tend to promote the therapist being more assertive or directive with clients than the psychoanalytic/psychodynamic and humanistic approaches (Reber & Reber, 2001).

A more relativist perspective associated with cognitive theory is constructivism (Granvold, 1996). There are many theoretical variations associated with notions of *constructivism* and *social constructivism* in psychology and sociology (*constructionism* is another related term). Constructivist views may

emphasize individual internal cognitive processes and states while social constructivism more formally integrates Seigal's relational dimension (although the terms may be used interchangeably).

2.2.2.6 Power, relationships, and applied practice. As touched on above, psychological theories of the self in applied practice influence the perspective and practitioner role in terms of determining the cause(s) of problems and the best treatment approach. They also influence the relational stance of the practitioner (e.g., doctor, psychologist, nurse, or social worker) with people receiving services in mental health/addictions treatment settings. One example specific to SD is in terms of the worker deciding to be more or less active in overtly or covertly directing the client towards adopting/suppressing a particular belief or behavior.

Rocco Cottone (2001) suggested that the social constructivist perspective in mental health reorients decision-making processes in treatment towards being more shared and respectful of the knowledge of the client. The social constructivist perspective also inferred that there is a reciprocal constructivist process occurring within and between clients and social workers (Granvold, 1996). Combined with postmodern ideas, constructivism/social constructivism has contributed to the development of psychotherapeutic treatment models such as solution-focused brief therapy (e.g., Berg & de Shazer, 1993) and narrative therapy (e.g., White & Epston, 1990). However, Foucault and critical theorists raise important questions about how power, knowledge, and truth are interrelated and permeate relationships, including ones between professionals, treatment

systems, and clients. Complex relativistic versus absolutist notions of power infuse these questions and concerns. For example, social constructivist practice may facilitate shared decision making and greater respect for the personal knowledge of the client; however, its subjective/relativist stance could, arguably, also lead to an infinite degree of elasticity among and between people in terms of evaluating and addressing issues of power use and misuse in day-to-day clinical interactions. Consequently, the approach could still potentially be highly directive within a co-constructing practice context (e.g., aggressively persuading clients to adopt alternative meanings of experiences).

Critiques of radical relativist views of the self (and, in turn, SD) can echo Taylor's communitarian critique of the modern self's radical first-person stance. This view suggests that there needs to be some absolutist external moral standards to be recognized, drawn from, and upheld. The critique recognizes and tries to protect and/or advance the rights and needs of people who are collectively particularly vulnerable such as children. Critical theory also, for example, argues that social interdependencies and asymmetrical or unfair advantages and disadvantages structurally exist and are perpetuated for some people but not for others (e.g., based on gender, ethnicity/race, class, disability, sexual orientation, and/or age). Consequently, shared absolutist standards need to exist to morally address illegitimate or unfair expressions of power in societies. The directive stance and actions of the program/practitioner vis-à-vis the client, regardless of theoretical perspective or well-meaning (e.g., utilitarian) intentions, is a key area

of concern in relation to mental health self-advocates meanings of SD. Checking worker directiveness is one traditional function of CSD in social work (McDermott, 1975).

2.2.2.7 SD and motivation in psychology. Motivational psychology is concerned with what energizes human behavior (Reber & Reber, 2001). A notion formally referred to as SD has only recently emerged in this psychological field. Edward Deci's *Self-Determination Theory* (SDT) argued for a multi-dimensional and compatibilistic view of the self.

SDT assumes that SD is a process of utilizing one's will. Will is seen as the capacity of the human organism to choose how to act based on the internal and external information available. Will is also involved in the intrinsic need of people to feel competent and self-determining in relation to their environment. At the same time, it integrates the importance of the environment in affecting peoples' will in relation to SD as a form of autonomy. SDT emphasizes the development of three different loci of "causality" (somewhat similar to notions of locus of control in social psychology and attribution theory) that motivate people:

- *Internal causality orientation:* Characterized by internal motivation and autonomy, and facilitated by responsive, informational environments. This orientation is thought to foster the highest degree of autonomy and self-competency or self-efficacy.
- *External causality orientation:* Characterized by people motivated by external rewards. Controlling environments are thought to prevent people

from resolving conflicts associated with being self-determining. However, such environments do facilitate developing self-competency.

- *Impersonal causality orientation*: Characterized by people having unresolved autonomy and competency issues. Environments that are non-responsive to persons' needs for autonomy and information are thought to undermine SD and self-competency.

SDT assumes that people struggle with conflicts around establishing trust and autonomy (labeled as SD conflicts). People experience self-competency, self-efficacy, or self-mastery conflicts in relation to their environments. Their specific environmental context affects the resolving of these SD and self-competency conflicts. People develop a locus of causality in relation to resolving these conflicts, or not. Peoples' locus of causality is assumed to be a stable feature or state of the self (Deci & Ryan, 2002).

SDT has been tested quantitatively in relation to athletic performance (e.g., Pelletier, Fortier, Vallerand, & Briere, 2001), educational performance (e.g., Guay, Mageau, & Vallerand, 2003), and medical treatment compliance (e.g., Williams, Rodin, Ryan, Grolnick, & Deci, 1998). SDT hypothesizes that an important determinant of involvement in, and compliance to, medical care is whether the client feels autonomous (i.e., an internal locus of causality) in treatment participation. Behaviors motivated by external pressures, contingent rewards, and punishments are assumed to promote an external locus of causality

that is not conducive to resilient internally-based motivations to get well (Sheldon, Williams, & Joyner, 2003).

Proponents of SDT state that it's application in mental health and addiction practice is best expressed through *motivational interviewing* (Sheldon, Williams, & Joyner, 2003). Motivational interviewing (Miller & Rollnick, 2002) emerged in addiction treatment in association with James Prochaska and Carlos DiClemente's (1982) *Trans-theoretical Model of Change*. Like SDT, Prochaska and DiClemente's model of change recognized that competing theories of the self and change do not fit or explain all people, all of the time. Unlike SDT, their model was developed inductively. The authors qualitatively explored the experiences of people who reported making major changes in their lives without professional help (they began with people who quit smoking cigarettes). They then analyzed interviews and compared generated themes with various theories and therapies in the area of addiction treatment. They inductively developed a heuristic model of self-directed change that occurs in discrete stages. The authors argued that treatment should support and facilitate this natural process of change rather than force on people some sort of deduced theory and its respective prescriptions.

Prochaska and DiClemente's trans-theoretical model proposed that various theories and therapies may have some potential value for helping different people at different moments or stages of his or her self-driven process of change. Consequently, the skill, wisdom, and knowledge of the professional focuses on

how best to nurture or motivate, support, and collaborate with the natural change process (through motivational interviewing) and how best to match helpful treatment approaches with an individual's unique self, goals, and his or her stage of changing (this approach is sometimes referred to as *eclectic* practice). (Miller & Rollnick, 2002).

The trans-theoretical model of change and motivational interviewing do not adhere to any one theoretical perspective. Supporting a person's internally motivated and self-directed processes of change is the key. The perspective is inclusive of various views of addiction (e.g., medical/12 step "disease" models, social learning theory, and self-medication models). It does not commit to any particular theory or beliefs about the self in relation to mental health or mental illness. Consequently, it is one influential addiction-related treatment framework that is being used to try to develop a more integrated and effective treatment approach for CDs (Meuser et al, 2003; Finnell, 2003).

Motivational interviewing (Miller & Rollnick, 2002) is directive in terms of using practitioner influence within a therapeutic relationship to openly promote change. At the same time, it is not meant to arbitrarily predetermine clients' goals; nor is it intended that the clinician arbitrarily decide for a person how best to achieve their goals. This practice approach integrates experiential learning in the process of change and it celebrates all change, no matter how small. William R. Miller and Stephen Rollnick (2002) discussed their concerns that practitioners could use their approach to unethically manipulate or exert "undue influence" on

clients in the name of change, through their power in the counseling relationship (p. 161-175). Their concerns included how the directiveness towards change inherent in the approach is used as the model is being adapted to different contexts (e.g., hospital rather than outpatient counseling settings), and issues (e.g., CDs; diabetes self-management). As touched on above in terms of worker power, SD, and directiveness, their concerns appear well-warranted.

2.2.2.8 Summary. The major different views of the self in psychology typically start out emphasizing the primary importance of one of Seigal's three dimensions. There is a subsequent trend among all the major schools in psychology towards an increasing complexity and integration of one or both of Seigal's other dimensions. This trend extends to practice that reflects increasingly eclectic approaches. As in philosophy, the trend towards more complex and multi-dimensional meanings of the self shows no sign of abating. Just as the philosophical views of Locke, Hume, Kant, Freud, and others influenced more absolutist views of the self in early psychology and social work, critical theorists and postmodern critiques are influencing applied mental health and addiction treatment fields today in terms of more multi-dimensional, compatibilistic, and complementary views of the self.

2.3 Social Work, the Self, and CSD

A generalist social work movement emerged in the 1960's and 70's (Bartlett & Saunders, 1970). The generalist view saw social work as a composite of key concepts, generalizations, and core principles relating to knowledge,

values, and interventions so that the social work base is “not the doing but what underlies the doing” (p. 129). CSD was included as one of the core principles.

The generalist model in social work includes a “person-in-environment” perspective of the self. The person-in-environment concept is usually discussed in terms of three interrelated, interdependent, and reciprocal dimensions of the lived experience: the natural, biological or physiological; the psychological (i.e., cognitions or thoughts, emotions and moods, and behavior); and the social (Kimberley, 2000; Avarim, 2002). The concept orients applied social work practice to the dynamic interactions or transactions of individuals and social facets of life, including the relationship between the worker and the client (Shulman, 1991; Compton, Galaway, & Cournoyer, 2005).

An “ecosystems” perspective is replacing references to person-in-environment in social work (Germaine & Gitterman, 1980). Mark Mattaini and Carol Meyer (2002) suggest that: “[the person-in-environment’s] hyphenated structure has contributed to a continuing imbalance in emphasis on the person or the environment. As a result, practitioners have often attended primarily to one or the other” (p. 3). They argue that “ecosystems” better upholds an interrelated, interdependent, and transactional perspective for different specialized social work activities across diverse fields of practice and contexts with different client modes (e.g., individuals, families, groups, and communities).

Both the person-in-environment and ecosystem concepts have their critics in social work. Critical theorists provide one example. According to Elizabeth

King Keenen (2004), critical theories may vary but they share conceptualizations that include:

- Human actions create patterns over time. Patterns translate into social structures. Such structures “define, limit, and inform possibilities for human action” (p. 540).
- Human action and dynamic social structures exist in an evolving spiral as each form and inform the other through their patterns of interaction.
- Practices or patterns of behavior may perpetuate or change the existing relations between people and structures.
- Practices act out particular configurations of culture, power, and identity.
- Configurations of culture and power that operate through human action lead to collaborative networks and asymmetrical or unfair relations.
- People are socially situated in different positions.
- Different positions specifically construct different perspectives, meanings, interests, and the access or use of power.

Keenan argued that a critical view more clearly articulates the symbiotic relationship among individuals and groups and their ecosystem. She suggested that the ecological perspective, in contrast, remains vulnerable to people assuming relationships are purely transactional in nature (although proponents of the ecological view argue otherwise).

2.3.1 Social Work in Mental Health and Addiction

In North America, the generalist movement shifted social work in mental health away from being such a specialty. Still, social work is said to be the current largest single professional group that provides mental health services in America (Gambrill, 2003). A NASW member survey in the U.S. (1999) found mental health to be the largest primary area of practice reported (39%).

While social work in mental health may be the largest practice field, the field of addiction appears to be one of the smallest. The same NASW survey (1999) cited above found less than 5% of respondents identifying addiction as their primary field of practice. There are many possible reasons for the lack of a strong social work presence in addiction treatment. Regardless, integrating addiction and mental health theory/practice knowledge is not necessarily going to progress any easier or faster in social work than in medicine, nursing, or psychology. Similarly, The Canadian Association of Social Worker (CASW) website (member site) also reports that mental health is the largest reported area of practice and addictions is one of the smallest.

2.3.2 The Self in Social Work

The early integration of the charity organizing and settlement house movements, the subsequent generalist practice movement, and the trend towards an ecosystems perspective all point to a social work view of the self that is fundamentally multi-dimensional. This is a different core disciplinary view of the self than the traditional organic or biological focus in health care (e.g., the

medical model) or the competing major one-dimensional theoretical movements in psychology. However, there is ongoing tension between proponents of various multi-dimensional conceptions of the self within social work. Different conceptions include more traditional atomistic views of the individual person transacting or self-constructing within an environment, communitarian “social SD” views of the self that do not radically disconnect the individual self from a family, cultural group, or community (e.g., Falk, 1988), and diverse critical theory/anti-oppressive perspectives that focus more on the recursive interconnectedness between people and social structures in relation to power, culture, and identity (e.g., Mullaly, 2002). All of these perspectives of the self tend to operate at a fairly abstract level in the social work literature. Each view tends to jockey with the others in trying to influence the profession, students, and practitioners. They also emphasize psycho-social facets of the self. For example, there is a trend to discuss and integrate notions of spirituality more into the social work perspective (e.g., McKernan, 2005). However, the organic physiological facet of Seigal’s bodily/material dimension of the self is often lacking.

One of the challenges that proponents of the different views above appear to share is the difficulty of translating and applying their preferred theoretical perspective of the self into social work’s many dynamic and often highly-charged applied practice contexts, including helping people who are dealing daily with the symptoms of CDs. The approach to this challenge that is also fairly consistent across the above views is to make theoretical assumptions about the meanings of

the self in terms of the client and then to focus their attention mostly on the role of the worker in practice contexts. The practicing social worker's "use" of his or her self in relation to the client, practitioner self-awareness, self-reflection, and more recently critical self-reflexivity have been repeatedly discussed and debated since the beginnings of social casework.

Mary Ellen Kondrat (1999) highlighted social work's difficulties with notions of self in the profession and discussed some conceptual differences between the above views. She suggested that: "professional self-awareness is widely considered a necessary condition for competent social work practice. Definitions of self-awareness rely implicitly on various meanings of the term 'self.' Yet, the question, what does it mean to be a self? is not directly addressed in the practice literature" (p. 451). Kondrat then addressed the issue in terms of the worker's "self" but not in terms of the client.

As Kondrat's article suggests, social workers will not typically specify a clear conception of the client "self" in practice (especially when one includes families, various groupings of people, communities, and so forth under the umbrella term of "client"). However, when notions of the self are discussed in the theoretical social work literature then they are often highly generalized and do not offer much more than general principles to apply in practice contexts (a challenge similar to codes of ethics discussed below). Consequently, a conception of the client meaning of self may often be assumed or implied through the practice setting such as an organic view associated with the medical model. Alternatively,

workers may assume or adopt one or more of the views associated with traditional, critical, or postmodern-related perspectives in philosophy, sociology, or the myriad of therapeutic models and traditions in applied psychology.

When the meaning of self in relation to the client is overtly conceptualized in social work theory or practice models, the inner world of the person and the outer world (e.g., the environment, ecosystem, and/or social structures) are usually included or integrated in some way. For example, the *life model* (Germaine & Gitterman, 1980) and the *interactional* practice approach (Shulman, 1991) overtly use ecosystems theory (an integration of general systems theory and ecological theory) in their practice models.

Howard Goldstein (1981) provides one detailed example of how the self is viewed in relation to social work practice. Goldstein, who cited psychologist Gordon Allport as an important influence, described his view of the self as an “active and transactional conception” that is best understood as a “state” and a “process”, and which can only be understood within its environmental context rather than as a separate “static entity” (p. 111). Generally speaking, Goldstein’s concept of self included:

- An individual’s interactions need to be seen within the context of time and situation.
- Perceptions and interpretations of experiences lead to consequences and adaptations (including the risk of the self being arbitrarily defined by others).

- The self is a system that searches for stability within dynamic inner and external contexts.
- Past-present-future and inner image-outer reality “dialects” are an important process of the self.
- The self is “intentional, future oriented, and in pursuit of meaning” (p. 112).

Another example of a developed concept of the self in a social work practice model is Sharon Berlin’s cognitive-integrative perspective (1996; 2002). Berlin’s constructivist view suggested that the self is both discernable from, and integrated with, the external world. She posited that the self is essentially our autobiographical memories that contribute to our different qualities of self-recognition and experiences. The memories are organized into patterns, schematic networks or “self-schemas.” (2002, p. 95) Self-schemas are both symbolic (i.e., one’s self-concept) but they also are “keepers” of gained knowledge from experience. The memories serve to construct a stable, consistent or unitary view of the self in various areas of life, both internally and with our environment (i.e., we are essentially “meaning makers”). Referencing studies in psychology, Berlin (2002) stated that a “healthy” self involves multiple, relatively independent, and largely complementary self-schemas that reflect “self-other interdependence” and “variability in the conceptions of self that are activated in different contexts and across time” (p. 96).

A third example of a developed social work view of the self is focused on oppression. Anti-oppressive theory and research in social work seeks to understand and address in practice individual and structural processes that underpin oppression, stigma, and discrimination (including traditional social work values, roles, and practices). The impact of oppression on an individual or group of people is often considered in terms of some people being “mentally colonized” by others, some people being given negative “labels” that socially define them, and some people exhibiting a “false consciousness” that negatively values his or her self in relation to others (Quintana and Segura-Herrera, 2003, p. 270). The anti-oppressive movement is particularly concerned with understanding how constructs of identity, senses of self, or our subjective views of our self develop and become fixed individually and collectively in relation to oppressive states, social structures, and/or processes (e.g., Furlong, 2003). Bob Mullaly (2002), a critical/anti-oppressive social work theorist, suggested that most anti-oppressive writers: “agree that oppression is linked to social conditions and that the environment... plays an important role in influencing the individual psyche....Conversely, there is broad agreement that the individual plays an active role in mediating the effects of environmental factors” (p. 122). Mullaly argued that oppression is characterized by multiplicity and heterogeneity rather than linear divisions between socially interpreted characteristics of the self such as gender, social status, sexual orientation, disability, or ethnicity/race. He suggested that most people can belong to more than one oppressed category, people can be

oppressed by others individually and collectively, and people can individually and collectively oppress his/her/their self.

Mullaly reviewed models of oppression such as the “single strand” model (one type or source of oppression is believed to be primary to other ones). He argued that this model does not capture the multiplicity of oppression, such as what a disabled woman of color might experience in terms of racism, sexism, and the stereotyping of her disability. Mullaly acknowledged there are pluralistic “parallel” models, but he suggested they still do not address the phenomenon’s relational and overlapping qualities. Mullaly supported an “intersectional model” proposed by Steven Wineman (1984). Wineman’s model is more like a web or net of intersecting forms of oppression that can mutually reinforce each other and cannot simply be isolated, understood, and addressed independently.

2.3.3 Client Self Determination

Mary Richmond (1917) is credited with inductively developing an empirically systematic (i.e., “scientific”) approach to early social casework theory and practice from the analysis of thousands of casework files and worker case notes. She is associated with the development of the *diagnostic school* of casework. Components broadly consisted of history, an early form of diagnosis (i.e., a systematic professional judgment), and treatment. Although attentive to the social dimension, the diagnostic approach to casework tended to work with individuals and/or families in order for them to adjust better to their social

situations rather than focus on changing the existing socio-economic environment (Turner, 2002).

By the nineteen-thirties, social work with groups and community development activities associated with the settlement house movement were growing (Biestek & Gehrig, 1978). Nevertheless, casework continued to dominate the field. CSD arrived in social work with the publication of Bertha Reynolds' book, *Between client and community* (1934). Reynolds was a psychiatric social caseworker and educator. Drawing on the work of Virginia Robinson, Reynolds promoted CSD as the key philosophical principle around which all casework should be organized. She never actually defined her view of self or specifically stated her meaning of CSD. This may be because SD was being talked about in relation to democracy and politics after World War I, there was a generally accepted notion of the ego and meanings of self in psychoanalysis, and/or because of assumptions associated with the inherent focus on self-reliance and self-direction in early diagnostic and functional casework. Nevertheless, the lack of a formal definition in Reynolds' work stands out in relation to social work's attempts over the next seventy-plus years to make sense of the concept and to operationalize it in practice.

Reynolds' philosophy was not widely adopted in casework. However, CSD came to be seen as integral to all social work activities despite its meaning remaining vague and debated (McDermott, 1975, Rothman, 1989, Taylor, 2006). For example, over the years, CSD has been described as a "liberating force"

(Keith-Lucas, 1963, p. 67), the “focal point of the value system in social work” (Biestek & Gehrig, 1978, p. 4), “one of the most prominent and secure pillars upon which social work is built” (Reamer, 1983, p. 254), and “the most confounding and professionally debilitating concept of all the intellectual principles undergirding social work” (Rothman, 1989, p. 599).

Perhaps because of the confusion around the meaning of CSD, the number of published social work research studies concerning CSD pales in relation to the number of scholarly discussions. Discussions tend to fall within three major categories: (a) discussions of CSD in ideal terms; (b) discussions that focus on CSD in ethical terms; and (c) discussions focused primarily on clients’ meanings, experiences, and outcomes. The categories are interrelated. They are distinguishable within discussions in terms of an emphasis in the text on one category versus the other two.

2.3.3.1 CSD ideals. Ideal as a noun refers to “a standard or principle to be aimed at” (Soanes & Stevenson, 2006, p. 707). Reynolds promoted CSD as an ideal to guide practice. Her idea of CSD supported creating more voluntary relationships between workers and potential clients (e.g., educating people about social work services and letting them choose to become clients), self-help, and client participation in casework (Reynolds, 1934). CSD ideals generally provide an overarching reference for applied social work to recognize and uphold the client’s right to self-direct, self-control, and to apply his/her/their own meanings to the indeterminable/unpredictable nature of their lives. Ideal themes fall into at

least three major sub-categories: CSD as a need; CSD as a right; and CSD as a fact.

Ideal positions supporting CSD as a “need” often involve beliefs that there is an inherent universal need among people for SD in order for personal growth to occur (e.g., Reynolds, 1934; Wieck & Pope, 1988) and/or to maintain and enhance physical health and wellbeing through personal choice and control over such areas as personal safety and security, affordable housing, and adequate food (e.g., Srebnick & LaFond, 1999). These CSD ideals are closely associated with the humanist and existential movements in psychology and social work. Ideal views of CSD as a right usually include complex moral discussions of individual and/or collective rights in relation to SD, freedom, and autonomy as well as political, legal, and civil rights that formally enshrine a perceived natural/moral right (e.g., Perlman, 1965; Biestek & Gehrig, 1978). In contrast, CSD as a fact of being human includes generalizations about physiological processes of each human body that are unique and self-driven (e.g., Carpenter, 1996) or practical functions that only the client can actually accomplish in treatment (e.g., Keith-Lucas, 1963). Ideal CSD discussions may promote one sub-category over the others (e.g., McDermott, 1975). Alternatively, the three may be mixed into an overall statement of the importance of CSD:

The importance of SD, according to this [Functional School] orientation, was placed in the very nature of man; and that was why it was a civic right in a democratic society, why it was a psychological need, and why it was necessary for effectiveness in social work” (Biestek & Gehrig, 1978, p. 55-56).

2.3.3.2 *CSD ethics*. Ethical CSD discussions focus primarily on the practicing social worker or the profession as a whole. Ethical discussions functionally try to forge a coherent connection between CSD as a generalized ideal with “front-line” applied theory/practice realities across a wide array of practice fields and contexts. The U.S. NASW *Code of Ethics* (1960) referred to a client’s right to SD. Subsequent revised NASW codes (1979, 1990, 1994, and 1999) continued to refer to CSD in some way. For example, the latest *Code* (1999) referred to CSD as an ethical principle and stated:

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients’ right to self-determination when, in the workers’ professional judgment, clients’ actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

Although the Canadian Association of Social Workers (CASW) formed in 1926 it did not develop a code of ethics until 1977. It was updated in 1994 and again in 2005. The CASW codes have also included references to CSD as an ethical principle. The latest *Code* (2005) stated that: “Social workers uphold each person’s right to self-determination, consistent with that person’s capacity and with the rights of others” (p. 4). A separate principle under the same value said that: “Social workers uphold the right of society to impose limitations on the self-determination of individuals, when such limitations protect individuals from self-harm and from harming others” (p. 5). The CASW *Code* included a glossary definition for SD:

A core social work value that refers to the right to self-direction and freedom of choice without interference from others. Self-determination is codified in practice through mechanisms of informed consent. Social workers may be obligated to limit self-determination when a client lacks capacity or in order to prevent harm [Regehr & Antle, 1997, p. 11].

The NASW and CASW codes share some similarities. Both refer to CSD as a “soft” or conditional right and both associate it with supporting the dignity and worth of people. It is interesting that the NASW used the term “promote” in relation to clients’ SD while the CASW used “uphold.” The use of the different terms suggest that the U.S. code leans towards a CSD meaning that guides workers to create opportunities for clients to be more “free” (i.e., positive freedom) while the Canadian code more conservatively guides workers to protect clients’ existing basic personal freedoms associated with citizenship (i.e., negative freedom) (see Berlin, 1969).

CSD meanings in professional codes of ethics are one attempt to establish some sort of a shared value, principle, and standard to help guide large numbers of social workers active across a wide array of different client modes and service delivery contexts. However, the meanings of CSD within these codes are so highly generalized or idealized that their utility in complex and dynamic day-to-day practice contexts is often criticized (e.g., Rothman, 1989). Ethical dilemmas and paradoxes abound with respect to CSD ethical statements and social workers exercising influence and authority in practice. The paradoxes are critical to understanding discussions in the ethics category. For example, one paradox involves social workers pursuing status as recognized “experts” in practice.

Professional recognition is “usually demonstrated by the powers and privileges conferred upon the profession by society” (Yelaja, 1985, p. 3). However, the more power the social worker gains, the greater the ability for the worker to override the client’s right to SD. From a critical theoretical perspective, the social worker may also have power and privileges that are asymmetrical to the client in relation to their respective socially constructed locations. If the worker does not recognize and be reflexive to the significance of these differences, and what they might mean to the client, he or she may inadvertently exercise undo influence or directiveness that negatively impacts on promoting or upholding CSD ideals (and, in turn, harm the client in some way). Alternatively, social workers may also use powers and privileges to advocate for and facilitate client abilities and opportunities to exercise and expand his/her/their SD.

Another paradox arises when structural conditions and practices that social workers are not directly responsible for are placed on clients (e.g., agency or system policies in health care; physician’s powers to direct interventions). People may become trapped into interventions or interactions with social workers against their will. A practice example in health care and mental health is where the physicians and psychiatrists have the responsibility to medically diagnose and prescribe treatment. Social workers may be responsible for implementing and monitoring adherence to interventions imposed by these authorities (Mackelprang & Salsgiver, 1996, Aviram, 2002). Such activities have led to critiques of social workers being naive, hypocrites or impotent vis-à-vis upholding CSD in the field

of mental health (Whittington, 1975; Cohen, 1988; Bentley, 1993; Avarim, 2002). However, social workers in these sorts of circumstances with clients may be able to use their expertise and authority to affirm and facilitate the empowerment of clients in ways that can lead to his/her/their being more self-determining.

Ethical discussions of CSD reflect at least four major themes in relation to the least harm occurring to clients and/or others in practice: the means and the ends; paternalism/maternalism; client capacity or competence; and advocacy. Means and ends relate to the ethical fit between professional CSD ideals and social workers' attitudes and/or actions with clients. One rationale argues that beliefs, practice, and outcomes need to be morally congruent. For example, a CSD ideal that emphasized philosophical notions of negative freedom or autonomy would lead to an absolutist ethical principle of CSD that restricted social workers from invading or intervening in any citizen's personal "space" in practice except under very specific conditions (e.g., McDermott, 1975). However, another absolutist perspective is closer to utilitarianism, where practices that are incongruent with an ideal of CSD that upheld autonomy are defended as appropriate for some later positive outcome for the person and/or a larger "good" for others (e.g., Davis, 2002). A third more relative perspective argues for dynamically matching supports and limits to CSD with changing client issues and circumstances (e.g., Murdach, 1996).

Paternalism/maternalism in ethical discussions is sometimes deconstructed into equally slippery notions of beneficence and non-maleficence. It is the ethical

rationale most often cited in discussions of CSD to support social workers trying to overtly influence, persuade, determine, limit, or coerce clients' beliefs, values, attitudes, relationships, thoughts, emotions, and/or behaviors. Marcia Abramson (1985) said that paternalism "is a form of beneficence in which the helping person's concepts of benefits and harms differ from those of the client's and the helper's concepts prevail" (p. 389). Alison Murdach (1996) argued that the literature on CSD has "paid too little attention to the protective treatment efforts necessarily undertaken by practitioners for the good of clients" (p. 31). However, Reamer (2006) cautioned that paternalism is an ethical problem when "interference" becomes normalized or is used to hide actions that benefit the individual worker or agency more than the client. He referred to the latter as "pseudopaternalism" (p. 109). Kristine Tower (1994) suggested that:

[In] the real world of human services, the constraints of time and limited funding are exacerbated by the demands of increasing caseloads[;] as a result, self-determination is frequently the first [ethical principle] to be violated in the name of expediency, protection, or cost containment" (p. 191).

Client capacity or competence discussions typically involve the social worker's overt or covert assessment, judgment, or diagnosis of client capacity or competence to appreciate her/his/their choices, to make self-directed decisions, and to realize the consequences of their decisions on themselves and/or others. The capacity or competency issue in ethical dilemmas often involves assessments of the perceived risk, imminent dangers, and/or verified harm to clients and/or others associated with the worker upholding or fostering CSD, or else restricting

it somehow. Abramson (1985) suggested that most social workers would agree that limiting CSD is justifiable if a client's actions would harm another person. However, she stated that it is much more complicated if others consider a client's actions simply "foolish" (p. 388) or else "when the act in question is harmful only to the person performing the act" (p. 389). Confusing competency with a clash of values or cultures is a theme often cited as a possible ethical trap for workers to not uphold CSD (Rothman, 2005). Barbara Nicholson and Gerald Maltross (1989) wrote that for professionals in health care "it often is easier to question a patient's competency than to recognize a legitimate conflict of values" (p. 235). Sharon Freedberg (1989) suggested that by simply "equating choice with virtuous, or at least approved, behavior, it is possible to discount client decisions" (p. 11). Other discussions in this area include:

- Relativist approaches to titrating paternal/maternal limits versus upholding CSD over time through workers' judgments of context-specific client capacities and degrees of risk (e.g., Murdach, 1996).
- The appropriate degree of worker directiveness or influence within a "helping" therapeutic relationship and specific contexts (e.g., Rothman et al, 1996).
- The risks to fostering CSD capacity over the long run if the client is consistently subjected to persuasion by the worker (e.g., Rothman et al, 1996).

Saul Bernstein (1960) wrote that supporting CSD based on a person's unexamined impulses is more a "surrender to instinctive drives than the expression of mature self-determination" (p. 39). However, Bertha Reynolds (1934) questioned "whether avoidance of the natural consequences of the client's choice really aids her development...to be free to choose means to incur risks (p. 105). Again echoing humanistic and existential beliefs, David Soyer (1963) argued that the experiential learning of clients was the key reason why CSD is so important in social work:

There are two reasons for supporting the self-determined aspirations of the client, even when they may seem farfetched. The first reason is simple: the client might be right, the worker wrong...The second reason for backing the client's aspirations is that only through life itself can the client really try, test, and temper his abilities, his fantasies, and his goals...This is how all people grow (p. 73).

Soyer acknowledged that there are times when certain constraints or limitations on client freedoms may need to be applied. However, the dictionary meaning of the term "aspiration" is related to hope (Soanes & Stevenson, 2006) and hope is a core theme of recovery for mental health self-advocates (see below). Soyer's meaning of CSD in relation to social workers upholding clients' experiential learning in relation to self-determined aspirations or hope may be one potential bridge to mental health self-advocates' vision of recovery.

Malcolm Payne (2005) defined advocacy as seeking to "represent the interests of powerless clients to powerful individuals and social structures" (p. 266). He identified advocacy and empowerment as "increasingly being used as a terminology to reflect client self-determination and openness in other theories of

social work” (p. 266). However, advocacy by workers on behalf of clients is increasingly being questioned and, instead, there is growing support for workers to collaboratively advocate with clients or facilitate client self-advocacy. Reasons for the shift include: greater appreciation of the risk to clients by the worker influencing or overriding the client in determining the best course of action in advocacy (Biestek & Gehrig, 1978); differences between workers and clients in terms of their values and standpoints (e.g., differences in gender, ethnicity/race, class, and age) which may inappropriately affect advocacy efforts and outcomes for clients (Hodge, 2003); and the risk of workers focusing on clients’ individual problems and solutions, while ignoring or avoiding tackling political/structural oppressive forces and processes (Spicker, 1990).

Different absolutist CSD ethical perspectives in relation to means and ends, paternalism/ maternalism, competency and capacity, and advocacy typically challenge one another in texts. However, relativist views that have to recognize context-specific idiosyncrasies of ethical dilemmas are typical in texts concerned with actually applying social work ethics in practice (e.g., Rothman, 2005). Many ethical responsibilities are shared and reciprocal; they may be seen as resting with the worker(s), the client(s), members of a health care team, an agency, family, and/or society. Nevertheless, the ethical onus is on the professional social worker to be reflexive, to be transparent, and to be prepared to defend the decisions they make, including those decisions that promote, uphold, or limit CSD.

2.3.3.3 *Client-centered CSD*. These discussions focus less on professional ethics and more on the client or the front-line worker in terms of the clinically therapeutic potential of CSD in social work practice. Weick and Pope (1988) help illustrate the distinction between client- and worker-focused viewpoints: “much of the current literature on this topic [CSD] has deflected attention from the recognition of client capacity for growth and instead has emphasized the decisions of the social worker. This shift in attention is crucial for the practice of social work, because it establishes a worker-focused rather than a client-focused perspective for practice” (p. 10). There are three subcategories of client-focused CSD views: practice knowledge, client empowerment, and client choice.

William Reid (2002) wrote that the most striking trend in social work practice knowledge over the past quarter-decade is the growing diversity of practice methods. Reid suggested that the postmodern discourse in social work is a main feature of the trend towards more strengths-based, multi-cultural, empowerment, anti-oppressive, solution-focused, and narrative approaches in mental health. He said that another trend associated with these approaches involves reformulations of the worker-client relationship that enhances CSD. This included generally seeing persons as having greater strengths and resources to be self-directing and as “full collaborators who contribute expert knowledge of themselves and their situations to the intervention process” (p. 9).

Francis Turner (1996a) compared 28 major social work practice theories and methods across 52 attributes. One attribute he examined was where each

theory stood on a "Freewill-Determination Continuum." Turner thought that four of the eleven theories and methods that he identified as strongly supporting freewill had solid social work beginnings: client-centered; functional theory; problem-solving theory, and task-centered theory. At the same time, he judged the traditionally influential general systems theory in social work as strongly weighted towards workers being deterministic with clients. Fifteen of the theories were judged to be either "about equal" (10) or "strongly determined" (5). Overall, Turner's analysis suggests that social work practice models do not lean towards being deterministic with clients. Nevertheless, the findings are somewhat mixed.

Client empowerment within the client-worker relationship is often cited as an exemplar of CSD therapeutically in practice. Judith Lee (1996) said that historical precedents for empowerment practice in social work include the settlement house movement, women's clubs, minority groups, early group work theorists, and the work of Bertha Reynolds. Molly Hancock (1997) stated that empowerment in social work: "is closely related to – but is more than simply an application of – the principles of client self-determination" (p. 229). Barbara Simon (1990), writing from a feminist perspective, argued that social workers interested in client empowerment can at best only "aid and abet" those who seek their own "power of self-determination" (p. 32). Concepts of empowerment in relation to SD in mental health recovery point to social work theory, practice, and research aligning with the interests and aspirations of people with mental health issues or mental illness. Kristine Tower (1994) wrote:

If practitioners align themselves with the interests of consumers, including consumer input and control, the result will be greater self-determination among clients and less ethical discord regarding paternalism within the helping professions" (p. 196).

The client choice and decision making subcategory is the most commonly referred to example of upholding CSD in practice. Felix Biestek (1957) developed the first widely accepted definition of CSD. He placed client choice and decision making as the primary proposition that defined CSD in social work:

The principle of client self-determination is the practical recognition of the right and need of clients to freedom in making their own choices and decisions in the casework process. Caseworkers have a corresponding duty to respect that right, recognize that need, stimulate and help activate that potential for self-direction (p. 103).

Biestek went on to say that the client's right to SD "is limited by the client's capacity for positive and constructive decision-making, by the framework of civil and moral law, and by the function of the agency" (p. 103). His definition was critiqued by some because the broad limitations rendered CSD as meaningless (Keith-Lucas, 1963; McDermott, 1975).

The voluntary client-worker relationship has been held up as an example of supporting CSD in practice since Bertha Reynolds. Yaheskel Hasenfeld (1987) stated: "much of the emphasis in social work practice theory is on the formation of this relationship that is voluntary, mutual, reciprocal, and trusting" (p. 469). However, he went on to argue that social work is largely agency-based, that worker-client relationships are often involuntarily formed by many of these agencies, and that practice theory does not adequately acknowledge the power the agency has over the worker and, in turn, over the worker-client relationship.

Few social work practice models organized around CSD have been suggested. The few proposed have not been empirically developed and tested (e.g., Petr, 1988). I was able to find only one graphic representation of a CSD model to guide practice. Stephen Gilson and Elizabeth DePoy (2004) proposed a hypothetical model that they said helped contextually clarify constructs such as SD, choice, empowerment, and self-advocacy. The authors noted that they refer to their conceptualization as SD and not CSD because they deduced their model from the perspective of the disability consumer rather than from the perspective of the social work profession or the social worker in direct practice. The model consisted of three axes in the form of an equal sided triangle. Each axis is a continuum. One axis represented foundational knowledge and skills that a person has, another axis represented "thinking" in relation to decision making (ranging from external control over choices and decision making to autonomous decision making), and the third was "action" (ranging from silence at one end, through need identification, to advocacy, and self-advocacy at the other end) (p. 6-9).

2.3.3.4 Summary. Social work has traditionally been more of an applied discipline than a theoretical one. Scholarly discussions of CSD in social work are characterized by attempts to develop idealized goals to influence the profession and ethical principles that can provide guidance and comparative references for operationalizing ideals in practice. Ethics can also help protect clients. However, there is no agreement on the operational meaning of CSD in social work practice. Idealistic and ethical discussions of CSD circle around

compatibilist/incompatibilist views of the self in terms of free will or determinism and absolutist/relativist standpoints towards practice. The literature includes many references to the importance of understanding CSD in terms of clients' meanings, experiences, and outcomes. What is striking, however, is that there is virtually no research into the meaning(s) or purpose of SD from the viewpoint of clients.

2.3.4 CSD Research in Social Work

Using a variety of literature search methods, I found twenty-three research studies on CSD using qualitative, quantitative, or mixed methods that were published over the past thirty years. The overwhelming majority of these studies examined social workers' beliefs, values, and/or behaviors in relation to deduced notions of CSD. For example, Jack Rothman, Wendy Smith, John Nakashima, Mary Anne Paterson, and Jean Mustin (1996) examined social workers' directiveness with clients among 35 experienced social workers in different practice fields that were randomly sampled from the field instructor pool of the UCLA School of Social Welfare. The first part of the study used in-depth interviews to examine the range of directiveness that participants used with their clients. The authors found there were four modes of worker directiveness with clients, ranging from least controlling to most controlling: reflective, suggestive, prescriptive, and determinative (i.e., coercive). Case vignettes were then elicited directly from the interviews. The second part of the study had an expert panel review the case vignettes and rate the ethical suitability of the degree of directiveness of workers in the vignettes. The study found that most workers

regularly used all four modes in their interactions with clients and that they were just as likely to be determinative with clients as reflective. The expert panel found that almost all the vignettes that involved reflective, suggestive, and determinative approaches were ethically suitable. The determinative mode was said to be clear-cut because it involved cases where there were discernable risks to "health, safety, and welfare or legal prescriptions to act, as in abuse situations" (p. 402).

However, they found that 17.6% of the cases where workers used a prescriptive mode were ethically unsuitable. I found no similar study that looked at the directiveness of social workers who had little or no experience in the field.

2.3.4.1 SD research in mental health or addiction. Four of the twenty-three CSD studies that I found concerned practice in mental health while only one concerned substance use or addiction (tobacco smoking). All the mental health studies explored social workers' attitudes towards supporting CSD in relation to involuntary hospitalization (i.e., involuntary commitment). The addiction study explored workers' attitudes towards CSD in relation to nursing home residents' choosing to smoke.

Rita Wilk (1994) and Melissa Taylor (2006) randomly surveyed U.S. social workers who registered with the NASW as specializing in mental health. Wilk used a quantitative approach with Likert-item questions. Taylor used a mixed methodology approach with both Likert-item and open-ended questions. So-han Yip (2003) surveyed social workers and physicians involved in involuntary commitment review panels in British Columbia (also using Likert-

item questions). The fourth mental health study used qualitative grounded theory methodology to explore mental health caseworkers' views of CSD in relation to their role in involuntary committing their clients to hospital (Encandela, Korr, Lidz, Mulvey, & Slawinski, 1999). Geri Adler, Michael Greeman, Holly Parker, and Michael Kuskowski (2002) randomly surveyed attitudes of nursing home social workers' in two U.S. states towards residents' choice to smoke. Again, they used Likert-item questions.

All of the survey studies operationally defined CSD differently. Wilk focused on hospitalized psychiatric patients' rights in five areas: involuntary commitment, environment and daily living choices, the right to treatment, the right to refuse treatment, and the presumption of legal incompetence. The degree of support for these rights was assumed to measure the degree of support for CSD. Taylor defined CSD in terms of client behavior emanating from his or her own "wishes, choices, and decisions" (p. 3). Her questions related to workers' attitudes towards CSD's utility and importance in practice, ethical conflicts involving CSD, and attitudinal changes towards CSD over time. Yip (2003) defined CSD in terms of autonomy and empowerment. Adler et al. (2002) defined CSD in relation to client rights to choose (in this case, to smoke in their residential "home"). They were interested in workers' support for such a right and workers' ethical concerns when client choice conflicted with some facilities' smoke-free policies.

Wilk found there was substantial support for the rights of the mentally ill among the social workers surveyed (N = 216). Overall, she found that the more abstract the CSD-related right was, the more respondents supported it; the more the right might directly impact on the social worker in some way, the less support it received (e.g., patients being able to examine his or her own records). Taylor found 97% (N = 320) rated CSD as important or very important in daily practice. There was not a high degree of distress reported by participants when practice situations seemed at odds with CSD, and they thought more about CSD in daily practice over time than when they first started in the field. Yip hypothesized that social work values of CSD would lead to more reports of ethical dilemmas among social workers than the physicians in relation to their respective involvement in panels that recommended continued involuntary hospitalization. Yip found that both social workers and physicians (N=39) had similar mixed feelings regarding autonomy and empowerment with respect to their panel involvement in coercive decisions. Adler et al. found that most social workers thought that residents did not have the right to choose to smoke and less than 14% (N = 113) ethically struggled with this position. Workers' own smoking behaviors were found to significantly influence their attitudes, such as those who smoked were more likely to support residents' right to decide in this area, or vice versa.

The mental health study that used qualitative grounded theory methodology drew client data from a larger study looking into involuntary psychiatric hospitalizations in a U.S. state. From the subset of data, eleven

involuntary hospitalized clients' social work case managers were purposively interviewed about their discretionary use of power. John Encandela, Wayne Korr, Charles Lidz, Edward Mulvey, and Tonya Slawinski (1999) found that the case managers thought that CSD was a central practice value. However, there were widely divergent views as to how they should help clients be self-determining. No actual grounded theory was generated. The authors concluded that CSD was too broad to be consistently translated into practice.

The studies share a number of traits. They include: defining CSD differently; focusing on professionals' attitudes and experiences in relation to CSD; focusing on most-restrictive environments and practices; and finding that attitudes largely supported CSD although its application in practice was of some concern due to the concept's vagueness or the perceived impact that upholding CSD might have on the worker. The Encandela et al. (1999) study's conclusion that CSD was too broad a concept to be consistently translated into practice is noteworthy because they do not consider the possibility that the clients could have helped clarify the value of CSD in practice.

The fact that I found only one CSD study concerning addictive substance use in some way was surprising. It may be that CSD studies by social workers in the field of addiction are published in journals that I did not review. It may also reflect the low participation of social workers in this field or, arguably, a potential bias in the profession of some kind towards this field of practice. However, it is just as surprising that there are so few CSD studies in the mental health field

given the large numbers of social workers practicing in the area. Although I found no CSD studies that focused on CDs there was one that did appear to have some relevancy to this review. Sharon Lawn, Rene Pols and James Barber (2002) explored the meanings of cigarette smoking among people with a serious mental illness who were involved with one Australian community mental health agency. Grounded theory was used to guide interviews and the analysis of transcripts. The study did not report that there was an immediate health risk from smoking for any of the participants. One theme was that smoking was a means for participants to feel more in control of their lives. Participants also reported that giving or withholding cigarettes was sometimes used by professionals to control them.

2.4 SD and the Mental Health Consumer/Survivor Movement

Mental health typically refers to the emotional, behavioral, and cognitive functioning aspects of our lives. Mental illness or mental health disorders refer to a broad range of conditions involving emotions, behaviors, and cognitions that can negatively impact on us and/or others. Severe mental illness generally refers to conditions that persist over time and have a severe functional impact. A formal medical illness or disorder diagnosis is identified by symptom classification. *The Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition, Text Revised* or DSM-IV-TR (American Psychiatric Association, 2000) is an authoritative source of criteria for symptom classification and categorical or differential diagnosis in North America.

There are many controversies associated with the concept and diagnosis of mental illness. At the most basic level is the question of whether mental illness exists at all or if it is a socially constructed designation or "label" that is based mostly on the subjectivity of the observer of the person and observer-subjectivity encompasses risks of biases associated with prejudice, stigma, and superstition (e.g., Szasz, 1974). Nevertheless, most people accept that we can be challenged in many ways, and that our lives could be potentially at risk, with conditions associated with conceptualizations of mental illness or mental health disorders. The classifications typically have some validity for social workers who, in the final analysis, are concerned with personal and social functioning of individuals, families, various social groups and other collectives.

Defining substance use issues or problems as a "disease" is also controversial (e.g., Peele, 1989). As with issues of mental illness, biased judgments and the stigma experienced by people with addiction issues can focus on an individual's responsibility for developing problems in the first place, and/or make an association between addiction and immorality (Barber, 1994). Nevertheless, substance use disorders and other behaviors associated with the notion of addiction are recognized as being often unhealthy and can put a person's life at risk. People tend to use non-medical terms like "addiction", "alcoholic" or "addict" to describe persistent and compulsive behaviors, psychoactive substance use, significant negative experiences (e.g., withdrawal) occurring when substance use is suddenly cut down significantly or stopped, and/or the progressive and

pervasive impacts on personal and social functioning associated with continued use. This designation is roughly the same as the DSM-IV-TR medical classification of a substance dependence disorder. The DSM-IV-TR also identifies substance abuse disorder where problematic symptoms are less severe or verifiable but can be interpreted as problematic or putting the person and/or others at some future risk. Addiction may also be used to refer to some patterns of behaviors that do not involve substances but are still similar in terms of their impulsivity, compulsiveness, and negative consequences (e.g., some eating disorders, problem gambling, and obsessive sexual, internet, or shopping behaviors). As previously stated, addiction issues have not been historically treated within most primary health care and/or mental health programs and services. This situation has persisted despite substance dependence being affirmed as a disease by North American medical associations.

As stated in Chapter 1, research suggests that people with mental health disorders are more at risk of developing substance use disorders than the general population (Meuser, Drake, & Wallach, 1998; Health Canada, 2001). Consequently, pressure is mounting on various health care, mental health care, and addiction systems, programs, and practitioners across North America to improve CDs treatment. Changes called for include treatment providers in both systems to work more directly with both issues, and to work less independently or in isolation from each other (Health Canada, 2001).

SD is not a term that is typically used, historically, in addictions theory, practice, or among people who self-identify being in recovery from substance use problems. However, notions of SD are important for many historically marginalized and oppressed groups in North America. This includes individual and collective self-advocacy activities by people with physical disabilities, developmental disabilities, and mental illness. Collectively, these groups are often considered under the umbrella of the disabled rights movement (Stroman, 2003). Mental health self-advocates may refer to themselves as “consumer/survivors.” This term is not necessarily a comfortable one for all self-advocates in mental health but it is often used in writings in this area. Generally speaking, “consumers” are considered to include people who tend to work collaboratively with family advocates, professionals, policy and program developers and so forth while the term “survivors” originally referred to those who saw themselves as having survived the treatment system as much as surviving the illness itself. Survivors tend to work outside the system and emphasize the recognition and upholding of basic civil rights for people with mental illness (Stroman, 2003). The consumer/survivor movement often refers to SD and self-direction as part of peoples’ subjective vision of recovery that is not defined, directed, and evaluated solely by experts and authorities (Tomes, 2006).

A mental health self-advocacy recovery vision arose in the last twenty years amid a renewed emphasis on deinstitutionalization and recognition of the rights of the disabled. William Anthony (1993) described this recovery as “the

development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (p. 11). Nancy Tomes (2006) saw the consumer/survivor movement as highly diverse and often divided over many issues. For example, some self-advocates might argue that involuntary treatment or compulsory medication programs lessen suffering in some cases while others argue they sabotage SD, channel public funds into corporate profits and professional salaries, and direct resources away from quality of life approaches that include affordable housing, fostering employment, and other social services. Despite the diversity of opinion, Tomes suggested that there is substantial consensus around a number of key ideas, including: "self-determination is a core principle of treatment" (p. 727).

Judith Cook and Jessica Jonikas (2002) saw mental illness recovery as not being about symptom cure or control. Instead it is about "learning to cope...in a way that allows the individual dignity, maximal self-determination, and the highest level of role functioning possible" (p. 311). Ruth Ralph (2000) discussed the role of empowerment and SD in recovery. She suggested that empowerment is a matter of SD and it occurs when the person can freely choose her or his own path to recovery and well-being. The Self-Direction Education Project (2004) stated that self-direction operationalizes five principles of a recovery-based philosophy of SD: (1) the freedom to decide how to live one's life; (2) the authority to control dollars that are available to purchase services and supports; (3) the supports needed to make informed decisions; (4) the responsible use of

supports and assistance; and (5) the participation of people with mental illness in the design, implementation, and evaluation of programs and systems (p. 1).

There is no single meaning of SD in the recovery movement. The ambiguity is consistent with the movement's emphasis on peoples' subjective perceptions of recovery, seeing people with mental illness as individually unique, and respecting their experiential knowledge (Stroman, 2003). However, this means that defining and operationalizing the concept of SD beyond general principles and values may be just as challenging within the mental health self-advocacy movement as it is in social work, psychology, and philosophy. Nevertheless, self-advocates are increasingly able to meaningfully participate in the debate on the meaning(s) of SD and how it is or is not integrated into treatment and recovery activities.

2.4.1 Consumer Focused Research and CDs

One of the important changes in the mental health treatment arena over the past decade has been the growing awareness of, and respect being given to, the voices of mental health self-advocates, patients, or clients (Tomes, 2006). A growing number of professionals, including many social workers, are aligning with self-advocates and calling for greater collaborative relationships with clients in treatment (Anthony, 1993; Bentley, 1993; Tower, 1994; Munetz & Frese, 2001) and research (Sullivan, 1994; Wilson & Beresford, 2000; Jacobson & Greenley, 2001; Turner-Crowson & Wallcraft, 2002). Of particular importance to this view of practice and research is the demand that professionals respectfully

include the experiential knowledge that people gain through living with a mental illness, creating their own vision of recovery, and being on the receiving end of treatment. Consumer/survivor self-advocates are generally supportive of research concerned with better helping people with mental health issues or symptoms of mental illness. However, they reject non-disabled professionals and academics monopolizing the meanings of technical knowledge, commanding how public funds for services are spent, pre-determining recovery goals, controlling evaluations of treatment and recovery outcomes (Stroman, 2003), and ignoring the damage that negative labeling can cause in association with being diagnosed with a mental illness (Frese, 1998; Munetz & Frese, 2001).

A few qualitative studies of people's experiences and meanings of recovery have been published (e.g., Deegan, 2003; Jenkins & Carpenter-Song, 2006; Deegan, 2007). For example, Patricia Ridgway (2001) used a phenomenological approach to analyze texts of four self-advocates who had written extensively about their experiences. Key recovery themes identified in these texts included: rekindling hope not despair; achieving acceptance and understanding of symptoms within a positive sense of self; reengaging and actively participating in life; recognizing recovery is complex, individually unique, non-predictive, and non-linear; and recovery is not accomplished alone. I found no studies that focused on SD and CDs from a mental health consumer/survivor perspective.

The self-help Alcoholics Anonymous (AA) movement has referred to recovery since its inception in the nineteen-thirties (White, 2005). AA avoids scientific definitions. For example, its view of alcoholism or addiction as an expression of a “disease” associated with an external agent, much like an allergy, is not defended to others in scientific terms and the movement maintains an arms-length relationship with treatment professionals and researchers. Recovery’s meaning is personal to each member and is revealed within a personal exploration of themselves through the program’s twelve principles or “steps” (AA, 1988). AA participation is voluntary, is structured, and directive. Abstinence is one pre-determined goal of recovery. AA is not associated with political calls for greater SD in addiction treatment. There are 12 step programs emerging that are geared specifically to people with CDs (Evans & Sullivan, 2000).

2.4.2 Summary

There is a trend towards valuing and incorporating client knowledge in mental health treatment and research. The consumer/survivor movement’s valuing peoples’ subjectivity and SD in mental health recovery appears to allow for people to make self-determined and self-directed decisions about addiction issues. There are similarities between the mental health self-advocacy movement and AA views of recovery. However, one major difference may be AA’s emphasis on abstinence as a pre-determined goal of recovery whereas mental health self-advocates appear to avoid pre-determined goals beyond improved quality of life and safety. Perhaps most important is that people living with, and recovering

from, mental illness have greater opportunities to meaningfully participate in the larger debate over evolving treatment services and supports. This includes people living with and recovering from CDs, given the fact that CDs are, arguably, a typical rather than atypical issue for people with mental illness.

2.5 Conclusion

There are other important conceptualizations of the self and/or SD such as those found in sociology, politics, and health care bioethics. For example, sociologist Erving Goffman (1922-1982) studied and wrote about how each individual self is socially affected and is expected to act or play a specific social role that changes in different micro-environmental contexts or spaces, including “patient” roles in psychiatric hospitals or asylums (1961). Another sociologist, Norman Denzin, studied and wrote about the “alcoholic self” and the “recovering self” from the phenomenological perspective of AA members (1993). He defined the alcoholic self as: “a self divided against itself, trapped within the negative emotions that alcoholism produces” (p. 373).

Political SD meanings surfaced in the early nineteen-hundreds. Woodrow Wilson linked SD with promoting international democratic practices and institutions after WW I (Lansing, 1921). Hitler subsequently referred to SD as justification to invade and “liberate” German-speaking people in Czechoslovakia, Austria, and Poland (Ronen, 1979). The United Nations *Charter* (1945) repatriated SD and it is now a significant political concept in international relations, law, and human rights (Kly & Kly, 2001). In Canada, political SD

meanings are an important part of the Quebec sovereignty movement and advancing the collective rights of First Nations people (Kly & Kly, 2001).

Finally, concepts of SD have emerged in U.S. health care in association with “right to die” directives and euthanasia debates (Ulrich, 1999). Autonomy is often a SD synonym in bioethics with respect to patients’ rights to be educated about their illness, patient rights to be informed of treatment choices, and patients’ treatment decision-making powers being supported and facilitated (Beauchamp & Childress, 2001). In this context, SD includes the use of advance directives in the event of incapacitation due to injury or physical/mental illnesses. A number of health care researchers have investigated many aspects and notions of patient SD over the last 15 years (e.g., Sansone & Phillips, 1995; Blondeau, Valois, Keyserlingk, & Lavoie, 1998; Eisemann & Richter, 1999; Srebnick et al., 2003). Nursing in particular has promoted the idea of patient SD in health care (e.g., Gadow, 1989) and nurse researchers have qualitatively explored mental health or addiction patients’ meanings and expressions of SD (e.g., Valimaki & Leino-Kilpi, 1998; Boyd & Mackey, 2000; McCann & Clark, 2004). Common themes among these studies’ findings include SD being a multi-faceted concept and participants valuing SD despite negative consequences sometimes arising from exercising it. However, the meaning of SD in nursing was described by Maritta Valimaki (1998) as “slippery and complex” and patients’ views are often not included in defining and operationalizing it in practice (p. 59).

There are also key “stakeholders” that have not been discussed but are important to meanings of SD in CDs treatment. Most important are families and loved ones of people living with, and recovering from, CDs (Health Canada, 2001). The fact that there are many other important views of the self and SD supports the main theme underlying this literature review: meanings of self and/or SD have been, and continue to be, highly subjective, highly contested, and highly confusing within and between academic fields and applied practice disciplines. Deduced, abstract meanings of SD show no traction in enhancing understanding of the concept in CDs treatment and recovery. The main theme of the literature review underlies my choice to employ qualitative grounded theory research to inductively explore the meanings of SD among people living with, and recovering from, CDs. Giving people with CDs opportunities to meaningfully contribute to discussions about SD in treatment and recovery seems reasonable, long overdue, and potentially critical to better understanding the concept.

Interest in CSD appears to be strong among mental health social workers (Taylor, 2006). However, as already mentioned, its meaning in social work is complex, typically vague, and continuously debated. Despite my belief that there is something very important held somewhere within the concept in social work; nevertheless, the scholarly debates have led me personally to feel frustrated with all the arbitrarily deduced meanings vying to influence me, and, in turn clients, in practice. This has fueled my interest in better understanding the concept through my doctoral studies and dissertation research.

Finally, mental health self-advocates give SD prominence in their subjective vision of recovery (Deegan, 2007). There may be a potential nexus between mental health self-advocates' meanings of SD and CSD in social work. This nexus could offer opportunities (and challenges) for social workers to better assist people with mental health difficulties. However, it appears to require social workers to seek to understand and work with clients' own meaning(s) of SD in relation to recovery rather than define it for them. Further, addiction issues need to be integrated because of the prevalence of CDs among people living with and recovering from mental illnesses.

CHAPTER THREE

Methodology and Methods

3.1 Introduction

Thomas Kuhn (1970) described scientific paradigms as worldviews through which all knowledge is filtered. An anti-metaphysical positivist or logical positivist paradigm has tended to dominate empirical research in the natural and social sciences over the last fifty years (Bloom, 1995; Guba & Lincoln, 2004). A positivist paradigm emphasizes the verification of a priori cause-effect relationships among variables considered to be objective, and their mathematical representation. Recently, there have been other empirical research paradigms gaining acceptance. Egon Guba and Yvonne Lincoln (2004) compared four currently important research paradigms in sociology across different variables: positivism, where an independent reality is “real” and can only be captured through certain research methods; “post-positivism,” where there is an independent reality but it can only be understood imperfectly; critical theories, where reality is “virtual” and shaped by social, political, cultural, economic, ethnic, and/or gender values; and constructivism, where realities are local, personally subjective, and transactional or co-constructed in social interactions. In social work, many argue that using a variety of empirical research methods and methodologies can potentially contribute to a deeper, richer body of knowledge and understanding of a phenomenon (Patton, 2002). However, choosing an

appropriate research methodology depends on it being logically defensible as an optimal approach to answering the research question.

3.2 Choice of Research Design

Inductive methodologies are conducive to exploring socio-behavioral phenomena that are poorly understood because the goal is to increase understanding, especially in terms of identifying patterns that may point to some larger principles (Babbie & Benaquisto, 2002). These principles can then be further explored and tested through subsequent qualitative and/or quantitative research approaches. In this way, a body of knowledge can be systematically built up that is empirically grounded. Francis Bacon (1939 [1620]) characterized the epistemology of science as a series of inductive steps from the experiential (i.e., empirical) “particulars” to a series of higher level “axiom” generalizations or conceptualizations of the phenomena being studied (p. 71). Inductive empirical inquiry is optimally suited to research into understanding the treatment and recovery experiences for people with CDs because assisting people with CDs is an area that is newly emerging, poorly understood, complex, and interdisciplinary (Co-occurring Center of Excellence, 2006a). As was noted in the previous chapter, notions of SD are consistently referred to in the literature as multi-dimensional in nature. Janice Morse and Seung Eun Chung (2003) noted that multi-dimensional abstract concepts are suited to inductive empirical inquiry that includes using qualitative methods. Qualitative methods are also considered to be particularly suited for exploring subjective experiences (O’Connor, 2001).

Consequently, I have concluded that qualitative methodology and methods are appropriate to answer this study's research question: How are meanings of SD, among sampled people in the south-eastern region of Ontario who self-report living with CDs, perceived in their treatment and recovery experience?

3.3 Qualitative Grounded Theory

My research interest in an inductive approach included remaining close to the subjective perspectives of participants. A number of qualitative research approaches are conducive to studying subjective lived experience and meanings. Narrative (e.g., Hurwitz, Grenhalgh, & Skultans, 2003) and phenomenological designs (e.g., van Manen, 1990; Moustakas, 1994) were considered. However, my interest also included the consideration of building bridges between peoples' own SD meanings, the concept of CSD in social work, and CSD enhancements as expressed in the understandings of people who are personally experienced in living with CDs, receiving treatment services, and in recovery. This bridge-building could help to improve social work practice that aims to help people with CDs recover in ways that are more respectful to their rights and needs. This interest moved me away from solely describing subjective meanings of SD.

Another consideration was my interest in the systematic development of understandings that would include future examinations of other relevant views of SD in CDs treatment and recovery, such as family members and loved ones. Exploring and describing the meanings of SD in treatment and recovery experiences among various stakeholders directly involved or affected by

symptoms of CDs could help social workers, whose professional values include CSD, better understand the client experience, clients' relationships, and ultimately inform more comprehensive recovery-oriented CDs theory and practice. Consequently, qualitative grounded theory methodology was chosen due to its inductive approach to understanding the experiential meanings of research participants, while also facilitating systematic theory development. The approach's attention to dynamic themes of process in analysis is an added benefit. Mental health self-advocates favor the argument that treatment and recovery are linked to dynamic processes of improving quality of life rather than static views of symptomatic states.

The grounded theory approach was developed by Barney Glaser and Anselm Strauss (1967). Grounded theory methodology and methods have been used by social workers to investigate a wide array of issues and concerns. Deborah O'Connor (2001) positioned qualitative grounded theory as an inductive methodology that is representative of the interpretive perspective in social work research. This perspective sees any theoretical statements as an interpretive portrayal of what is studied but not an objective universally "true" picture of an independent reality. O'Connor described grounded theory as representative of a bridge or a "middle ground" that rejects many aspects of classic positivism but maintains the position that researchers "need to avoid the subjectivity and error of naïve inquiry through the judicious use of method" (p. 140). Kathy Charmaz (2004) also saw qualitative grounded theory as providing a bridge among research

methodologies. She emphasized that grounded theory is a systematic interpretative view of the research process that begins with and develops analyses from the viewpoint of the experiencing person. Charmaz (2006) further delineated constructivist interpretive qualitative grounded theory methodology; this view suggested that theory is not so much discovered as constructed. Consequently, researcher reflexivity is important with respect to their own interpretative paths and products, as well reflecting upon those of research participants.

This study seeks to explore, describe, and systematically organize data in such a way as to generate concepts of SD that remain grounded in participants' retrospective experiences of CDs treatment and recovery. Through statements of relationship, the concepts are organized into an integrated theory that can be used to account for participants' meanings of SD. The results are not generalizable beyond the people, time, and place of the study. The results hope to offer *heuristic* value to social work research and practice in relation to enhancing understanding of SD in CDs treatment and recovery (i.e., heuristic in the sense that it serves to indicate or stimulate investigation as well as potentially helping solve problems in practice but there is no guarantee of success). Ultimately, this study hopes to contribute to the systematic development of further research questions and inquiry that aims to better understand and assist people facing the challenges of CDs.

3.3.1 Application of Grounded Theory Methodology

Methods are a set of procedures and techniques for gathering and analyzing data. Qualitative methods include sampling and analyzing observations,

interviews, and/or written texts (Berg, 2001). Interviewing is a form of directed conversation that facilitates the in-depth exploration of participants' meanings of experiences (Charmaz, 2006). In this study, in-depth interviewing was the primary means of data collection. In-depth interviewing was chosen to allow for issues and meanings associated with SD to emerge, be explored, and clarified (Babbie & Benaquisto, 2002). The researcher was the primary data gathering instrument. Data analysis followed procedures and principles outlined by Strauss and Corbin (1998) and Charmaz (2006).

3.3.1.1 Approach to the literature. As mentioned in Chapter Two, the use of the literature in a qualitative grounded theory study is different than in quantitative studies. For example, one purpose of the literature review in quantitative studies is to describe and support the deductive hypothesis to be tested. Except for editing, the review is usually completed prior to data collection. The literature review here was written in concert with the findings and discussion chapters. Literature is used in this study to: orient the reader to relevant concepts, issues, and debates in the literature; provide transparency to the reader of my perspective of the area of enquiry that led to the choice of research methodology; set the stage for the presentation of the analysis of the findings; and to discuss in relation to the findings (Strauss & Corbin, 1998; Charmaz, 2006).

3.3.1.2 Researcher preconceptions. As much as possible, being reflexive or critically aware of my preconceptions to the area of study is important because of the potential for such preconceptions to drift the analysis away from remaining

grounded in the data (Strauss & Corbin, 1998). Reflexivity, as well as transparency with the reader, can help minimize the harm of such preconceptions on the research process and data interpretation. As mentioned in Chapter One, a major potential source of preconceptions is associated with my CDs clinical experience or location. My experience may help sensitize me to the participants and the research area but it may also influence my direction of questioning, management of the interview process, analysis, and/or interpretation. Another potential source is my past exposure to social work meanings of CSD and debates as to its meaning in the social work literature. This background could help me appreciate the challenges people with CDs face in relation to SD and treatment, but it could also influence my conceptualizations of participants' meanings. For example, my personal experience as a practicing social worker in health care includes exposure to the common bioethical assumption that SD means individual autonomy. I found myself often assuming this meaning when I was writing. A third major source is associated with my social location as a "white and middle class", middle-aged male who has not personally experienced being a client of addiction or mental illness treatment services, or having a disability. Despite my attempts to remain reflexive to my social location in relation to theory building; nevertheless, readers of the findings and discussion are encouraged to keep my social location in mind. Researcher reflexivity is one way of attending to researcher preconceptions influencing the research process. Other aspects of ensuring research rigor are discussed below.

3.3.1.3 Sampling. Strauss and Corbin (1998) stated that when building theory inductively, the sampling concern is with “the representativeness of concepts and how concepts vary dimensionally” (p. 214). They referred to purposive “theoretical sampling” as completed when categories of concepts are saturated (i.e., no new substantive concepts or categories are emerging with further sampling). The authors go on to say that the number of participants needed to fulfill theoretical sampling cannot be arbitrarily determined with certainty before beginning a study. I estimated that between eight and sixteen participants would be needed based on the experiences reported in other published research studies using this method. Eight adults subsequently participated in this study.

Purposive sampling was used to recruit participants. Purposive sampling reflects the non-representative selection of a sample based on my knowledge of the population and the purpose of the study (Babbie & Benaquisto, 2002). This study’s purposive sampling approach reflected the inclusion of participants who represented negative case examples, such as two participants’ non-substance related addictions. Another participant did not agree with his professional diagnoses and did not identify himself as having a mental illness or substance use problem *per se*, although he was engaged in monitoring and managing both his mental health in relation to “stress” and alcohol use. The purposive sampling approach also included identifying a certain geographical location and means of accessing potential participants that needed to be distant from where I worked professionally for ethical reasons. Consequently, a peer support program was

contacted in a locale that was separate and distant from where I lived and worked. The peer support program had a number of satellite drop-in centers across a large geographical area. There was a combination of rural and small urban environs in the sampling area. I met with the program's administrators, gave a presentation to the peer support staff, visited satellite drop-in centers across their region, and provided written materials explaining the study in more detail and how to contact me. The program supported my inquiry, let people know about the study, and helped potential participants to get in touch with me. Sampling occurred in 3 separate locales: a medium sized city and two small towns.

Participation criteria were ethically necessary to ensure participant safety. Criteria were broad and inclusive: (1) any person over 21 years of age and who was comfortable speaking English; (2) who self-identified as having experienced symptoms of CDs; and (3) who was not currently experiencing symptoms of suicide ideation, homicidal behavior, paranoia, or any other potential symptoms or circumstances that could have impacted on their ability, at that time, to safely participate. I met in person or spoke on the phone with potential participants to discuss the criteria, explain the study further, answer any questions, and give the person a chance to know me. An explanatory letter was provided (Appendix I) and a consent form to participate was reviewed (Appendix II). Participation was voluntary and based on mutual agreement. Consent forms were signed and copies given to each person prior to interviewing.

Participants chose the locations where initial and follow-up interviews were conducted. Their convenience of time, place, and comfort level were primary considerations. Interviews were done in a manner designed to protect the confidentiality and anonymity of those interviewed. Three people requested both interviews be done in a private space at one of the peer support program's locations. One of these three chose to also have a support person be with her during the follow-up interview. After the first interview was at a peer support program location, one person requested that the follow-up interview occur at another location. Two requested to meet for both interviews in neutral office locations. Two asked for both interviews to occur in their home.

Permission was granted for all but one interview to be digitally recorded. One participant wanted to do the initial interview in a written format. This was done in four staggered sections of questions from the interview guide (Appendix III) that facilitated the questioning unfolding based on the responses of each previous set. The person agreed to meet and have the follow-up interview recorded. Follow-up interviews were scheduled within three weeks of initial interviews. One follow-up interview occurred outside this time period due to weather and the physical health of the participant. The digitally recorded interviews were transferred onto my personal computer. I transcribed all interviews. The staggered written responses from the one initial non-recorded interview were combined into a single transcript for analysis. The transcriptions provided the raw data for analysis. Six participants requested to keep a copy of

their first interview transcript after reviewing it. All but one participant requested a copy of the findings summary. I was unable to reach one person who had requested a summary. The remaining six received a summary.

3.3.1.4 Participants. Three males and five females participated. Ages ranged from twenty-seven to fifty-nine. No participants identified themselves as being part of a particular ethnic or cultural group outside of being “Canadian”. Mental health and substance use disorder diagnoses varied a great deal in relation to symptoms and different substances being a problem. Most participants also had a broader view of what could be a problem or addictive substance for an individual in recovery than what is generally discussed in the literature. For example, one person identified “pop” as the only substance she had ever been addicted to but she had been treated for a non-substance addiction issue associated with sexual behaviors (she was included in the study). Another participant spoke of needing to avoid “red dye” in processed food because it worsened his attention deficit symptoms.

3.3.1.5 Saturation. Saturation was considered to have been achieved after eight participants. Charmaz (2006) said that saturation occurs when “fresh data no longer sparks new theoretical insights, nor reveals new properties of your core theoretical categories” (p. 113). Strauss and Corbin (1998) referred to saturation as “reaching the point in the research where collecting additional data seems counterproductive; the ‘new’ that is uncovered does not add that much more to

the explanation at this time” (p. 136). Both note that determining saturation is somewhat arbitrary and evaluating the value of “new” is a matter of degree.

Sampling was considered to be saturated after eight participants. The grounded theory was supported by existing data analysis and was found to be able to accommodate participants’ unique subjective meanings of SD. The grounded theory encompasses a fusion of interrelated elements, processes, and power that uniquely and subjectively contribute to a person’s meaning of SD in relation to CDs. An attempt was made to theoretically sample another male to explore and compare in more detail potential gender differences and similarities in meanings of SD. Two males subsequently expressed interest. Through discussion of the research project, one male did not feel safe with discussing aspects of his past and the other male’s work situation suddenly made it a problem to meet. Theoretically sampling more male participants was not pursued for feasibility reasons as it could have required going to a new geographical region, making linkages with a different peer support program, and gaining approval for changes from Memorial University’s research ethics committee. Exploring possible differences in meanings of SD in terms of gender and other characteristics, including ethnicity/race and age is recommended in Chapter Six.

3.3.1.6 Research interviews. The emphasis on understanding participants’ meanings and the complex nature of SD as a concept led to designing the study with an initial interview focused on exploration and a subsequent follow-up interview for participant confirmation, clarification, and augmentation of

meanings in the initial interview transcript (i.e., “member checking”). The second interview also gave me the opportunity to ask follow-up and clarification questions to expand and advance my understanding based on an analysis of the first interview text. This allowed me to question emerging theoretical categories and dimensions based on the analysis of previous participants’ data as the interviewing of new participants progressed. The average recorded length of the first interview was 85 minutes. The follow-up interview average was 68 minutes.

A semi-structured interview guide was used because of the ambiguous, abstract nature of SD meanings in the literature and SD not being a term generally used by people in every-day language. Open-ended questions were developed (Appendix III). Questions were based on my practice experience, conversations with consumer/survivor self-advocates, and sampling of the literature – especially texts associated with social work and the consumer/survivor movement.

Three mental health consumer staff members of a mental health peer support program in a locale separate and distant from the participant sampling locale agreed to sit on a Peer Support Advisory Committee. The committee represented another attempt to mitigate researcher bias. The questions were reviewed by this committee for bias and refinement. The list was used as a common pool of possible questions I could draw from as initial interviews unfolded. Questions attempted to cast as wide a net as possible in terms of giving participants open-ended opportunities to respond. This included giving people

opportunities to comment on their meanings of SD in relation to gender, the physical environment, urban-rural locales, and cultural considerations.

3.3.1.7 Data analysis. Strauss and Corbin (1998) suggested that qualitative grounded theory data analysis methods involve a series of discrete coding activities or procedures. The authors emphasized that coding, in action, is a “dynamic and fluid process” that involves repeated comparisons and questioning between new raw data and the data already analyzed into conceptual themes and categories (p. 101). The interaction between collection and analysis occurs throughout the sampling process until a full range of categories are identified and relationships are established between them that contribute to the theoretical whole. Charmaz’s (2006) description of coding is similarly outlined. Printed transcripts texts were open coded using the traditional “cut and paste” method. Computer software packages automate the coding, indexing, retrieving, and storing of qualitative data. There is some concern that their use can sacrifice in-depth analysis of data despite their potential advantages (Hesse-Biber, 2004). Computer coding software was considered and rejected as I was looking for the fullest immersion in the data as possible.

The first participant reviewed his initial interview transcript and answered further questions in February, 2007. Getting information out about the study, connecting with potential participants, and interviewing continued until November 2007 when saturation was considered to be achieved. Data analysis continued until the dissertation thesis was completed and submitted. The initial

semi-structured interview guide remained the primary pool of questions used in initial interviews. Reflexive memos were written about issues and ideas arising throughout the interviewing process, including possible ways to improve the interviewing process with subsequent participants, my clinical and social location potentially impacting on interpretations, obvious “in vivo” code words arising in the early transcripts, and early ideas of potential categories and sub-categories.

I came to understand the dynamic nature and fluidity of data analysis right through to thesis completion. For example, I wrote a literature review draft prior to beginning the study. The draft did not highlight the importance of the meaning of the “self” to meanings of SD; I apparently saw SD more as a conceptual whole. It was only after the second participant spoke of how adding her meaning of “self” onto “determination” had dramatically affected her understanding that I started to consider the primary importance of subjective meanings of the self in relation to meanings of SD. This led me to re-examine meanings of SD in the literature. I found that scholarly texts and research findings in social work also appeared to overlook the potential importance of subjective meanings of “self” in understanding what SD (or CSD) might mean. The importance of meanings of self in understanding SD was confirmed and enriched with further sampling. Participants’ *sense of self* became the initial organizing concept in data analysis.

Microanalysis begins immediately in grounded theory with the first transcribed interview. It involves open or non-selective identification of discrete concepts (i.e., each concept as a labeled phenomenon), reported actions, or

reported events through line-by-line examination of words, phrases, and/or sentences in the raw data interview transcript. Sampling was paused after follow-up interviews for the first three interviews were completed. Pausing allowed for focusing more on microanalysis after consultation with members of the thesis and advisory committees.

Conceptualizing is the first step in theory building and involves the grouping of similar “events, happenings, and objects under a common heading or classification” (Strauss & Corbin, p. 103). An example from this study involved the first two participants making references to the importance of notions of “stubbornness”, “being determined”, and “commitment” in relation to meanings of SD. These notions eventually were incorporated into one of three components making up subjective meanings of SD. It is referred to as *being determined* (the other components are *the standpoint of self* and *determining processes*).

As interviewing and analysis was resumed, rough written notes were often developed into memos to help generate, and further question, potential groupings. Comparisons were continuously made between the tentative categories of like-concepts (i.e., codes) already being considered and newly emerging phenomena. If newly emerging phenomena shared some facet or characteristic with any existing category (e.g., “stubbornness” and “loyalty”) then it was placed there. If not, then a new tentative classification was created; Charmaz (2006) referred to this stage of early coding as “focused coding” (p. 57). The identification of early categories leads to considering the range of their potential meanings, their

properties, and their associated dimensions. This helps re-examine the degree of “fit” among concepts placed within each category and the further specification of each category’s sub-categories that denote such things as “where, when, why, and how a phenomenon is likely to occur” (Strauss & Corbin, 1998, p. 121).

The naming of categories also begins to occur, often associated with researcher knowledge, researcher insight, or words/phrases within the raw data that are particularly striking. For example, “will” was initially considered as the name for the component that eventually became “being determined.” Will was not ultimately chosen because only one participant referred to it specifically (in relation to “will power”) and also because of the potential influence of preconceptions associated with this historically powerful but vague Western term on the reader.

Microanalysis often involves axial coding. This method focuses on identifying and understanding how sub-categories relate to the category they have been grouped into. Strauss and Corbin (1998) suggested that axial coding helps reassemble the broken down raw data categories and their subcategories into some early sense of the whole. Diagramming can help map out their connections. They also suggested that axial coding adds to the record of the analytic process, thereby helping make the interpretive process more transparent and accountable. However, Charmaz (2006) suggested that axial coding can be risky in the coding process because it can cast “a technological overlay on the data” that may inappropriately influence the final analysis (p. 63). Axial coding was utilized to

develop illustrative figures in this thesis. For example, two figures in the findings (Figure 4. 7 and Figure 4.8) highlight relationships among and between the three components of SD meanings for two interrelated but discernible senses of self: *the primary sense of self* and *the more nuanced sense of self in CDs recovery*. I found that consciously maintaining a stance that the figures represented artificial “snapshots” of dynamic phenomena helped avoid the figures shaping rather than reflecting analysis.

Data collection was paused again after six interview transcripts were collected to focus again on analysis. The emerging theoretical scheme was further refined and theoretical saturation was considered to have been achieved when data collection and analysis for two more participants (one female and one male) was completed. The theoretical scheme was shared with two members of the Advisory Committee (the third member had to withdraw from participation due to health reasons). Summaries of the findings were provided to six of the eight participants. There were no reported concerns with the findings generally or with how meanings were presented. Feedback included findings being “really interesting,” participation was difficult at times in terms of sharing difficult memories, and that participation was overall a positive experience. The final stage of data analysis was integrated with the writing of this thesis.

Charmaz (2006) suggested that theoretical coding occurs when the researcher begins to examine between-category relationships developed from the microanalysis of data. Hypotheses are developed that theoretically link two or

more of the categories together. Integrating the categories enables the construction of a larger, logically defensible theoretical scheme grounded in the data. The larger theoretical scheme distinguishes theory building from simply describing themes in the data analysis. Strauss and Corbin (1998) referred to a selective coding as the final step in the process of analysis. They suggested that there needs to be a tentative central or core category grounded in the data. This central category pulls the other categories together to form a theory that explains the whole and can “account for considerable variation within categories” (p. 146).

This study’s analysis moved to include selective coding and testing the fit of possible core theoretical concepts that were emerging from the data during another pause after six participants had been sampled. The larger theoretical frame (i.e., the sense of self) emerged, theoretical saturation was being considered, and the thesis writing stage was initiated. One of the challenges at this stage was making sense of changes that participants were sharing about how they viewed their sense of self (and in turn meanings of SD) over the course of his or her life experiences. This observation and challenge led to the development of an organizing metaphor of an audio mixing board that digitally mixes different audio tracks into combined music outputs. The “mixing” process includes an experiential *positive feedback loop*. The mixing board metaphor helped highlight how the three SD components fused into participants’ subjective meanings of SD. The positive feedback loop helped conceptualize how meanings of SD not only

differed among the participants at any point of time but how they also could shift for each person through the course of his or her life.

Process coding occurs throughout an analysis. It helps identify and integrate a “series of evolving sequences of action/interaction that occur over time and space, change or sometimes remaining the same in response to the situation or context” (Strauss & Corbin, 1998, p.165). In this study, process coding suggested that the experiential positive feedback loop was associated with a trend among participants over time to develop a greater attention to, and integration of, nuances of meaning in relation to his or her self, their ecosystem, mental health, mental illness, addiction, and CDs recovery.

Strauss and Corbin (1998) also referred to the need to locate the developed theory in structural terms of the “macro and micro conditions in which it is embedded” and in process terms of the “actions/interactions” of the theory with its environmental context (p. 182). As previously mentioned in Chapter Two, the “person-in-environment” or “ecosystem” perspective is one of the distinguishing features of generalist social work (despite its critics). Consequently, grounded theory methodology and methods that integrate coding of processes and paying attention to the micro-macro context appears to be particularly suited to social work research. This facet of analysis contributed to the organizing concept being finalized as: *the sense of self within his or her ecosystem.*

3.4 Ethical Considerations

The research followed ethical guidelines as outlined by the *Tri-Council policy statement: Ethical conduct for research involving humans* (Canadian Institutes of Health Research et al, 2005). Data collection and analysis was initiated following proposal approval by Memorial University's Interdisciplinary Committee on Ethics in Human Research (ICEHR) (Appendix IV).

Voluntary participation was ensured through repeatedly informing participants that they could withdraw at any time; that the study was for dissertation research purposes; and reviewing steps for protecting anonymity, confidentiality, and potential harm. Consent forms (Appendix II) were discussed, signed, and copies given to participants. Distress arising for a participant through the interview process that was unanticipated or unexpected was considered to be one of the main risks to participants. To help address the risk, potential participants were made aware of this concern at initial contact, through reviewing an explanatory letter (Appendix I) and their consent form before signing, and, again, through reviewing the study's nature, purpose, and potential risks immediately before interviewing began (Appendix V). It was also discussed before commencing that if any distress was identified or expressed then the interview was to be paused and attention paid to supporting the participant. A safety plan (Appendix VI) was reviewed at the end of each interview. It included identifying people the person could reach out to and/or ways to contact me if they had any concerns develop later. I did not leave until the participant could foresee

no difficulties. As mentioned above, a couple of participants commented that the interview process was difficult at times in terms of memories associated with their experiences; nevertheless, all spoke of the experience being worthwhile and the opportunity to share their stories having value to them. One participant reported no difficulties with the first interview but did find seeing and reviewing the written transcript a bit overwhelming. Consequently, she invited a support person to be with her to review the transcript and answer any follow-up questions.

A second potential major ethical risk involved ensuring anonymity and confidentiality. Ways of addressing this concern included:

- Discussing ways participants may want to disguise themselves through using pseudonyms during interviews and/or in interview transcriptions.
- I was the sole person transcribing the recorded interviews.
- The computer used to transcribe, interview recordings, memos, and transcripts was kept in a locked location in my home office.
- Interview transcriptions having uniquely identifying information removed and being given a unique random code number that only I could connect with the contact information and name of the participant.
- Participants reviewing their coded and anonymity-protected transcript to ensure they were protected.
- Members of advisory committee only having access to samples of anonymity-protected transcripts.
- Persons having access to the raw research data were limited to me, and the

three members of the thesis committee should they so request.

- Recordings, names, and contact information of participants are to be destroyed within one year of the completion of the thesis defense.
- The advisory committee members signing agreements that they will ensure confidentiality (Appendix VII).

3.5 Research Rigor

Some researchers argue for the adoption of different criteria to ensure rigor in qualitative research than traditional notions of reliability and validity associated more with positivist methodology and quantitative research methods. For example, Lincoln and Guba (1985) advocated for the adoption of “trustworthiness” criteria in terms of four dimensions: (1) credibility (i.e., the extent to which study findings and future interpretations reflect participants’ point of view); (2) transferability (i.e., the applicability of the study’s findings in other contexts); (3) dependability (i.e., reliability); and (4) confirmability (i.e., methods for establishing the accuracy of the data collected).

Janet Morse et al (2002) argued that validity and reliability are used by qualitative researchers in Europe. They suggested that the evolution of trustworthiness criteria in North America has shifted from procedures that ensure validity during the course of inquiry to post hoc assessments that risk missing threats to rigor until it is too late to correct them. Post hoc assessments include audit trails, participant/member checks, and using written reflexive memos. They suggested that poor “investigator responsiveness” (IR) is the greatest threat to

research rigor. Positive IR included: the investigator remaining as “open” as possible to interpretations of the data during collection and analysis; the researcher’s use of sensitivity, creativity, and insight during data collection and analysis; and the researcher being willing to relinquish any ideas that are poorly supported, regardless of the excitement and the potential that the ideas may first appear to have. They argued that poor IR is not easily identified by post-hoc strategies and suggested ways to protect rigor from poor IR threats included: methodology and method congruence; theoretical sampling; seeking negative case examples; seeking saturation that ensured replication in categories; collecting and analyzing data concurrently, thinking theoretically (i.e., ideas emerging from the data are reconfirmed or verified in new data); and theory development (i.e., moving systematically between a micro perspective of the data and a macro conceptual or theoretical understanding).

This study’s research design and process reflects rigor in terms both IR and post hoc assessments. As described above, adhering to the structure and spirit of qualitative grounded theory studies as outlined by Strauss and Corbin (1998) and Charmaz (2006) addresses virtually all of the ways and means to insure good IR. Further, adding reflective pauses allowed for the sharing, reviewing, and gaining feedback on my decisions from members of the thesis committee and the advisory committee during the sampling and analysis process. Conceptual drafts were circulated to the thesis committee following both pauses that reflected

adjustments. Consequently, thesis committee members had texts that reflected analysis developments (including relinquishing ideas not supported by the data).

Finally, Post hoc strategies incorporated into the research study to support trustworthiness included:

- The maintenance of records and materials for audit trail.
- Peer Advisory Committee briefings and bias checking.
- Member checking by participants to ensure the accuracy of their meanings.
- Soliciting Thesis Committee reviews of analysis.
- Sharing and discussing a summary of findings and a draft of the theoretical scheme with participants who wished feedback.
- Presenting and discussing a draft of the theoretical scheme to the staff of the mental health peer support program that assisted me.

CHAPTER FOUR

Findings

4.1 Introduction

This chapter begins with a descriptive synopsis of the participants and an overview of the development and conceptualization of the grounded theory of participants' meanings of SD in CDs treatment and recovery experiences. Presentation of the SD categories, their sub-categories, important dimensions, and relationships that support and illuminate the grounded theory then follows. A summary concludes the chapter. Pseudonyms are used to protect the anonymity of the participants as well as to personalize their words.

4.2 Descriptive Overview of Participants

Participants' ages ranged from 27 to 59 years of age. The average age was 42. Three males and five females were interviewed. Male participants' ages were: 32 (Brian), 45 (Malcolm), and 56 (Sam). Female participants' ages were: 27 (Alexis), 36 (Colleen), 40 (Susan), 42 (Carmen), and 59 (Teresa). When asked, participants did not identify themselves as being associated with any specific ethnic, cultural, or racial group.

All participants except Alexis and Sam had been married; however, no one was living with a spouse at the time of interviewing. All but Alexis, Brian, and Colleen had children and all but two participants' children were adult-aged. One participant who had young children shared their care with her parents and an ex-partner. The other participant's young children lived primarily with his ex-partner.

Susan, Colleen, Alexis, Sam, and Brian completed high school. Susan had also taken college courses. Brian was working on his Bachelor's degree and Sam had completed a university program. All participants had worked full-time at some point in his or her life. All participants were receiving disability benefits at the time of interviewing and four also had some form of paid employment. Seven of the eight participants were actively volunteering in a variety of interest areas, including helping others with mental illness and/or addiction issues.

4.2.1 Mental Health, Mental Illness, and Treatment Contact

Brian, Malcolm, Susan, and Carmen had brief contacts with professionals around mental health issues when they were 12 or under but they had no further contact for the next five to ten years. Alexis and Colleen had their first contact in their early twenties, during a "breakdown" or crisis. Teresa had her first contact in her late thirties, again associated with a crisis or "breakdown." Sam briefly stayed voluntarily at a psychiatric hospital in his first year of university. He had no further contact until a forced treatment experience occurred in his late twenties (he had two other similar experiences since). All but Alexis reported that their first contact with mental health services occurred prior to any regular substance use. Alexis said she first started regularly using psychoactive substances at age 12 and then became aware of "whispers" in her mind two years later.

All participants except Sam were involved with professional mental health treatment services at the time of being interviewed. All but Sam and Alexis regularly met with a psychiatrist and took prescribed psychiatric medication.

Alexis was working on emotional self-management with a psychologist but not using prescription medication. Teresa and Colleen were involved with “assertive” community treatment programs which are intensive “wrap-around” case management and treatment programs provided in the community for people with serious functional difficulties associated with severe mental illness. Carmen was the only participant who had not ever had any involvement with mental health peer support services, programs, or supports.

Table 4.1 shows mental health and substance use disorders that participants self-reported being diagnosed with (by gender). Bi-polar disorder (including Cyclothymia) was the most common diagnosis. Receiving multiple diagnoses was the norm. The average number of non-substance use diagnoses was four for each female participant and three for each male. All but Susan and Teresa said they had received an initial mental health disorder diagnosis when they were a youth or young adult (i.e., under 25). Susan and Teresa said they were first diagnosed in their thirties. All but Susan and Sam said that their early diagnoses changed or were added to, and treatments changed, with subsequent contacts with different physicians and/or psychiatrists. For example, Alexis and Teresa were diagnosed initially with a form of schizophrenia based on crisis contacts with mental health services. Both said that the diagnosis was later changed by other psychiatrists. Sam said he was involuntarily diagnosed with schizophrenia in his late twenties. He has avoided contact with mental health professionals since that time.

4.2.2 Substance Use, Misuse, and Addiction

No participants were involved with addiction-specific professional programs or practitioners at the time of being interviewed. Brian, Malcolm, Colleen, and Alexis had previous direct dealings with addiction-specific treatment services. Sam and Colleen had occasionally attended community 12 step addiction-related meetings.

Susan reported having problems consuming too many soft drinks or “pop” and she had been diagnosed with an impulse control disorder associated with sexual behavior in her thirties. She said she had not ever misused psychoactive substances typically associated with addiction. Carmen self-diagnosed herself with a binge eating disorder that she thought was a form of addiction. She said the behavior started in her late teens and lasted until her late twenties. Although she had smoked cigarettes since her teens, Carmen did not use other drugs or alcohol until her early thirties. She experienced substance dependence issues with alcohol and then crack in her early thirties (after she had stopped binge eating). References to *addiction* in the grounded theory are inclusive of substance dependence, Susan’s problems with soft drinks, her impulsive behaviors associated with sexual activity, and Carmen’s binge eating behavior.

Table 4.2 shows substances reported as most misused, abused, and/or being dependent on by gender and pharmaceutical drug group. All but Susan smoked cigarettes. As stated above, Carmen did not use substances other than cigarettes until she was an adult. Teresa reported no substance use other than

Table 4.1: Participants' Reported Mental Illness Diagnoses by Gender

Diagnoses	Male (N=3)	Female (N=5)	Total (N=8)
Bipolar Disorders	1	4	5
Major Depressive Disorder	2	2	4
ADD/ADHD	2	2	4
Schizophrenia	1*	2**	3
General Anxiety Disorder		2	2
Posttraumatic Stress Disorder (Abuse)		2	2
Impulse Control Disorder	1 (anger)	1 (sexual behavior)	2
Borderline Personality Disorder		2	2
Differentiated Identity Disorder		1	1
Eating Disorder		1	1
Obsessive-Compulsive Disorder	1		1
Schizoid Affective Disorder		1	1
Seasonal Affective Disorder		1	1
Sleeping Disorder		1	1
Substance Abuse/Dependence	3	4	7

*Diagnosis not viewed as valid by person – assessed under duress of forced hospitalization.

**Initial diagnosis during first crisis/contact with psychiatry – subsequently changed.

(More than one mental health issue or diagnosis may be reported by an individual; diagnoses not necessarily viewed as legitimate or accurate by individuals)

Table 4.2: Substances Reported as Problematic and/or Associated with a Substance Use Disorder Diagnosis, by Pharmaceutical Drug Group and by Gender

Substance	Pharmacological Drug Group	Male (N=3)	Female (N=5)	Total (N=8)
Cigarettes	Nicotine: stimulant	3	4	7
Alcohol	Central Nervous System (CNS) sedative-hypnotic	3	2	5
Cannabis	Hallucinogen, sedative, stimulant properties	2	3	5
Cocaine/Crack	CNS stimulant	1 (cocaine)	2 (crack)	3
Oxazepam	CNS sedative: tranquilizer	1		1
Talwin	CNS sedative: narcotic analgesic		1	1
Heroin	CNS sedative: narcotic analgesic		1	1
Ritalin	CNS stimulant		1	1
Soft Drinks	Caffeine/sugar: CNS stimulant		1	1
"Red Dye"	Food additive	1		1

(More than one substance may be reported by an individual; person may not agree with current or past use being identified as a substance use disorder or major problem)

trying a few cigarettes in her teens. She had her first ever drink of alcohol in her mid-twenties, she did not begin to smoke cigarettes until her late thirties, and she drank alcohol problematically for about 3 years in her early forties. The remaining five first used alcohol and/or cannabis as a child or youth. Colleen was encouraged to use cannabis by some family members as early as age 9. Malcolm and Alexis were around 11 or 12 when they first used alcohol and/or cannabis with friends. Sam and Brian began to try drinking and/or smoking cannabis in their mid- to late-teens. Malcolm, Alexis, and Brian reported experimenting with a variety of psychoactive substances such as ecstasy, “magic mushrooms”, and/or “acid” in their youth; however, they said that these substances did not become problems. No participant identified problems associated with drinking too much coffee (although all said at some point they have had to manage how much coffee they drink). Malcolm found that “red dye” food additives had a seriously negative effect on his hypomania symptoms and his ability to focus his thoughts.

4.3 Theory Development and Conceptual Overview

Understanding participants’ meanings of SD typically started with an open-ended question early in the first interview (e.g., “what does self-determination mean to you?”). Three of the first responses were highly tentative:

- Malcolm: As in what? Determined to stay the way I am?
- Colleen: Self-determination – what does that mean?
- Teresa: I really don’t know.

Although tentative, Malcolm's use of "determined" and "the way I am" shared connotations with the other five participants' first statement of meaning for SD:

Carmen: I automatically think of my stubbornness.

Sam: Well, it has a lot of different meanings, you know.

Determine, determination, hard determinism, soft determinism, vote NDP, making up your own mind – not manifest destiny or destiny, being responsible for oneself.

Susan: Control!

Brian: Basically that people will achieve what they set out to [do].

Alexis: I am done with this [previous way of life] forever.

Participants agreed that SD was not a term that they would generally use in their everyday life. They initially focused on meanings of "determination" However, Carmen said at one point in her follow-up interview (underlining represents an emphasizing tone):

I think that is the intimidating part of it [self-determination], right there – the first word... I have so much trouble taking care of my self and respecting my self. I did not respect my self for a very long time. I think the self is what totally threw me off. Because determination – I have used that word a million times. But as soon as you throw that self on there it totally seemed to have changed...it made it more personal...there are so many words that could come off of this and so many feelings and emotions and moods that could come from this. But it is that word self...I am a determined person – who isn't? But throw that word self on there and it just changes everything.

From these initial statements and further exploration, three broad categories of meanings of SD were interpretively generated. Two categories are rooted in meanings of "determination" (*being determined* and *determining*). Susan

expressed these two categories succinctly in terms of substance use: “I am determining not to use the drugs and alcohol and I am determined not to use them.” The third category is rooted in meanings of “self” (*standpoint of self*). It is captured by Susan in her statement that SD “just defines who I am!”

Microanalysis of the first three interviews, and with each subsequent participant’s transcript, suggested that the categories are fundamentally interrelated and together contribute to uniquely subjective, multi-faceted meanings of SD. For example, Brian referred to “conditions conducive” to SD:

I believe that self-determination involves an interaction of factors. Setting – not all options are available at all times. Past experience shapes current perspectives and future behavior...There can only be a choice if two or more options exist. Conditions conducive means absence of limitations; it also depends on the individual’s appraisal.

Analysis identified five interrelated *standpoint of self* subcategories: *beliefs and values; attitudes towards self; attitudes towards ecosystem; sense of control; and aspirations*. The sub-categories are the key elements of SD meanings. Element is defined as “a basic constituent part...a group of a particular kind within a larger group” (Soanes & Stevenson, 2006, p. 462). *Determining* encompasses key processes of participants’ meanings of SD. There are two interrelated process sub-categories: *decision making* and *knowledge building*. The *being determined* category represents the dynamic energy, force, or power that permeated participants’ meanings of SD and, in turn, powered self-directed actions. Figure 4.1 shows the early mapping of categories and their respective sub-categories.

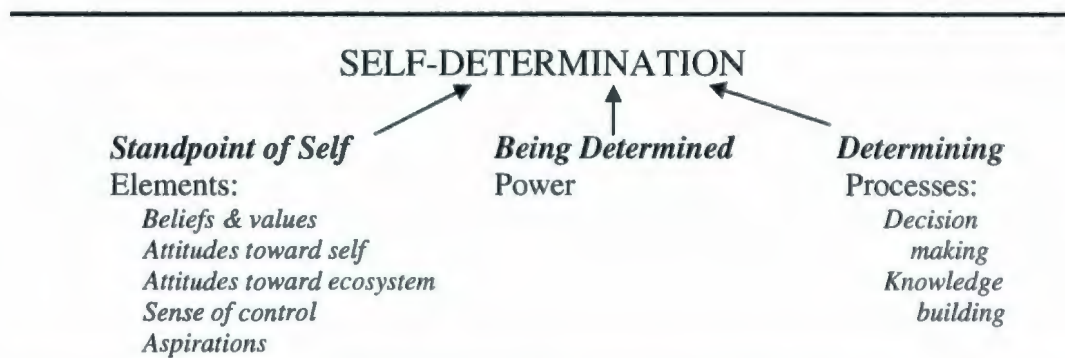


Figure 4.1: Self-Determination Meanings: Initial categories and sub-categories

4.3.1 Organizing Concept and Metaphor of SD Meanings

The categories (and respective sub-categories) were organized into a grounded theory of participants' subjective meanings of SD in CDs treatment and recovery experiences. The organizing concept is: *a person's sense of self within his or her ecosystem*. Here, "sense" refers to: "an awareness of something or feeling that something is the case...a way in which an expression or situation can be interpreted; a meaning... be vaguely or indefinably aware of" (Soanes & Stevenson, 2006, p. 1310). Synonyms include: feeling, awareness, consciousness, sensation, intelligence, intuition, judgment, coherence, and meaning (Oxford, 2001). Each participant's *sense of self within his or her ecosystem* encompasses the dynamic interplay between the self and his or her physical, socio-cultural, spiritual, and psychological environmental context, from participant first-person points of view. Figure 4.2 shows the components of SD meanings within an ecosystem that highlights bio-psycho-social-spiritual dimensions. As mentioned in Chapter Two, social work critics of the term "ecosystem" argue that it can intentionally or unintentionally symbolize a self separate from the ecosystem and

imply that the two transact but are not integrated. Participants were found to *discern* distinct aspects of his or her self from his or her ecosystem and its dimensions; however, an outright separation was never evident in relation to recovery. Consequently, a broken dash/dot line around “SELF-DETERMINATION” in Figure 4.2 symbolizes the “open” boundaries of a discernable self integrated with his or her ecosystem. Critics also argue that “ecosystem” implies a neutral concept that does not integrate issues of asymmetrical structural power issues in relationships. This inductive grounded theory’s use of “ecosystem” attempts to be inclusive of but not limited to asymmetrical power issues in personal and/or structural interactions and relationships. Figure 4.2 attempts to symbolically integrate asymmetrical power issues through the arrows’ different shapes and sizes. Two-way arrows symbolize influence reciprocities. One-way dashed arrows from the self symbolize the self’s capacity to asymmetrically influence aspects of the ecosystem (e.g., some other individual; advocating for systemic service reforms). In turn, one-way arrows from an ecosystem dimension symbolize its capacities (e.g., other people; structural beliefs, values, and processes in society) to asymmetrically influence or assert control over aspects of a participant’s life or self. Asymmetrical structural

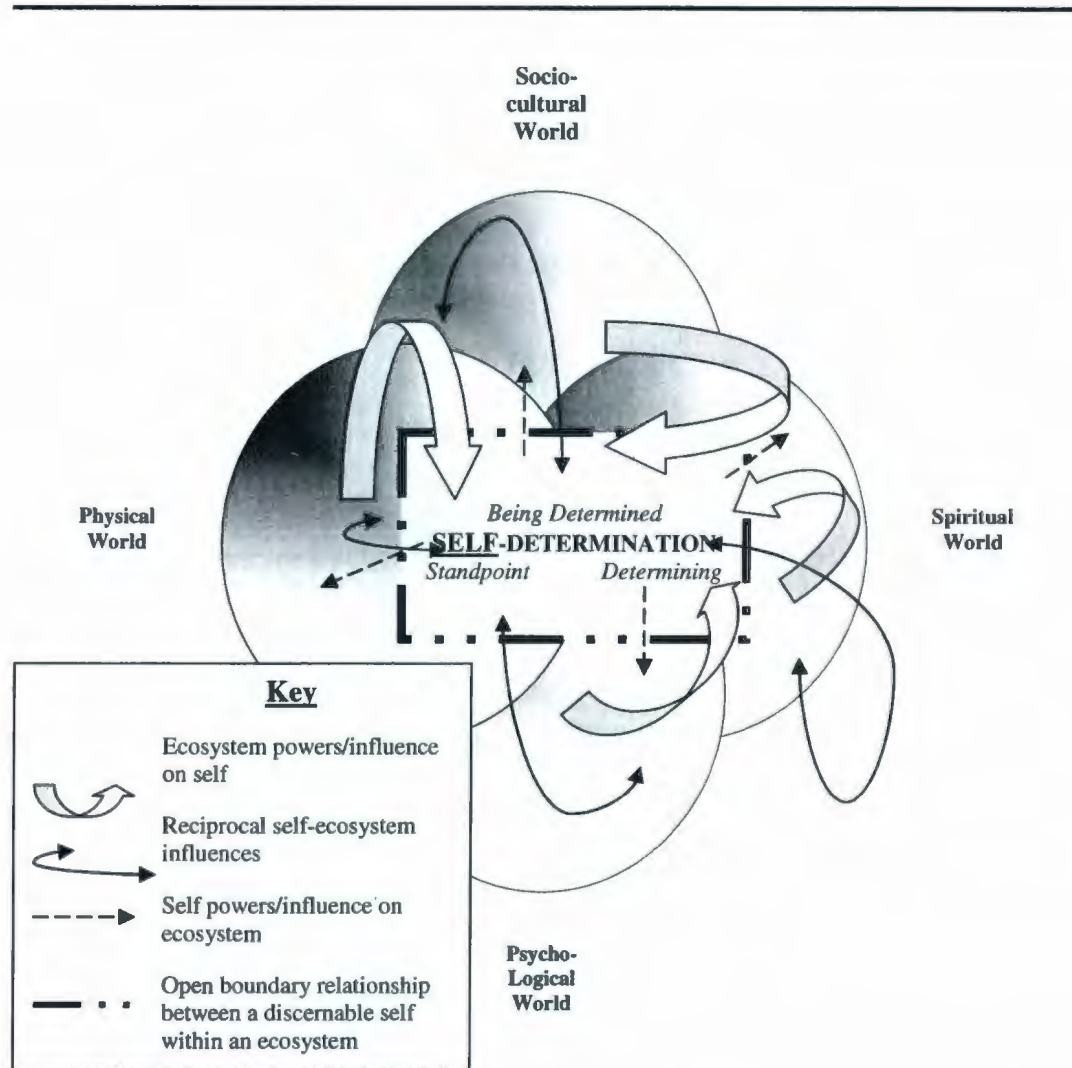


Figure 4.2: Self-determination within the ecosystem

powers are suggested by the greater width of one-way arrows originating in the ecosystem.

Grasping the dynamic nature of the interrelated SD elements, processes, and animating power is aided by use of an organizing metaphor. For example, an audio mixer or mixing board is a device that can adjust or sculpt (e.g., balance, position, effect, equalize, and so forth) different audio channels into a uniquely

combined audio output or sound image called the *mix* (e.g., music). The SD standpoint elements represent the different routers and sliding level controls of a mixing board. The SD processes are the self's "hands" that set, maintain, or adjust the mix by establishing and potentially adjusting the various controls reactively and/or proactively. "Being determined" powers both the mixing itself and the content of the mix. The combined mix is a person's unique and subjective meaning of SD. Each person's SD mix guides, supports, and energizes his or her self-directed actions through decision making (which is not restricted solely to "conscious" decision making). The elements, power, and the processes are the contributing *components* of each person's unique SD meaning mix (Figure 4.3).

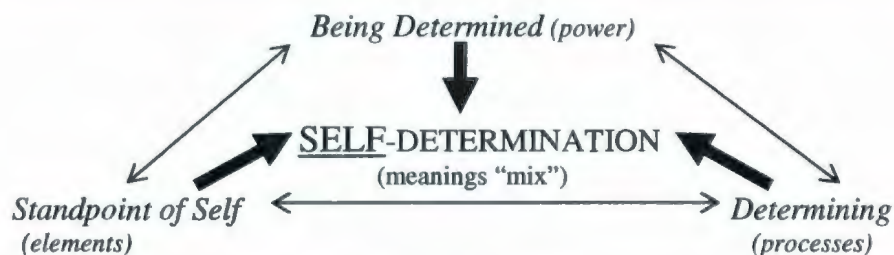


Figure 4.3: Self-Determination Meanings: Fusion of components

Sense of self relationships and interactions within his or her ecosystem integrates the potential for other people and/or ecosystem-based "forces" (e.g. social structures; weather) to, at any potential moment, impact on a participant's SD components (e.g., support or oppose; inform or direct; challenge or provide opportunity). As a result, participants' SD mixes were always potentially in some

sort of tension or flux, internally and within integrated relationships/interactions, with his or her equally dynamic ecosystem.

The organizing metaphor also incorporates a knowledge-building *positive feedback loop potential*. Experience with the mixing board controls, internal/external influences, and outputs or outcomes provide cumulative knowledge to actively shape and direct processes and outputs over time. Positive feedback loops in systems are “deviation amplifying” and drive shifts towards growth and change, while negative feedback loops reduce deviation and thus drive shifts towards equilibrium (Hudson, 2000, p. 218). The positive feedback loop is associated with participant descriptions associated with developing a more “nuanced” sense of self over time which, in turn, affected their subjective SD mixes. The feedback loop potential provided participants with opportunities for increasing their skill and knowledge in relation to understanding, maintaining, and/or adjusting aspects of SD components and, in turn, his or her SD mix. This self-knowledge positive feedback loop (as well as negative loops that defend SD meanings) suggest that regulating needed degrees of relative stability or balance of the sense of self within growth and change represents a key potential function of participants’ SD meanings in CDs treatment and recovery experiences. This self-knowledge positive feedback potential is best described as a form of *hermeneutic circle* because:

- The gaining of self-knowledge has no determinate endpoints.
- It involves a continuing potential for examination of the discernable self’s

“parts” (e.g., SD components) in relation to the “whole” (i.e., the sense of self within his or her ecosystem) and vice versa.

- It also involves an ongoing potential for awareness, critically questioning, and reinterpreting meanings of the past and future (e.g., one’s subjective narrative) with continuously new self-ecosystem experiences in the present and vice versa.

4.3.2 Temporal Changes

SD meanings were a unique mix of the three components of the theory at the time of interviewing. Each person’s SD meanings had also changed over his or her lifetime, in relation to his or her sense of self. Initially, the participants established what is being called a relatively stable *primary* sense of self within his or her ecosystem. Over time, participants developed a more *nuanced* sense of self within his or her ecosystem associated with consciously pursuing CDs recovery. Meanings of SD defended or maintained the respective sense of self and/or changing aspects of it. Changes to the primary sense of self were associated with a general trend evident among participants towards developing greater attention to, and integration of, “nuances” of meaning. The term, “nuance”, refers to subtle differences in or shades of meaning and expression (Soanes & Stevenson, 2006, p. 979). This trend towards more nuanced views and meanings was particularly identifiable in relation to self-standpoint shifts. Overall, the standpoint elements in CDs recovery were described as becoming more situationally relative,

compatible, and discerning. Primary self standpoints typically held and defended more absolutist, generalized, incompatible, and indiscriminate views.

4.3.2.1 Relativistic. More situationally relative standpoint views associated with CDs recovery were exemplified by a common refrain in interviews:

“everybody is different.” Relativistic views also prevailed in the meaning of “recovery” for participants. People focused more on improving their experience of living rather than envisioning recovery in absolutist terms, such as being “cured” of mental illness symptoms, being completely abstinent from all substances perceived as potentially problematic (although some did choose abstinence for themselves), or being completely compliant with prescription medication use (although they were usually willing to consider it with recommendations from people they trusted).

4.3.2.2 Compatible. More compatible standpoint views (i.e., holding coherent mixtures of relativistic and absolutist views) were exemplified by peoples’ understandings of SD as a “right.” They saw SD as more of a soft or conditional right for everyone and needed to be mediated by each person, as well as socially, due to its subjective nature and, consequently, its potential to drive destructive conflicts. However, they said that this view was different from how they might have answered the question in the past. Alexis, for example, said: “to get money for drugs I was definitely self-determining but I did not have a right to do 99 percent of the stuff I was doing.” Carmen saw SD as a soft right generally but it was absolute for her specifically in terms of survival: “I think of it [SD] as

survival. We have a right to survive.” Subsequent interviews confirmed this view of SD in recovery as generally conditional but also absolute in relation to survival.

4.3.2.3 Discerning. A dictionary definition of the verb “discern” includes “recognize or find out” and “to see or hear with difficulty” (Soanes & Stevenson, 2006, p. 408). More discerning standpoint views in CDs recovery were exemplified by expressed views of mental illness and substance use/misuse. Mental health, mental illness symptoms, substance use, or non-substance addictions often had no discerning meanings to participants when they were young (i.e., their primary sense of self). Malcolm stated: “you didn’t sit down [with friends] and talk about illnesses. You sat down to talk about music...we were not thinking about abusing it [drugs and alcohol]. The thought of abusing it – you did not think that way.” Colleen saw her mental health, illness symptoms, and drug issues as a young adult as: “[It] fitted in together. All just like a ball.” Mental illness came to be seen as more located as a part of the self among the majority of participants and substance use/misuse as located as more a part of the ecosystem in association with pursuing recovery. Developing more discerning views seemed to help people see more ways that they could try to better deal with both issues separately and together. For Alexis, she came to see her substance use/misuse as involving more of a self-determined “choice.” Although she emphasized that this did not equal a greater “easiness” to address them, it did help her develop more effective targeted strategies to tackle them, many of which were

different than how she worked with her illness symptoms. She saw no “choice” in terms of her mental illness symptoms (only in how she managed them):

Drinking or using is a choice. You don’t have a choice to hear voices, you don’t have a choice to have mood swings or whatever, you know...Like, I do believe in the fact that some people have that addictive personality... The choice [to not drink or use] is a lot harder for some people to make and when some people start doing something it is harder for them to quit than maybe others, but it is still a choice.

The trend towards nuanced meanings pertained to the other two SD components as well. For example, the primary sense of self’s power associated with being determined often was not really “seen” by the participant or else very value-laden generalized meanings were attached to it (e.g., stubbornness was seen as all “bad” and commitment all “good” regardless of the context). In contrast, this Power of the self came later to be seen by people as involving combinations of features associated with meanings of stubbornness, commitment, persistence, dedication, and loyalty. As well, the power came to be seen as more neutral in nature and then judged situationally in relation to a particular context, issue, or goal.

Overall, the awareness and integration of greater nuances of meaning occurred like stones dropping into a pool of water – the stones caused waves that rippled through the interrelated SD components, potentially affecting the sense of self and, in turn, meanings of SD. Stones tossed into the pool could be of different sizes and cause different sizes of waves. Some “waves” appeared to be absorbed or resisted without apparently causing a significant shift or change. Some appeared to have some impact that cumulatively contributed to a gradual shifting

over time. Still others were like boulders hitting the water and whose waves had an immediate significant effect. These catalytic experiences were often associated with what participants described as sudden standpoint shifts (e.g., “waking up” to some aspect of their self and/or their ecosystem such as an addiction being in control of his or her self). One element of the standpoint (e.g., the sense of control) might be particularly “hit” and cascade through the other elements, SD components, and the sense of self as a whole.

As mentioned above, the knowledge-building positive (hermeneutic) feedback loop is thought to be behind the trend towards developing greater attention to, and integration of, nuances of meaning. Generally, programs or professionals that pushed pre-determined absolutist, incompatible, and indiscriminate views of the self, the ecosystem, treatment, mental illness, addiction, or recovery were not highly trusted by participants with a nuanced sense of self in CDs recovery. In contrast, professionals who worked collaboratively with participants and respected their “nuanced” views, even if there was not always agreement, were more trusted and valued.

4.3.3 The Components of SD Meanings

The following sections present in more detail the standpoint of self elements, determining processes, and the power of determination of a grounded theory of SD meanings in CDs treatment and recovery experiences. Presenting the three components, their respective sub-categories, dimensions, and relationships separately is not only complex to do in a coherent manner but it also is artificial.

The grounded theory conceptualizes the components as fundamentally synthesized into participants' SD meanings that exhibit temporal change and are expressed within dynamic self-ecosystem relationships that are integrated and reciprocal (but not necessarily symmetrical in terms of power issues). Nevertheless, presenting them separately helps support their place in the theory, highlight key contributions that they make to the grounded theory, and set the stage for discussing different facets of the grounded theory in the next chapter. The summary at the end of this chapter attempts to "re-mix" or fuse the components back together again. The summary includes two figures. Figure 4.7 provides a visual representation of the components and relationships interpreted as important to the primary sense of self. Figure 4.8 does the same for the more nuanced sense of self associated with CDs recovery.

4.4 SD: Standpoint of Self Elements

Each self-standpoint element usually emerged and was understood only in relation to one or more of the other elements. For example, an attitude towards his or her self often was formed only in relation to interpretations of experiences that also contributed to attitudes towards other people, groups, or society in general. Greater discernment (but not a complete separation) between the elements occurred over time. For example, Susan stated: "the more I get healthier and get to know more about my illness and stuff, the more I see in my own family, and I'm like, 'you're not normal – I'm normal!'" Figure 4.4 highlights the self-standpoint elements that are the focus of this next section.

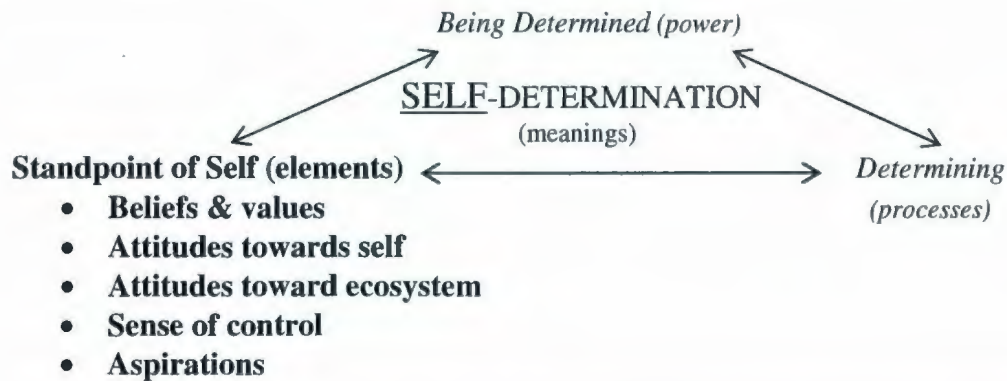


Figure 4.4: Self-Determination Meanings: Standpoint of self elements

4.4.1 Beliefs and Values

Beliefs involve: "the emotional acceptance of some proposition, statement or doctrine" (Reber & Reber, 2001, p. 86). Here, they refer to participants' spiritual/religious beliefs. Values are abstract principles concerning behavior within a particular family, culture or society, "which, through the process of socialization, the members of that [family], culture or society hold in high regard...[and] to hold something in esteem based upon one's evaluation of self" (Reber & Reber, p. 783). Beliefs/values contributed to each SD mix in ways that included: providing a guiding framework for decision making; providing evaluative references for the setting and adjusting of the other standpoint elements; and being a source of power associated with being determined about someone (including the self) or something. Primary beliefs/values were established in childhood and tended to be absolutist in nature. Participants' recovery was associated with a greater awareness of these primary beliefs/values and questioning their utility. Questioning could lead to re-affirming primary

beliefs/values, discarding them, or adjusting them in ways that were more situationally relative, compatible, and discerning in association with CDs recovery. Examples are presented below.

4.4.1.1 Spiritual/religious beliefs. Teresa and Susan's religious beliefs involved a Christian religion. Both attended church as children, did not attend for a period as adults, and then returned to their church in recovery. Alexis was not a member of a religious group but spoke of having strong spiritual beliefs. Carmen integrated a spiritual belief in nature with a belief in God while Malcolm chose to follow spiritual principles of a Central American indigenous belief system. The remaining three did not have strong beliefs. Sam and Brian viewed religion as socially learned cultural or family values. Colleen said she attended church but for social reasons and to enjoy the music rather than because of having strong beliefs.

Four people related religious/spiritual beliefs to SD in terms of making decisions. Susan said: "just believing that someone is out there beyond us and that no matter what happens he is right there guiding me to make the right decisions." Four participants' beliefs also supported or energized their being determined. Carmen said: "I believe in 'Ma Nature.' I believe that she is a big healer...it recharges me. It's like a battery recharger." Alexis said her beliefs gave her energy to carry on through life-threatening experiences: "I think there is something out there, you know, like I think things happen for a reason and kind of everybody has a purpose and there's some reason why I am alive...I am alive and I didn't die when there were so many times when I really should have been dead."

4.4.1.2 Values associated with responsibility, freedom, caring, and compassion. All participants referred at some point to “responsibility” and meanings of SD. All but Sam said that they used to associate responsibility mainly with guilt, failure, and being responsible to, and for, others. Carmen spoke of a how her recovery has been aided by a change in her meaning of responsibility:

[I’ve learned that] it wasn’t that I felt responsible; it was the things I was responsible for. And what a difference that is. A whole new take because once you know what you are doing and that you are responsible for this happening because you actually are – not because somebody makes you feel that way or you make yourself feel that way. Because it is something you are doing and you are responsible for it and you can stop it. It’s when you use responsibility for things you can’t control. You can struggle for the rest of your life if you keep that thought pattern.

Susan said her responsibility in recovery included taking care of her daily living (e.g., “paying your bills”) and managing her mental health: “putting my own thoughts and feelings and stuff into control and not having them spurt out.”

Teresa and Susan also spoke of their meaning of responsibility in recovery included taking better care of their self rather than focusing mostly on being responsible for, and to, others. Teresa said:

I was forced to be, how do you say, to be a woman that had to work real hard at doing things and I didn’t get my teenage years in because somebody always needed me and I was always there but I need something else now...I am going to try [to take care of myself]. It is hard but I am going to try.

Six people spoke of freedom, individualism, or independence and SD (autonomy was not mentioned). Freedom, individualism, and independence were related to responsibility and SD, but their meanings were not the same. For

example, Sam said that SD meant people could self-determine the degree of personal freedom versus externally-determining structure in their life that works best for them:

A lot of people don't want to be totally free, you know, a lot of people like some structure in their lives...some people do like being told what to do by someone they particularly trust or respect, you see.

He referred to people who choose to have little structure in their lives as "individualists" (he described himself as a "semi-individualist). Carmen also said that freedom and SD were close but not the same: "I would see freedom as one of the tag words that you would draw a line from [SD] ...and put freedom and self-respect and independence."

All spoke of their values in terms of the importance of helping, caring, being loyal to, or having compassion for other people while expressing their SD. Sam and Brian referred to this view in terms of reciprocal responsibilities. Essential to this value was seeing, respecting, and caring for others as worthy human beings, as participants in recovery increasingly demanded others to see them. Five participants' primary sense of self reflected a view of compassion or caring that emphasized caring for others such as partners or children (Carmen, Teresa, Susan, Brian, and Colleen). While Sam was unsure, Malcolm and Alexis said they focused more on meeting their own needs (especially when substance dependence was at its height). In contrast, the nuanced sense of self in CDs recovery was characterized by all participants valuing caring for, and about, others while balancing this with caring for his or her self in compassionate ways.

4.4.1.3 *Stigma and CDs*. Open-ended questions offered people a chance to share their meanings of SD in relation to beliefs, values, stigma, prejudice, and CDs. Stigma is a social designation; “a mark of disgrace associated with a particular circumstance, quality, or person” (Soanes & Stevenson, 2006, p. 1417). Prejudice is a: “preconceived opinion that is not based on reason or actual behavior” (Soanes & Stevenson, p. 1132).

Racial/ethnic/cultural differences and gender were probed. No participants identified themselves as being part of a specific racial, ethnic, or cultural group beyond seeing themselves as “Canadian.” None felt their SD in treatment was limited in some way based on their racial/ethnic/cultural characteristics. Participants felt that there were obvious biological differences between the genders that could affect people holding different meanings of SD (e.g., women and pregnancy). However, all felt that religious beliefs and/or socio-cultural values unnecessarily created gender-related stigma and prejudice. They all thought that these socially constructed differences still existed and they had to deal with them on a day-to-day basis. They also shared the view that gender-based beliefs/values were no longer as powerful as they once were and that their personal meanings of SD were not qualitatively or fundamentally different based on gender. Carmen spoke of becoming more aware, and her perception shifting, in relation to gender-related values/beliefs: “I used to have those feelings [about gender differences and freedom]...I don’t think it [SD] is gender related. I honestly don’t think...I think that society made things gender related and it is not

supposed to be that way.” Female participants felt that their SD was not as negatively impacted in terms of gender once they became aware of, critically questioned, and adjusted certain self-limiting gender beliefs/values that they had absorbed in youth.

Most participants were concerned with professionals having beliefs/values about substance use/misuse in relation to mental health or mental illness that were stigmatizing or prejudicial. Most participants also thought stigma and prejudice was improving for people with mental illness and this often supported their SD. However, five of the eight participants suggested that stigma or prejudice about addiction issues often “trumped” their mental illness symptoms being seen in a better light. Alexis said that while she had not experienced stigma associated with addiction among mental health “counselors” she does continue to run into it with psychiatrists: “from psychiatrists, definitely yes! Either they think you are an addict or you don’t really have a mental health thing because it is just because of the drugs.” Brian gave a structural example:

I know of some people who were denied ODSP [Ontario Disability Support Program] benefits because of the existence of an addiction co-occurring with the mental illness. So, if the mental illness was there and the person meets the criteria then great but if that criteria is there but the individual also uses or has been diagnosed [with a substance use disorder] then you are ineligible.

4.4.2 Attitudes towards Self and Ecosystem

A dictionary definition of “attitude” is “a settled way of thinking or feeling” (Soanes & Stevenson, 2006, p. 85). The concept of “attitude” is a central one in social psychology but, like CSD in social work, the denotative meaning is

not widely agreed upon. Still, the meaning of attitudes in psychology includes a number of common themes: a judgmental stance or intention towards someone or something (e.g., positive, negative, neutral, or ambivalent); they can be unconscious (i.e., “implicit”) or conscious (i.e., “explicit”); they involve emotions, cognitions, and actions; they contribute to behavior (some argue more in terms of cause-effect than others), and they may be stable but they also hypothetically have the capacity to change (Reber & Reber, 2001).

Participants’ attitudes overlapped with the other SD elements, especially beliefs/values. Often attitudinal evaluations were described as being referenced against expectations based in their beliefs/values. Early attitudes settled and became *ambient* within participants’ primary sense of self. They were ambient in terms of becoming automatic or normalized – they were described by participants as the only way they saw things at the time and other different views were either not considered or else automatically rejected. They generally were described as working in the background; like ambient room temperature that one is used to and so not really noticeable until becoming uncomfortably hotter or colder.

Experiences often were interpreted in ways that reinforced already established attitudes. If experiences were contrary to primary attitudes in some way, then they were described as often being ignored or discounted. This appeared to avoid destabilizing primary attitudes. However, these contrary experiences are interpreted in this theory as having the capacity over time to gradually increase conscious awareness of established, ambient primary attitudes.

Increased awareness tended to lead participants to critically question certain attitudes and to potentially change them. One example involved people going from general positive or negative attitudes towards all professionals' trustworthiness to more ambivalent or neutral ones in recovery. This more neutral stance in recovery appeared to allow for more discrete positive or negative judgments based on direct experience with specific individuals that they interacted with. Some experiences were described as causing sudden rather than gradual shifts in awareness of primary attitudes, quickly critically questioning them, and potentially quickly adjusting them in some significant way. These "catalytic" self-ecosystem experiences are interpreted as being associated with knowledge-building processes and are discussed below.

4.4.2.1 Formation of primary attitudes. These two attitudinal elements are presented together because this is the way that participants described them as forming when they were young. Unfortunately, some could be associated with what can best be described as horrific betrayals with devastating effects. For example, Carmen kept running from home to escape abuse. At 12 she was put into a psychiatric hospital program. A male psychiatrist sided with the denials of abuse expressed by her mother and step-father, subjected Carmen to "mental criticisms," and subsequently abused her after sedating her with medication (he was later charged). Her primary attitudes, with respect to these early experiences, included both an attitudinal fear of the social world around her (e.g., specific people and also social structures including "family" and "treatment") and a highly

generalized negative attitude towards her self. At one point, she said: "I thought I was an evil person...that I had these things happen to me." Her self-standpoint in recovery was associated with a movement towards greater relativistic attitudes overall about other people as she found some who were trustworthy and caring while still running into many others who were not. She also discerned more between her attitudes towards her self and facets or dimensions within her ecosystem and was more circumspect of her attitudes in relation to being determined in some way.

In terms of CDs treatment experiences, all but Sam spoke of needing to regularly assess the trustworthiness of authorities or experts on a person-by-person basis in recovery (Sam avoided them all). This view was arrived at from different primary attitude "settings" (e.g., highly distrustful or highly trustful). Sam remained most distrusting of authorities and experts. As mentioned previously, he had voluntarily stayed at a psychiatric hospital in his late teens for a couple of weeks due to difficulties with stress. However, he had been subsequently involuntarily hospitalized on psychiatric grounds and was the only participant to not perceive himself as dealing with some form of mental illness *per se*. Still, he said that all professionals are not the same and some probably could be trusted, but he was not interested in the risk and effort to find them.

4.4.2.2 *An evaluating awareness of self and SD meanings.* Participants described not having conscious awareness of attitudes towards their self when they were children. Attitudes appeared to arise through meaningful but

disconnected “jigsaw pieces” of self-awareness in their childhood, youth, and early adulthood. The pieces arose in relation to his or her interactions with the ecosystem, especially social interactions with parents, family members, peers, and adults associated with schools, child welfare, police, and medical professionals. Experiences appeared to be subjectively organized by participants into a generalized “picture,” “story,” or theory of both his or her self and the ecosystem that integrated value judgments (e.g., a subjective narrative). Missing pieces of the picture were simply filled in and alternative overall pictures that also might fit with pieces of experience were not considered or were rejected. As mentioned above, externally-based beliefs/values were often standards that participants compared his or her experiences with in order to generate their respective evaluations. Evaluations of personal experiences in relation to these external standards led to internalized self-appraisals. Once established or “set”, these primary attitudes became integrated and ambient within the sense of self.

Primary attitudes about the self were largely negative for Teresa, Colleen, Alexis, Carmen, Brian, and Malcolm. Early attitudes were more positive in nature for Sam and Susan. Participants’ experiences of abuse, family losses, and/or peer conflicts in high school were found to be highly associated with negative views of his or her primary sense of self. Externally introduced notions of having mental health problems or addictions and directive interactions with professionals typically did not help counter any negative attitudes towards the self and often reinforced them. Brian, for example, felt socially marginalized for much of his

high school years. He saw himself as struggling with attention deficit disorder and compulsive tendencies, which he is now working on with a psychiatrist he trusts. He struggled with self-esteem as a youth and was diagnosed with depression. His attitudes included assuming that all authorities and experts knew what they were doing and were trustworthy. He then had a physician at university who arbitrarily reported his cannabis use to the government when he simply wanted to renew his driver's license and needed her signature. He said she "tricked him" as he did not understand the implications of sharing with her that he used cannabis. His license was not renewed based on the physician's report, he was subsequently caught driving, was charged, incarcerated, abused in jail, and tried to kill himself. He said the experience with the physician shocked him; he always trusted a doctor's judgment and yet felt there was no hard evidence he knew of that his use of cannabis was associated with any clearly immediate problems with his health or operating a vehicle (although she clearly wanted him to stop). The experience reinforced his existing "tendency towards self-doubt, difficulty to grow, and problem solving."

It was not clear if early experiences contrary to primary self-attitudes that appeared to be rejected or ignored still contributed to eventual shifting of attitudes. Nevertheless, the hermeneutic positive feedback loop suggests that subtle, gradual shifts are likely (as well as sudden ones discussed below); the metaphor of stones being tossed in the water and creating waves implies that even small ones could "erode" to some subtle degree what they impact against. Seven

of the eight participants' primary attitudes towards self/ecosystem were described as having shifted to varying degrees around the time when they reported pursuing CDs recovery. Carmen said her self attitude was changing within her over the past five years: "I have a lot to be proud about!" She is now more confident with professionals and will even share her decision-making processes on an issue-by-issue basis with professionals she decides that she can trust.

Part and parcel with participants' primary appraisals of self were early judgments of their self-knowledge and self-efficacy which, in turn, impacted on their determining processes of SD meanings. For example, Brian, Colleen, and Carmen said they saw others as knowing better about things than they did when they were young. Consequently, their meanings of SD were more covert, tentative, and defensively expressed. Susan's statements were mixed. Sam did well in high school and worked in a biological research station before going to university. His primary attitude is interpreted as being positive about his own self-efficacy and knowledge which, in turn, is interpreted as contributing to his meaning of SD being more overt and assertive. Alexis, Teresa, and Malcolm held primary stances that they "knew best" or they were "out to prove something" to others but this was not so much in a positive sense but more in relation to feelings of anger against self and others, a general "stubbornness" with authority, and a generalized "distrust" of others after traumatic experiences. Malcolm, for example, said that he took a drug for ADD that made him feel like a "zombie" when he was 9, at the insistence of his public school. His parents took him off it

after a few months due to the side effects but the school still insisted he take it. He was suspended, strapped, and the school brought in child welfare authorities who threatened to take him away if his parents did not keep giving him the medication. Malcolm's father then died when he was 12 and Malcolm said he started smoking cannabis regularly with friends at school shortly thereafter. The cannabis use appeased school authorities because he was now easygoing when he was high. He acknowledged that this suggested to him that he knew how to find his own solutions (including self-determining which substances worked for him) and not to trust authorities. An uncle subsequently coached him in hockey as a young teen and goaded him to be aggressive and violent in order to be "a man." He reports: "I left home when I was 16...I ruled the world, I made the rules."

All but Sam reported significant changes to their attitudes in terms of valuing their self-efficacy and knowledge in recovery. The movement was towards more generally balanced and situationally discerning attitudes. Those who thought others knew best developed more faith and confidence in their own personal knowledge and decision making while those who thought they knew best moved more towards seeing others as sometimes knowing helpful things too (and that they did not have to do everything alone). Malcolm stated it succinctly: "you say, 'hey, I am today's biggest next best thing to Wonderbread' only to find out you haven't gone through the batter yet." Sam's attitudes appear to have changed the least. He continues to generally distrust mental health professionals'

knowledge and intentions, at least as it applied to him. Nevertheless, he did not see professional help as always bad for others.

4.4.2.3 Caring about his or her self. This attitudinal dimension was often mentioned in relation to responsibility beliefs/values mentioned above. An awareness of the need to care for one's self, in terms of nurturing or compassion, often emerged in association with mental health or addiction-related crises in adulthood. Susan, for example, did not think that being a woman per se contributed to her not caring for her self before her crisis in her thirties; nevertheless, she did see this primary attitude as stemming from her family context that included gender roles: "I think we grew up seeing my mom please my dad, just in little things, so I think that is how we learned to put people first but not your self. My mom put us first and not herself so we grew up knowing we were last on the list." Her attitude towards caring more for her self in recovery included ending a relationship with a boyfriend while she was in an intensive treatment program: "before I would put the kids first or I would put my parents first or anybody that came in contact with me. It could be guys – I was there to please them and I didn't myself. Now it is me first."

Despite her "me first" statement, she now balances caring for her self and others in compassionate ways. For example, she regularly volunteers with her peer support center, her children are the "light of her life," and she hopes sharing her story might help other people in some way. In contrast, Alexis held more of a primary attitude along the lines of "me first." She said: "I didn't care about

friends. All I care about was getting money and getting high. I didn't care who I hurt." However, she went on to say in relation to her CDs recovery: "now I do. I care about myself and I care about everything." Brian, too, said he emphasized taking care of others rather than himself in the past. His ex-wife also struggled with the effects of CDs. He said he looks back on his marriage and although he feels good about trying to help his ex-partner, he also feels he stayed in the relationship longer than was healthy for him and he is still recovering from the experience. Again, over time, participants' described how their attitudes in CDs recovery had shifted from caring primarily about others towards caring more about one's self or else caring more about others if they had tended to care primarily about his or her self. They were more situationally discerning between the two and they actively balanced both overall (often in relation to more nuanced interpretations of guiding beliefs/values).

4.4.2.4 Negative attitudes and substance use. Five people said that in hindsight their substance use/misuse was related to negative or "bad" attitudes towards themselves, their lack of caring about themselves, and/or not knowing any other way to take "good" care of his or her self. SD and self-direction was expressed accordingly. For example, Colleen was abused as a child. She shared that some family members introduced her to cannabis when she nine and that she enjoyed its effect: "when I started doing the pot – the weed – or the hash oil, I would do it and I would be stoned for 4 or 5 hours, and I wouldn't care what happened." She became a ward of child welfare when she was 11. She

experienced various foster families and group homes. She said the experience left her wondering “who I really was” and she felt abandoned by all in this quandary, including child welfare authorities and experts. She finished high school and worked but at age 22 she had a “breakdown”, attempted suicide, and was hospitalized. She did not report substance use problems as a teen. However, following her crisis she began to misuse a prescribed narcotic painkiller and a tranquilizer. Their effect echoed how she perceived the effects of cannabis when she was a young child:

I used it [painkiller and/or tranquilizer] for numbing, a lot of numbing. I didn't want to think. I didn't want to see. I didn't want to hear what was going on...I didn't want to deal with anything. I was tired of trying to deal with something, trying to figure it out. And you get to certain point and then you get let down –when you are trying...you are thinking, ‘hunh, I don't want to deal with this anymore. I am done.

4.4.2.5 Distrusting/fearing the ecosystem. Most people held primary attitudes associated with not only seeing themselves negatively but also distrusting his or her self in many ways. This was a major issue for people when reconciling having chronic mental illness symptoms and/or addiction issues (e.g., self-determining that they had persistent biologically-based self-control issues often led them at first to distrust their thoughts and feelings even more). However, distrusting people or dimensions of the ecosystem were closely related, equally powerful if not more so, and particularly pertinent to SD meanings in CDs treatment. Again, a general distrust of the self versus a distrust of his or her ecosystem as an abstract whole (e.g., references to “society” or the “world”) was not consciously discernable in relation to the primary standpoint. Again, over

time, the two were not so much separated from each other but different aspects of each became more discernable. A distrust of ecosystem forces and dimensions, based on real experiences of being harmed or betrayed, was the most consistent theme behind support for the importance of SD in CDs treatment and recovery.

Participants agreed that as children they saw all adults collectively as “authority,” regardless of the relationships they had with them (e.g., parents, teachers, police, and child welfare workers). They did not discern between “authorities” and “experts.” Although distrustful beliefs and values of authority may have been picked up in childhood by some; nevertheless, primary distrustful attitudes towards authority were associated with them having experienced verifiable abuse, trauma, or indifference at a time of crisis that involving authorities/experts. A number of such experiences have been mentioned.

The distrust of the ecosystem was a key primary attitude that endured for Carmen, Malcolm, Colleen, and Alexis well into their adulthood. In contrast, Brian reported that he generally trusted adults and authorities until he was eighteen (he originally went to college to become a police officer). As mentioned above, his attitudes shifted towards being more distrustful after the physician betrayed his confidence and a subsequent cascade of traumatic events. Sam and Susan are also interpreted as having generally positive attitudes towards others in relation to trust that shifted through experiences in their late twenties or early thirties. Sam’s first forced hospitalization still weighs heavy on his mind. Susan’s

distrust became pronounced after leaving her husband, becoming involved with a man who abused one of her children, and an arsonist lit her home on fire.

Adjustments reflecting more relativist or situationally discerning attitudes towards authorities/experts occurred for all participants to varying degrees over time. Their attitudes in association with recovery typically viewed authority as not all good or all bad (including Sam). For example, the distinguishing characteristics that legitimized the use of authoritative powers among participants in recovery was whether it was applied in a way that they discerned to be balanced, thoughtful, saw the person as worthy and unique, and took into account the person's context. In other words, power and control was exercised in ways that they subjectively viewed (at least in hindsight) as "fair." Malcolm describes it as: "you're going to give me a fair shake in life."

Participants in recovery also viewed professionals as sometimes being authorities, but not always. Susan saw that difference in terms of power and control: "an authority is just like a parent being an authority with their kids – boss them around. You are taking that control from the child. A professional has the education to know what they are talking about." She went on to say that experts help a person gain back greater control. Participants agreed that authorities used some sort of power or threat to determine or coerce you in some way, whether or not they knew what they were talking about or had good intentions. Participants tried to avoid, ignore, or suffer through people who presented themselves as experts but who acted primarily as authorities in treatment contexts. However,

recovery from CDs was seen as requiring “partnerships” with professionals and/or peers that were discerned to be trustworthy “experts” in relation to:

- Being caring, careful, and respectful to the client.
- Being knowledgeable about what they were talking about (especially through personal and/or clinical experience).
- Being willing to share their knowledge with the client.
- Being willing to learn from the participant.
- Being able to consider relativistic views of mental illness, addiction, and treatment decisions.
- Being willing to work collaboratively with the participant (especially when views and decisions do not always agree).
- Being supportive of his or her SD except at times when they and/or others were seriously in some kind of risk.

People sometimes “shared” or even temporarily “delegated” aspects of their SD in terms of decision making with experts that they trusted. For example, Malcolm now delegated decisions about medication to his psychiatrist despite his earlier attitudes: “I’ll go with his decision right now because this guy, he’s been fair with me.” Overall, participants spoke of recovery being assisted through a respectful and supportive context that promoted shared professional-client expertise.

These trust/distrust attitudes towards authorities/experts were consistent among all the different types of professionals that participants encountered. In terms of social workers, Susan had contact with social workers in relation to her

parents having custody of her children. She described these social workers as “authority.” She also had social workers working with her in the intensive mental health treatment program. She described these social workers as “experts.” She said they were experts rather than authorities because “they were more caring towards you than they were trying to take the power away from you. They were trying to give you power so you could handle it – solely.” Carmen, Malcolm, and Sam (who worked in a social work role in a jail) were neutral to the profession. Some helped and some did not. Only Alexis did not remember having any contact with social workers per se. Role and/or agency context was not a deciding factor in how people in recovery saw social workers or other professionals as either authorities or experts. Instead, these discernments in recovery were made on a person-by-person basis.

It should be noted that health care professionals and other authorities and social systems such as schools and child welfare, were not the only external influences that caused, contributed to, or reinforced fears of people within their ecosystem. For example, Carmen continued to be blamed by some family members for her behaviors as a child when she was in her twenties. Sam had a roommate who tried to kill him, and Susan’s experiences after leaving her marriage were described above. However, negative experiences with treatment programs and practitioners were associated with many participants’ primary distrustful/fearful attitudes and contributed to SD meanings reflecting and guiding people away from reaching out for help well into their future.

4.4.2.6 *Connections*. The importance of social connections and self/ecosystem attitudes was evident in relation to SD, the use/misuse of substances associated with the primary sense of self, and CDs recovery. For example, Carmen, Brian, Alexis, Sam, Teresa, and Malcolm all reported seeking and gaining greater acceptance or belonging (including “partying”) among substance using peers, while still distrusting and feeling marginalized by the socio-cultural dimensions of ecosystem that they saw as a whole (e.g., “society”; “the world”). All reported holding these fearful, distrustful attitudes towards this ecosystem dimension prior to using substances socially. Carmen and Teresa’s problems with alcohol developed only after both started to use it socially following their marriages ending and feeling emotionally and socially adrift. Susan’s sexual behavior issues also emerged after her marriage ended. Her decision to address her sexual addiction also involved a changed view of belonging in relation to her social world. Generally, substance misuse or addiction-related behavior came to be seen as no longer so important socially because attitudes towards this dimension of the ecosystem were less black-or-white in terms of its distrustful nature and/or addictions came to be seen as no longer being a viable or “good” route to achieve a micro “bubble” of belonging within perceptions of a larger hostile world.

Participants who decided to have an occasional beer or joint in recovery despite past problems did not speak of using them to find, in such desperate ways as in the past, connections with others or a sense of belonging. Sam was one

exception in terms of continuing to regularly use alcohol for strong social reasons. He expressed the difference for him between prescription medication and his use of alcohol: “you drink to excess because you need to be drunk, not to be sober...beer’s designed and marketed to be drank to relax, better than guzzling down valiums, and more sociable too.”

Most participants who described connecting with others around substance use/misuse said they eventually saw these people as not caring about them as a person and an important expression of connection with others was lost. This was often associated with the participant being in some sort of difficulty (e.g., to do with mental health crisis, substance-related issues, or legal problems) and their friends were no where to be found. However, another factor appeared to be important in relation to recovery and adjusting generalized distrusting attitudes towards his or her self – people who did not compassionately care about his or her self said that, for some reason, they suddenly began to. In the past, being betrayed or abandoned was almost to be expected if they did not care about his or her self.

All participants said they were actively involved in finding a renewed sense of belonging with others in his or her recovery that did not revolve around substance use or addiction-related behaviors. All had reconnected to some degree with some family members, his or her children, old non-using friends, peer supports, trustworthy professionals, and more abstractly with society as a whole. Society as a whole was viewed by all but Sam in a more balanced or neutral way in terms of being hostile or trustworthy to the participant. Spiritual/religious

beliefs appeared to help some participants to feel less socially threatened in recovery. Views in recovery were also more compatible – people held absolutist attitudes of what was dangerous to them (e.g., certain drugs or people) within a more relativistic or situationally discerning view of others overall.

People self-determined limiting or avoiding people they “used with” in CDs recovery and actively sought new connections not organized around substance use. This included participants not organizing connections around formal 12-step addiction peer support participation. In contrast, six of the participants did organize some connections in CDs recovery around mental health peer support programs. Professionals who were perceived as not caring were described negatively in a number of different ways. One example involved a number of participants referring to some professionals they had experienced as “pill pushers” in a tone similar to their references to past “drug dealers.” These professionals were said to have pushed prescription drug use as the only hope for recovery in absolutist terms. However, experiencing authorities or experts who were caring, and who wanted to make a connection with them, sometimes cascaded through the standpoint of people who had primarily distrustful attitudes. Participants said a key part of this cascade occurring was that they wanted to make rather than reject such a connection with a professional.

Wanting to make a connection in relation to CDs recovery was usually associated with at least four factors: (1) people were in some sort of different physical/social space; (2) they felt abandoned or betrayed by “status quo friends”

(e.g., substance using peers); (3) they said their stubbornness or commitment (i.e., their being determined) to stay the way they were was wavering; and (4) they felt their survival was in jeopardy figuratively or literally. Hoping to connect at these times and then being rejected, deferred, or harmed reinforced their primary negative attitudes towards authorities/experts or contributed to adjustments towards more distrustful attitudes among those whose primary attitudes were more neutral or positive to seeking help. Malcolm's connection was with a prison guard who said "hi" to him every day and treated him with respect, no matter how much Malcolm tried to insult him or ignore him. He began to think that the guard might know how Malcolm could "get out" quicker and so he gave him a "chance." The guard turned out to be trustworthy (e.g., he never used shackles on Malcolm), they keep in touch to this day, and Malcolm now determines whether treatment professionals are trustworthy on a person-by-person basis.

Carmen's attitude began to change when she met the first professional, a female family physician, whom she felt finally "believed" her story of abuse and "believed in" her as a person. She subsequently saw an uncaring female psychiatrist who reinforced her distrustful attitudes and she backed off again. She eventually reached out again in a new rural area she had moved to. A female transportation coordinator went out of her way to help Carmen and this, she felt, contributed to a more sudden shift in her attitudes at that time. She can now make careful connections with males and females despite her fears. Alexis left an abusive boyfriend, was living in an abandoned van, and was caught stealing from

work for drugs. She ended up at a YWCA where she met a counselor with whom she still talks. Teresa became suicidal in her late thirties after her husband had left. She was hospitalized but did not experience a positive treatment connection until she was hospitalized again three years later and met a new psychiatrist. He helped her make her own sense of her mental health struggles. At the time of interviewing, Colleen had a new psychiatrist that she finds does not really listen to her. Fortunately, she has a good connection with her mental health caseworker. Brian eventually found a psychiatrist he now trusts and collaborates with. Finally, Susan remembers how she voluntarily agreed to stay in hospital after her series of tragedies. She sees herself as “lucky” that she got the psychiatrist she did:

When his patients needed him he was always there – night or day. ...he would sit and talk to you for an hour and usually appointments with psychiatrist are 5 or 10 minutes and you are out the door again....the ones here that I have had – she’s 10 or 15 minutes at the most and you are out, you are done...that was a big thing for me – having somebody I would be able to trust – because most people I didn’t. And it was one person I could and I could tell him anything, it didn’t matter what it was, and he was always there...a feeling of easiness and I knew that I was safe there...if I had a problem he would always look it up on the internet. And we would sit down and discuss what the internet said. Or, he would go to his colleague and tell his colleague that he had a question...he never left you hanging – he always found some way to get you an answer.

4.4.2.7 Attitudes towards physical/social space. Open-ended questions

probed participant meanings of SD in relation to attitudes towards the physical dimensions of their ecosystem. As mentioned above, Carmen viewed the physical world as a spiritual experience that helped re-energize her power of being determined and animated her SD and self-direction. She was the only one who referred to the physical world in a way that was independent of people and social

structures. The physical aspect of the social ecosystem was relevant to SD and recovery for more of the participants in relation to an integrated physical/social "space." For example, Alexis liked a lot of noise and people around her. She spoke of being energized by a cityscape in a way that was similar to Carmen's benefit from nature. Malcolm was neutral. Sam described "semi-rural" as his preference. The rest preferred rural or small towns because they felt less anonymous but not crowded.

Four lived at some point in very large cities. They thought that the social pressure overwhelmed them and the anonymity was depersonalizing. Carmen thought that her impulsive move to the country after her marriage ended, and another bad experience with a psychiatrist was, in hindsight, critical for her recovery. "Isolating" herself in an area with fewer resources available left her actually feeling more validated with the professionals she was able to find there: "I wouldn't have made it if I had stayed in the city...there has to be some sort of personal. You are talking about the most personal stuff in your life so you can't be a number." Malcolm also found himself in a different space when he said he first turned towards CDs recovery – solitary confinement. In hindsight, he found that being in the cell space alone started a change in his awareness of his self, mental health, addiction, and change:

The freedom they give you is when they lock the door...your freedom to think...free time away from alcohol or substance...you're using your brain instead of just saying, 'ok, if I put this up my nose or just swallow that'll answer today's problems'...but now, opening your eyes and saying, 'ok, hey, how do I deal with it?' Well, when you're in a 4 by 4 – and I'm not talking about a truck – yeah, you get to use your mind a lot.

However, as mentioned above, Brian was also incarcerated at one point. The impact of his experience was opposite in almost every way to Malcolm's and led him to integrate more distrust into his attitudes towards authorities/experts. Other people spoke of being in a different social/physical space prior to recovery that could just as easily have caused them to harm themselves or even be killed by others. Consequently, being in a different physical/social space alone is not interpreted as being predictive of a participant deciding to pursue recovery and could, unpredictably, be harmful to CDs recovery.

4.4.3 Sense of Control and Aspirations

Malcolm said: "kids have a dream, you know. Try to follow the dream." Control refers to ways or means of restraining, restricting, compelling, or regulating something or someone as well as the power to determine a certain course of events, (Soanes & Stevenson, 2006, p. 311). The term, *aspiration*, is future oriented and refers to "hope or ambition" (Soanes & Stevenson, 2006, p. 79). The aspiration element was referred to in interviews by participant references to "dreams", "hopes" and "goals." They overlap with control in terms of what the purpose or desired outcome is behind controlling someone (including the self), something, or a desired course of events.

Goals often represented steps within a larger pursuit of participants' aspirations. Consequently, goals could change while aspirations remained the same. This was described by a number of participants in relation to his or her sense of control and substance use/misuse or addiction-related behaviors. For

example, aspirations of wanting to feel more in control for a number of participants was pursued via goals of using/misusing substances prior to pursuing CDs recovery. Goals of not misusing substances in CDs recovery were associated with, arguably, the same aspirations when participants perceived that addiction and/or mental health symptoms had taken control of his or her self, substance use was now more of a threat than a help, and he or she wanted to take back more control of his or her life. The two standpoint elements are presented together as they were closely entwined in participants' statements of what SD meant to them in CDs treatment and recovery.

4.4.3.1 Formation of sense of control and aspirations. People thought, in hindsight, that their early sense of control involved beliefs/values that people generally should be able to determine almost anything about their self and achieve their desired goals, no matter what. One primary standpoint "setting" that subsequently was established and that was especially evident among those who had been abused was that they had little or no ability to control or determine aspects of his or her self, the surrounding ecosystem, or a desired course of events. Other participants reported having early experiences that were associated with forming a sense that he or she did have control over his or her self, the surrounding ecosystem, and a desired course of events. These participants reported running later into aspects of their self and/or their ecosystem that they could not control, regardless of how determined they were. Over time, all participants developed more situationally relative, compatible, and discerning

standpoints in relation to SD, his or her self, the ecosystem, their sense of control, and their aspirations.

As mentioned above, participants thought that they should have or gain control over his or self, the ecosystem generally, and what was necessary to achieve their aspirations. As with the formation processes of primary attitudes, discrete self-ecosystem interactions were subsequently organized, like the attitudinal jigsaw pieces discussed above, into a generalized image, theory, or personal narrative that reflected how they subjectively judged their abilities and expectations in relation to the standard belief. Some spoke of feeling that he or she had little or no ability or means to self-determine his or her self, the ecosystem, or their desired course of events and that this was "bad." For example, Carmen and Colleen reported concluding that they felt that they had failed somehow when they were children by not protecting themselves from abuse by adults. Both also said they believed, as young adults, that they had failed to protect others they cared about and were responsible for (e.g., Carmen's younger sister and Colleen's children). As mentioned above, expectations associated with a more positive primary sense of control were established and were defended by other participants who had experienced some early goal successes.

Mental health crises were strongly associated with participants fearing they would, or had, failed in relation to achieving or maintaining their important goals and aspirations. Recovery from CDs was associated with people re-adjusting or reorienting their self-determined goals to include more nuanced

aspirations of having a life worth living. A life worth living included needing to effectively manage one's mental health, mental illness, and addiction issues.

People saw SD as fundamental to their sense of control, hope, goal setting, decision making associated with aspirations, maintaining goals achieved, or changing their goals. Typically, early substance use was perceived as either neutral to their control and aspirations or actually helped them feel more in control (Sam continued to hold this view in relation to managing "stress"). Self-determining a goal of pursuing recovery from CDs was associated with the majority of participants' finding at some point that they had lost control to an addiction and/or mental illness symptoms. The value and use of prescription medications to the person in recovery was also evaluated very specifically to how well it supported a participants' aspirations, including helping enhance his or her sense of control. The treatment process vis-à-vis participants' aspirations in relation to being in control (e.g., coercive versus collaborative medication recommendations) were described by all participants as being just as important to recovery as the medicinal effect alone.

4.4.3.2 Controlling versus influencing. CDs recovery was associated with people consciously adjusting their primary sense of control "setting" (often in concert with questioning their beliefs/values pertaining to meanings of responsibility and freedom). The sense of control associated with CDs recovery brought forward more situationally relative and discerning notions of control in relation to the self, the ecosystem, and the future. This shift led to different

decision making in recovery that valued more their attempts to influence rather than control his or her self, aspects of their ecosystem, and/or desired outcomes (i.e., they were less emotionally dependent on desired outcomes or trusting of “guarantees” of success). Unexpected or undesired outcomes appeared to be experienced as less traumatic or self-damning failures. More nuanced views of control were evident in many participants’ statements that related SD to complex combinations of internal states, ecosystem contexts, and external asymmetrical powers they faced over their lifespan. Carmen stated:

When we’re not in control? When it is something that we have no control over. Oh, as children we have none, as an employee, as a member of society. There are so many situations...those are the key words – ‘not allowed.’ So, yeah, we are all entitled to it [SD]. We are all able to do it. But there is a cap on it...*And are there reasons for that cap?*... Yeah, because self-determination is going to be different for every single human being. ...Oh, there is so much you can play with that. There are just so many ways. But I would not have gotten as far as I am right now without it though. I think, I think the number one stopper; the number one thing that puts the cap on it though is ourselves.

4.4.3.3 Substances, control, and goals. As mentioned above, people said that their substance use was initially benign or else it was positively related to their primary sense of control issues. In turn, this helped their pursuit or maintenance of important goals and aspirations. People said that, at that point, they were going to misuse substances no matter what anyone else might try to say or do. For example, Teresa only began to smoke cigarettes in her late thirties, shortly after her husband left her (she said she a tried a few as a teenager but did not like it). She said: “I decided I’d like to try it again and then when I tried it I liked it – it kept me under control...yeah [like medication].” Her doctor continues

to try to get her to stop and she said she has cut down. However, she dared me – she said “just try” – in anticipation of me suggesting she stop in our interview (which I was not about to do). Carmen did not start drinking until her early thirties. She said that it was helpful to her goals of needing more fun in her life. However, she emphasized that it was just as important in terms of her sense of control: “that is why we call it bottled courage – that is what it was all about. It was the only way that I had control.” Malcolm used alcohol and cocaine heavily in his twenties and thirties. He indicated: “I didn’t think I could go a day without it. This was my control of my life.” Colleen’s substance misuse helped her not care, think, or feel – which was her goal at the time. Brian continues to use cannabis and anti-depressants because he finds they help manage his depression and ADD; however, he abstains from alcohol and other non-prescription substance use because he knows from experience that they make managing things worse. Sam avoids cannabis and all other drugs except alcohol which he uses, at least partly, to manage stress: “I do enjoy the drink. This is more reasons than excuses but I have a lot of stress.” Finally, Alexis said that the major reason she used was to party; however, she found that drugs had an added benefit for many years – they helped her manage the voices:

It probably started when I guess like I was 14 and it started...I kind of heard voices and it was just more of whisper – stuff that didn’t really make sense. And I didn’t know what to make of it. And I was also kind of getting into drugs at the same time and the drugs would kind of take that away...every psychiatrist tells me, ‘oh the drugs make the voices worse’ but not true.

Non-substance addictions also were associated with control and aspirations. Carmen said she recently made sense of her binge eating as being all about gaining weight in order to limit men's advances after so many abuse experiences. Susan related her addiction-related sexual behavior partly to her needing someone: "I think it was more of contentment, having someone there constantly."

Decisions to address substance use or addiction-related behaviors were associated with people self-determining that addictions had taken over control of their life and were now threatening their important goals (including survival). In other words, they had lost control and they now wanted control back. Alexis stated: "the substances were freeing [at first] – yeah... [but later] they do, they totally control you, totally." She said that at age twenty-two, she risked talking "real" to a counselor at the "Y" despite her distrust of authority because she realized that "ok, you're just way out of control", that her life was in danger, and that she actually wanted to save herself. She later relapsed and avoided help again until last year when she decided suddenly to turn her life around again: "I totally lost control. I sunk to a whole new level." She wrote a poem entitled, *Crack*, which symbolizes how the drug took control and how she now views it (Appendix VIII). Teresa spoke of realizing suddenly at one point, and for no reason she can put her finger on, that she was out of control with her drinking: "I really don't know what made me stop but I just didn't want to drink no more. I thought, 'oh my, if you don't start doing something and take control of your life, you are going

to die.” Malcolm said: “I just woke up one day and I said it is time to take control of me. The parole board, the guards – they just, ‘this ain’t the same guy. What happened?’” For Carmen, regaining control was associated with addressing her eating issues on her own. For Susan, it meant dealing with her sexual behaviors with professional and peer assistance.

A number of participants’ decisions to avoid or stop mental health or addiction treatment were also associated with their sense of control and fears of failing to achieve goals or aspirations (including simply surviving). Teresa recounted how she felt during her first hospitalization in 1993: “that was terrible [in the hospital in 1993]. I thought I have to get out of here or I am going to die.”

People stopped or avoided medication when they subjectively determined that it did not help enhance their sense of control (this included the directive way that medications were prescribed and monitored). For example, Malcolm and Alexis said they felt like “zombies” on some medications. When there was little willingness on the part of a professional to adjust them or try to help them without medication, then they stopped taking them, overtly or covertly. Both described returning to using problem substances or they tried new substances that they then became addicted to. In CDs recovery, both sought new ways to cope and function without relapsing. Colleen also struggled with medication side effects. One prescription made her feel too sedated one part of the day and too agitated at another. She expressed her concern to her psychiatrist but he kept upping the dosage. She covertly stopped taking them. Teresa was heavily medicated when

first hospitalized. She said: “my psychiatrist put me in the hospital for 3 ½ months ...and he just kept putting me on more pills and more pills and more pills. Finally I got, ‘I’m going home. I am not staying another 3 months.’ So, I went home and threw out all the pills he gives me.” When participants thought that medication helped increase their hope associated with their aspirations (especially perceptions that medication helped their sense of control issues) then they valued taking them and “compliance” was less of an issue.

4.4.3.4 *Goal failure, crises, and hope.* Participants spoke of having many aspirations when they were young. Regardless of their sense of control, all had degrees of success in pursuing related goals and achieving them. Malcolm aspired to be a famous rock musician. He took lessons, found he had some talent, and played professionally for a number of years. Teresa said that her dream of family love and the goals to achieve it were clear to her by age 12: leave her mother’s home as soon as possible, work, find a partner, have children, and raise a family – which she did. Susan went to college for a year. Her goals included getting married and having children – which she did. Brian’s goal was to work in law enforcement and he completed a college degree in this area. He was married and attended university before his experience with the physician there and subsequently losing his license and being incarcerated contributed to him quitting university (he hopes to soon return to school). Alexis wanted to party but she was also determined to finish high school, which she did, and she has mostly worked since that time. Colleen too was determined to finish high school despite living in

group homes and constantly running away – she did graduate. She worked after high school until her breakdown in her twenties, but a few years later she fell in love and married. Although the marriage did not last she said it was good for the first few years. Sam worked at a biological research station in his last year of high school and then went to university where he continued to do research. He worked as a counselor after university and has an adult son with whom he keeps contact. Carmen survived her teens without being hospitalized again, married, had children, and worked as a chef. She had a good relationship with a man for number of years after moving to the rural location. They remain friends although they are not still together.

However, important “failures” in relation to major goals and aspirations were profoundly felt life events for all participants and were closely intertwined with mental health crises, mental illness symptoms being exacerbated, and substance use problems developing or worsening. For example, Malcolm reported his substance use did become an issue at one point for the band he was with and they asked him to clean up. He said he tried to stop on his own but he found that what he now sees as symptoms of mental illness “got worse.” He went back to using harder than before, quit music, and joined a gang engaged in crime.

In relation to mental health and mental illness, people who had failed to achieve important goals or aspirations, or those whom had successfully attained something feared losing it somehow (e.g., marriage), were often at a point where their power associated with being determined was at risk of collapsing (e.g., why

care, keep trying, or keep going?). This experience was associated with feeling there was of “no hope” and they described how they typically plunged into a crisis. Suicide was often considered, and attempted by some.

For some, their first experience with mental health symptoms significantly interfering in their ability to function personally and socially, and subsequent mental health diagnosis and treatment, followed major goal failures or losses. For example, Teresa discussed her experience of achieving her goals associated with being married, having a family, owning a home – and then losing them: “I guess I tried to live by rules to the fact that some day I am going to be out by myself in the whole world and my life is going to change and turn around – which it did. I made it turn around. And then in 1993 I couldn’t do it.” She was first hospitalized in 1993, started drinking daily shortly thereafter for a number of years, and she has struggled with severe mental illness symptoms ever since.

As analyzed above, the failure to achieve goals and aspirations, or hold on to those already attained, was also associated with people deciding at some point that they needed to change their substance use or non-substance addiction behaviors on their own. Eventually, all but Sam said they risked reaching out for help or else making a connection with treatment. Reaching out occurred despite many participants’ attitudes of fear and distrust towards treatment professionals, programs, and systems – treatment was seen as the last chance, the best chance, or the only remaining chance of finding some hope. Carmen expressed her state before finally asking for help in the following way: “I was scared. I honestly

thought I was going to die...this is what I felt was happening and whether it be literally or if it was just a figurative thing – I don't know what it was but I felt I had to get help.” Although people reached out for help and most did find someone they could trust; nevertheless, SD and self-direction remained important. When SD was willingly delegated to others, it was viewed as temporary by participants.

Hope reenergized the “power” associated with being self-determined. Hope was often associated with attitudes shifting towards being more nurturing and compassionate towards the self. Hope was also found when a person was looking for help and ran into someone that the person felt cared and believed in them. For some, these people were associated with authoritative limits being placed on the participant (often at a time of crisis). Professionals who somehow tried to work with participants’ aspirations rather than ignore or clash with them helped give them hope. Such people took the participants['] experiences into consideration, framed treatment as a means of better achieving goals, and demonstrated a willingness to adjust limits and goals over time. Finally, hope, was intrinsically linked to self-determined goal adjustments that were both important and perceived to be achievable, including non-absolutist goals of recovery that focused on improving quality of life. Non-absolutist recovery goals and aspirations occurred for most people in association with a deep acceptance that they should not expect to always be in complete control of his or her self, aspects of his or her ecosystem, or achieving a desired future goal of not having mental illness symptoms or be at risk for addiction problems.

People continue to pursue and achieve goals within a more nuanced sense of control in recovery. Alexis returned to working part-time and is looking at becoming a veterinarian technician. Sam was renovating his apartment and upgrading his computer despite very tight funds. Malcolm worked with people who have schizophrenia and speaks to young people in custody. He said that he had achieved his original goal of becoming a “somebody” – he said he was just going about it the wrong way before. Colleen was volunteering and taking courses on managing her emotions. Susan was also volunteering, sharing the care of her children, and considering college. Brian was working and hoping return to university. Carmen started writing a book, was thinking of starting a self-help group for people with Fybromyalgia and histories of trauma, and was focused on nurturing relationships with good friends. Finally, Teresa was enjoying spending time with her friends and family, helping people whenever she can with a kind word or a prayer, and reminding herself that she is loved by many.

4.4.3.5 Survival versus living. Participants agreed that aspirations and goals associated with “surviving” and “living” were different. All agreed that SD is basic to both but that SD was viewed as more of an absolute right in relation to his or her survival but it was conditional in relation to a less tenuous experience of living. A number acknowledged a perception of survival versus living was subjective, such as in terms of their changing view in relation to some moods such as depression and/or physical states such as opiate or cocaine withdrawal. Most also spoke of how others may view this right differently than they did, regardless

of mental illness or addiction. For example, Sam said that many of the gang members he knew would “make self-determination their [absolute] right, no matter what.”

Brian and Sam mentioned Mazlow’s hierarchy of needs in terms of basic survival and mental health issues, using substances to cope with the effects of traumatic life experiences, using them to help them face perceived ecosystem dangers, and/or using to help them simply avoid withdrawal illness with dependence. Participants’ other needs or goals, once survival was perceived as secure, were varied and collectively associated with “living” (i.e., no hierarchal structure was interpreted other than between surviving and living). Alexis said: “well, surviving is just, I don’t know, staying alive, not being dead. Living is...purpose in life and enjoying it.” She added in the follow-up interview: “Living, you have your hopes and dreams.” Carmen said:

When you survive you have to struggle. It is a fight, it is a battle...surviving is constantly having to prove that you deserve something or that you deserve to live...surviving is totally different than living because surviving – you are always going through something.

Suicide was mentioned by some. They saw it as a potentially self-determined goal and a self-directed action, especially in relation to a failure of some sort to achieve or hold onto important goals/aspirations and the absence of hopes and dreams to gain, reclaim, or replace them. However, a more discerning view of suicide was typically associated with participants’ recovery. The view often included critically questioning their suicide ideation as partly biologically generated and consequently not always or completely a trustworthy “message” to

act on. Many used substances to help blunt or numb suicidal ideation in the past. A number said that medication might help with these thoughts and feelings but they also have to challenge the “trustworthiness” of their suicidal thoughts/feelings in the moment. Using their personal “power” and actively being determined to push through the difficult time was also mentioned as part of managing suicidal ideation in recovery. This more nuanced view also appeared to contribute to people seeing more, or different, choices at these times. However, the knowledge they gained through experience with these times suggested to them that their thoughts and feelings cannot be “cured” or totally controlled. They said that reoccurrences could lead to relapses with substances in the future if they perceived that use (including misuse) was the only way to survive, despite risks such as becoming addicted again or overdosing.

4.4.3.6 CDs recovery. CDs recovery involved participants self-determining to pursue a goal of improving his or her quality of life through consciously managing mental health and/or substance use issues. SD meanings and self-direction in recovery reflected this orientation. In this way, there was a relationship with enhancing one’s sense of control in new ways (e.g., given old ways such as substance use that no longer worked) and self-made decisions to focus on managing mental illness symptoms, not use/misuse substances, use/not use prescription drugs, and/or try other forms of treatment (e.g., psychotherapy; case management; physical exercise; acupuncture; peer supports). Mental illness symptom management goals were relativistic and focused on influencing

symptoms in ways that improved the person's subjective experience of living or quality of life. The shift in emphasis allowed them to look more to goals associated with "living" in spite of symptoms and/or substance use issues rather than just survive and wait for some external cure, merely engage in a vision of the future that involved desperate bids to achieve absolutist goals of recovery predetermined by others, just survive, give up, or die. As mentioned above, collaborative work with professionals who helped augment a person's sense of control in terms of both process and content of treatment interventions, including "fair" limits under certain circumstances, was highly valued.

4.4.4 Standpoint: Summing Up

The standpoint elements are interrelated with each other, with the ecosystem, and with the other two components of SD meanings. Participants appeared to value the relative "stability" of their standpoints within these dynamic interrelationships, whether associated with the primary or nuanced sense of self. However, it was also evident that they had experienced great growth, shifts or changes in their sense of self over time. SD meanings and self-direction may play an important role in regulating subjectively perceived needs for degrees of relative self-stability within growth and change.

Most participants spoke of how they came to realize that they had largely automatically defended their SD and self-direction (or surrendered it) when younger (e.g., associated with the primary sense of self). In recovery, all spoke of a greater conscious awareness of self. All but Sam spoke of choosing to share or

temporarily delegate facets of their SD and self-direction in recovery spiritually and/or to people they “trusted.” Consequently, SD meanings and self-direction did not simply point to “more” or “total” autonomy, freedom, or control of self in relation to the ecosystem. Instead, participants pursuing CDs recovery exercised SD in ways more characterized by selectively fostering their autonomy, upholding it, exercising it, sharing it, and selectively accepting limits on it or temporarily delegating it. The next two sections look more closely at the other two components of SD meanings: *determining* processes and *being determined* about someone (including the self) or something.

4.5 SD: *Determining Processes*

The major SD processes are knowledge building and decision making (Figure 4.5). Knowledge supports and guides decision making and helps organize the self-standpoint elements of SD meanings in ways that, arguably, contributed to regulating the relative stability, security, integration, coherence, and continuity of the sense of self simultaneously with experiencing if not pursuing self-growth, shifts, and changes; all within dynamic self-ecosystem contexts and interrelationships. Decision making includes reactive and proactive decisions, rational decision making skills, and intuitive or “gut” decisions. Decision making is the exchange point between SD meanings and self-directed actions.

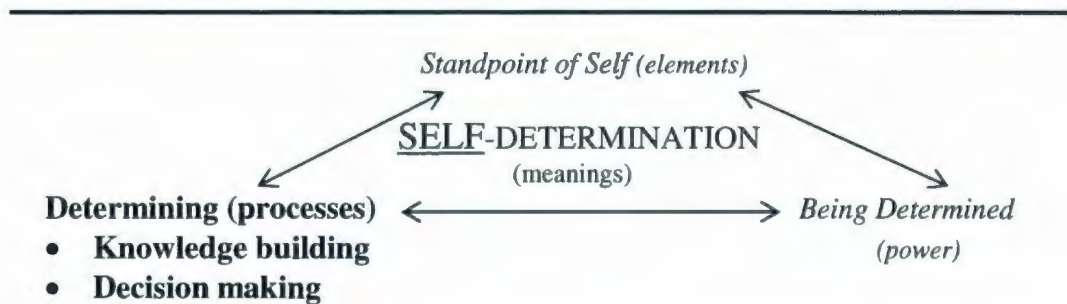


Figure 4.5: Self-Determination Meanings: Determining processes.

4.5.1 Knowledge and Knowledge Building

The grounded theory conceptualizes two knowledge bases. One is generalized, rooted in the ecosystem, and not based on the personal experiences of the participant. The second is rooted internally in each person and is gained through meaningful personal experiences (i.e., experiential learning).

Participants described knowledge based in the ecosystem as having two branches specific to this theory of SD meanings. One was the religious or spiritual beliefs and socio-cultural values discussed earlier that participants were educated or socialized into through family, schools, and other socio-cultural interactions with individuals and structures or institutions. The other was “expert” or “technical” information about the self, the ecosystem, mental health, mental illness, addictions, treatment, and recovery. The expert/technical information typically was associated with professionals and scientific research (although it was sometimes also associated with peer or self-help movements and programs). It could be accessed through interactions with “experts” or “authorities” personally or else through information transfer via books, journals, magazines, the

internet, television, and radio. In contrast, experiential knowledge was gained through participants' cumulative memories and interpretations of important self-ecosystem experiences and outcomes.

The primary sense of self was characterized by knowledge that was primarily rooted in the ecosystem and whose utility to the person and his or her life experience was not actively questioned. Knowledge gained through experiential learning was generally described by participants as being subservient to externally-based knowledge and meanings when they were young. Expert/technical information was also not critically questioned but instead was perceived as meaningless or else either generally adopted or generally rejected. In CDs recovery, participants more actively questioned their knowledge gained from past experience, their established primary beliefs/values that they were educated into at a young age, and how expert/technical information applied to them (i.e., experience-based knowledge had shifted towards no longer being viewed as subservient to externally-based knowledge). The knowledge-building (hermeneutic) positive feedback loop is interpreted in this grounded theory as the process by which knowledge is cumulatively gained, assessed, and used differently by the more nuanced sense of self in CDs recovery.

4.5.1.1 *External knowledge: Beliefs/values.* As previously stated, the utility of a participant's primary beliefs and values was not found to be critically questioned when he or she was young. Malcolm referred to the external foundation of these early forms of knowledge in terms of being "programmed

when young,” Susan spoke of it as being “essentially told what to do” when she was a child, and Teresa referred to it as “following the rules” of getting a job, getting married, having children, and building a house. When life experiences contrasted with expectations associated with their primary beliefs/values then participants became confused and often distressed. This “dissonance” was most clearly associated with experiences involving trauma and abuse, rejection by peers, grief and loss, the failure to achieve or maintain goals, an inability to control symptoms of mental illness, and/or an inability to control or stop patterns associated with addictions. The trend in recovery towards a greater attention to, and integration of, nuances of meaning was associated with participants gaining critical awareness of previously unquestioned beliefs/values. Recovery was characterized by participants rejecting certain primary beliefs or values, re-committing to others, or, more typically, adjusting them in ways that fit better with the experiential knowledge they had gained over time and were found to simply work better vis-à-vis CDs recovery. Adjustments could reverberate through standpoint elements and influence subsequent standpoint realignments, SD meanings, and the sense of self overall.

4.5.1.2 External knowledge: Expert/technical. Most people said that expert/technical information about mental illness and/or addiction was inherently negative and had no practical use to them prior to their deciding to pursue recovery. Malcolm said “what did I know, I was a kid?” when asked what ADD meant to him when he was young. Carmen spoke about watching experts on a

television talk show talk about how people who were abused were more likely to turn around and abuse their children. This information reinforced her negative attitudes towards herself and contributed to her decision to not pursue joint custody of her children when she left her marriage.

However, recovery included participants actively seeking out externally-based expert/technical information (for Sam it was primarily to protect his rights). This self-determined pursuit of expert/technical information was incorporated into the knowledge building positive (hermeneutic) feedback loop. Participants made personal and subjective sense of expert/technical information through synthesizing it with, or grounding it in, their personal knowledge. In other words, they more actively self-determined the personal meaning(s) they took from the generalized expert/technical information. Used this way, the expert/technical information also could contribute to a greater understanding of the self and/or contributed to critically examining and potentially adjusting the meaning(s) of life experiences and personal knowledge (which could then influence self-standpoint elements and, in turn, the sense of self overall). The expert/technical knowledge was also actively worked with in recovery in ways that appeared to help participants regulate the relative stability of their sense of self in relation to growth and change, all integrated within his or her ecosystem. For example, all but Sam had chosen to take courses or programs that educated them about their diagnosed mental illnesses and different ways to manage them. Even Sam expressed an interest in an assessment; however, he was not sure he could trust

anyone's opinion at this point. Brian, Malcolm, Colleen, and Alexis had also taken courses or programs on substance misuse. Susan attended a program that included learning more about her behavioral addiction and how she might deal with it. It seemed that the longer a person was actively engaged in CDs recovery, the more he or she self-determined personal meanings of expert/technical information about mental illness and addiction. Translating into personal meanings or making personal sense of expert/technical information mirrored participants questioning externally-based primary beliefs/values and internally-based knowledge associated with past experiences discussed below. In turn, they more consciously determined meanings that they perceived as facilitating their CDs recovery.

Examples of making personal meanings or sense of expert/technical information about mental illness and addiction in recovery included Alexis' struggle to make sense of her different diagnoses. She has decided for herself that: "I think it should just be called mental illness...I don't think you can group a bunch of people and say all these people have bi-polar or all these people are schizophrenic. I think everybody might have a little bit of each thing." Based on this self-knowledge, she chose to take a course on the self-management of emotions. Teresa provided another example. She was first told she had schizophrenia and then bi-polar in her early forties. She was heavily medicated, left hospital, and threw out all the pills. She started using alcohol and had some enjoyable times until it got out of hand. She was hospitalized again three years

later and met a psychiatrist who helped her make her own sense of her symptoms and suffering; she said he told her that she simply was “very sick girl with a case of bad nerves.” She added that she was “living with a broken heart.” This interpretation of expert/technical information associated with mental illness made sense to her and helped her integrate her symptoms into her sense of self in a way that helped her cope and helped her grow in ways that improved her quality of life. Malcolm connected his addiction issues experientially with consistently causing his anger to become uncontrollable “for no good reason” (regardless of expert/technical explanations). He said liquor did this but not the occasional beer. Consequently, he abstains from all liquor and has a beer “once in a blue moon.” Susan has to manage her tendency to have other differentiated sides of her personality “take over” under stress, especially the personality associated with her addictive behaviors in the past. She avoids non-prescription substances because she fears that use would hinder her ability to maintain the re-constituted coherent sense of self that she had lost.

4.5.1.3 *Internal knowledge: Experiential learning.* Personal experience can be thought of as always occurring. However, people related only certain experiences that were integrated into their self-knowledge. Externally-based knowledge that was internalized, together with knowledge building through experiential learning, is interpreted here as being synthesized into each person’s unique and subjective self-knowledge *library* of meanings. This body of

knowledge provided a base for each person's meaning of SD. The person's subjective self-narrative reflected or helped to organize this self-knowledge.

The positive (hermeneutic) feedback loop of knowledge building infers that new knowledge can, potentially, be added to the existing body of personal knowledge or "library" through interpreting ongoing experiences, through reinterpretations of past meanings and experiences, and/or through the interpretation/reinterpretation of externally-based beliefs/values and expert/technical information. Building new knowledge replaced or, more typically among participants, adjusted, enriched, or adapted existing knowledge and skills.

4.5.1.4 Internal knowledge: The hermeneutic circle. Knowledge building was hermeneutic in the sense that knowledge associated with a participant's primary sense of self was found to be more consciously known to participants over time and more likely to be critically questioned. Critical questioning could lead to new understandings that shifted the person's overall self-knowledge. At the same time, accumulating new self-knowledge had the potential to continually inform or stress already interpreted past experiences, established beliefs/values, already internalized expert/technical information, and established goals and aspirations. Hermeneutics assumes that this circular or spiral process can continue with no endpoint.

4.5.1.5 Seeing patterns. Participants critically working with their self-knowledge in recovery often referred to seeing important patterns in relation to their self and/or those in their ecosystem. Carmen, for example, stated: "I used to

be a runner. I have a saying up on my wall now that says, 'if running is not the answer then that leaves deal with it!'" Teresa found Christmas to be very painful. She now plans carefully how she spends this time and with whom. Colleen said she realizes part of her difficulties with interacting with others is she grew up relying on tones of voices to try to avoid abuse: "the way my family works is tones [of voice]. We were never allowed to show emotion or anything...so I go by your tone and if your tone is elevated then I am going to fight with you because I know you are ready to fight with me." Finally, Malcolm saw an important pattern in his use of substances over the years and his anger: "the alcohol – I thought it was helping. It was bringing the anger. Then the anger gets a hold...even today I know if I drink the hard stuff, yeah, like one minute we are talking, the next minute we are on the floor acting like it is WWF." Another example of participants' seeing patterns in the ecosystem is the prejudice many spoke of experiencing from professionals because of past or current substance use that could "trump" seeing their mental illness in a better light. Sam saw another pattern among treatment professionals and programs that he deals with regularly – many don't recognize his knowledge and he knows that they are trying to be experts about things when they "don't know what they are talking about."

4.5.1.6 *Catalytic self-ecosystem experiences.* As mentioned before, expert/technical information, or alternative interpretations to participants' interpretations of experiences, that somehow conflicted with the established primary sense of self were often described as being ignored, attacked, or viewed

as meaningless before pursuing CDs recovery. However, they may still have had an effect. The grounded theory assumes that the hermeneutic positive feedback loop is always active to different degrees. The person and/or others may not be aware of subtle “erosions” in the foundation of his or her primary self-standpoint that could cumulatively contribute to gradual or sudden shifts. Catalytic self-ecosystem experiences were distinguished by particularly dramatic descriptions of sudden changes in perspective by participants. These experiences often disrupted or challenged self-standpoint elements in ways that were immediately noticeable to the person, for “good or for bad.” They stand out as a dimension of participants’ knowledge building by references to: “waking up,” “shocked”, “a light bulb going on,” “opening my eyes,” “deciding one night to go to detox,” “throwing out the pills,” and “a fog lifting.” Brian had one negative catalytic experience mentioned above that led to his greater distrust of authorities/experts. He related another positive one when he went to college:

In terms of public school and high school...I didn't fit in and people would make fun of me or some people would rumor that I was gay and stuff like that...that...and at the time, you know, 'holy shit, I am hated by everybody' ...I guess one of the shocks was when I went to college...you don't see fistfights, you don't see people doing that disrespectful behavior that you do in public school...they're more accepting of people's choice or status or functioning...so that was a shock...going to college was a shock.

Catalytic self-ecosystem interactions were unique and uniquely unpredictable. Many of these experiences were key milestones, good or bad, of the primary sense of self. Others were interpreted as contributing to a shift to a more nuanced sense of self in CDs recovery. For example, Malcolm remembered

seeing the Beatles on the Ed Sullivan Show when he was little and it was the catalyst for him to pursue becoming a famous musician. His determination was engaged for the next fifteen years in pursuing this goal and giving it up was one of the most traumatic and difficult experiences of his life. The psychiatrist abusing Carmen when she was a child was the catalyst for her to avoid all mental health or addiction treatment professionals for over twenty years. She was tenacious in this pursuit and a profound fear of dying was her only reason to finally reach out for help in her thirties. Sam's forced hospitalization had a catalytic effect on his trust of mental health programs and professionals that continues to drive him to avoid all treatment connections.

Catalytic experiences were consistently associated with six participants' reports of when they remembered becoming highly motivated or determined, and determining or planning to act in some way that involved pursuing CDs recovery. These particular catalytic experiences are interpreted as kick-starting or shifting the person in a way that contributed to a move towards developing a more nuanced sense of self. They seemed to trigger a person becoming more aware of ambient primary self-standpoint elements and dimensions, questioning them, and potentially adjusting them in ways characterized by their being more situationally relative, compatible, and discerning. They also were associated with people becoming more critically evaluative of outcomes associated with their power to be determined about someone (including the self) or something (e.g., discerning more between helpful and unhelpful facets of their stubbornness or loyalties). As

mentioned previously, a number of common factors were associated with recovery oriented catalytic experiences, such as: people were not able or willing to maintain primary SD self-standpoint element “settings” or views (e.g., their determination to stay the way he or she was wavered or collapsed); they feared they could not survive without changing or finding help; they were somehow distanced from normal micro-ecosystem influences (e.g., being abandoned or betrayed by established friends and family); addiction and/or mental health issues were seen as having taken control and threatened important goals (including survival); at least one “new” person at this moment was perceived as caring and wanting to help; and the participant instinctively felt that he or she needed to “connect” with someone.

Brian, Teresa, and Colleen’s recovery-associated catalytic experiences involved experiencing psychiatrists who they felt saw them as unique and worthy people, educated them about their symptoms in ways they could understand, treated them collaboratively, and respected their self-knowledge. Susan’s psychiatrist who, as mentioned above, was catalytic to her in terms of trust referred her to an intensive 3 month treatment program. She stayed at the program during the week and with a boyfriend on weekends. She remembered experiencing a sudden change at the program in terms of men in her life:

I was dating a guy while I was in the intensive program during the week. ...I just woke up one day at the intensive program and I’m like, ‘I don’t like him. Why am I living here?’ So, I just went back on the weekend and packed up and went back to my parents.

Colleen's catalytic change associated with recovery included stopping all drugs (including medications). She said she stopped all substances because she suddenly decided that she wanted to think again after years of wanting/needing to be numb: "I was so out of it most of the time that I did not know what was going on and after doing that for 3 or 4 years I said, 'forget it, I don't want to do this anymore, I want to be able to think on my own.' And then I started realizing, 'ok, stop this drug and start thinking.'" Carmen, Alexis, and Malcolm's catalytic experiences have already been mentioned. Carmen's occurred after she had moved to a rural locale and had reached a point where she believed that her survival was at risk if she did not find some outside help; she felt fearful. She found a transportation coordinator who went out of her way to help her access professional services. Alexis ended up at a YWCA after being charged with stealing. There she met a counselor with whom she still has periodic communication. Finally, Malcolm's catalytic experience occurred in solitary confinement where a guard kept trying to connect with him until Malcolm finally gave in.

4.5.2 Decision making

Participants agreed that decision making was another critical process of SD meanings. Carmen said that we are self-determining "in every choice we make." Decision making and experiential learning were closely related. Participants spoke of learning by doing it as the way to ultimately know how to make decisions that are right for you. Alexis stated: "you gotta make the right

ones. I think you learn over time.” Most participants held uniquely relativistic and internally compatible views of making right decisions in recovery. For example, experiential learning appeared to inform participants that sometimes “right” decisions for one person were not right for another. Also, the majority spoke of how “right” decisions at the time turned out not to be so right later on (and vice versa). This inability to often know when a decision was right or wrong until well into the future appeared to contribute to participants’ sense of control becoming more situationally relative and their determination to see decisions through to be more contextually discerning in CDs recovery. Another feature of this SD process associated with recovery from CDs was the greater type and range of choices they often could “see.” Finally, the process of decision-making is also interpreted as the point when participants’ SD meanings are translated into self-directed behaviors. The self-directed behaviors are the only part of the grounded theory that can be observed.

4.5.2.1 *Seeing choices.* On one hand, all participants agreed that there is always a potential limit to the number and type of choices people may have, depending on the internal/external situation or context. This was true in terms of their physical body, aspects of their sense of self they may or may not be aware of (e.g., primary standpoint elements’ “settings”), and in terms of interrelationships with his or her ecosystem. However, “seeing” choices was also uniquely subjective. Carmen spoke of the subjective experience of not seeing choices before recovery in terms of having people around her who drank, used other

substances, and did not treat her with respect: “I didn’t have a choice – I did have a choice but you choose to surround yourself with familiar things.” Greater recognition of available choices in recovery was associated with less absolutist and more relativistic, compatible, and discerning standpoints. Discerning more choices led people to believe that they had more space in which to exercise SD and self-direction. Professionals who helped participants see more choices and generally supported their decision making were highly valued. Arguably, the range of choices associated with more nuanced views afforded participants greater opportunities to regulate needed degrees of self-stability within growth and change.

The majority of participants in recovery spoke of being more “tuned in” to trying to see more choices than in the past. A number said that limits associated with some aspect of the ecosystem were bad enough and that many were perceived as inappropriate, abusive, unethical, or unfair. These sorts of limits needed to be addressed personally and structurally. However, prior to CDs recovery, most said that their view of external limits was often highly generalized – they were believed to be “too big” or complicated – and so they tried to either follow them or avoid dealing with them. In recovery, many spoke of seeing more choices in how to deal, or when to not deal, with external limits.

Another area of growth in recovery was becoming more aware of how they might also be unnecessarily adding even more limits onto themselves than aspects of the ecosystem were already potentially applying (e.g., through gender-

related religious beliefs or socio-cultural values that they had uncritically absorbed and integrated into their self-standpoint when younger). Adjusting aspects of their self-standpoint elements so as to be able to discern more between their self-imposed limits, relevant external limits, and what might be done about them was associated with participants seeing more choices. Seeing more choices, in turn, was described as contributing to feeling able to be more self-determining overall. This, in turn, appeared to facilitate more positive attitudes towards his or her self, which, in turn, nurtured a more positive sense of self overall in recovery.

Participants agreed that helping people see different treatment choices and giving them every possible opportunity to make independent or collaborative decisions, except under exceptional circumstances, was essential for people to learn to make their own “right” decisions, build trust with helpers, and pursue his or her own CDs recovery. For those who recognized that they wanted to automatically delegate their decision making to others then collaborative, shared decision-making helped more than being persuaded or coerced to make autonomous decisions. Carmen thought that offering real choices and independent or collaborative decision making opportunities not only supported SD ethically and built trust in treatment relationships but it may also be helpful clinically: “see how we take those choices and see what kind of choices we make because it could be an old pattern. It could be a venture – trying something new. I just know that as soon as you tell somebody they don’t have a choice – things change [negatively].”

As mentioned previously, a number of participants spoke about how discerning between aspects of his or her substance misuse, abuse, or dependence and his or her unique experiences with symptoms of mental illness was important to their recovery. The discernment was often discussed in relation to seeing problem substances (or medication prescriptions) as more of something external to his or her self or located more within a facet of their ecosystem, while symptoms of mental illnesses were viewed as more of an internal and fundamental aspect of his or her self. As already presented, Alexis stated:

Drinking or using is a choice. You don't have a choice to hear voices, you don't have a choice to have mood swings or whatever, you know...the choice [to not drink or use] is a lot harder for some people to make, and when some people start doing something it is harder for them to quit than maybe others, but it is still a choice.

Brian spoke of choosing to see and deal with his mental health issues in terms of acceptance: "I am free to accept my illness and symptoms or to deny the same." He has come to know that accepting them helps him work with symptoms rather than either always ignore them, constantly fight (and lose) against them, or simply surrender his sense of self to them. However, he was able to "push away" substances in a way different than his mental illness symptoms. A number described how such discernments helped them to see more ways to possibly tackle their problems with mental health and addictions separately and/or together.

The value of seeing addiction as an "illness" or "disease" was mixed, especially in relation to seeing choices and making decisions. Some thought that seeing addiction as an illness helped them accept addiction issues in ways that

lessened their expectation that they should be able to control their use or behaviors (and experiencing failure if they could not). Others, in contrast, thought that seeing an addiction as a disease limited or weakened their determination to not relapse. This was because the disease view did not fit with their experiential knowledge of not misusing substances in the past or else seeing an addiction as a disease made it a core negative part of his or her self and that, consequently, they would face not just relapse risks but actual relapses forever.

4.5.2.2 *Making "right" decisions.* As noted above, seeing more choices, if a participant had little confidence that he or she could make the "right" pick or else he or she feared any outcome, could be traumatic. Colleen said she felt pressured by her treatment program to make her own decisions but she also feared not only damaging her recovery (which could lead to suicide ideation for her) but also their reactions if things did not turn out well. She said she thought this fear of treatment in recovery may be related to her experiences as a child but the fear remained strong, regardless of her insight. Her difficulties with making right decisions were shared by most of the other participants to varying degrees, especially in the past.

Some participants related their lack of confidence with making "right" decisions more to symptoms of their mental illness, such as impulsiveness, than a lack of experience in decision making or self-efficacy per se (Sam was the exception as he rejected being labeled as having an illness per se). All participants in recovery saw decision-making difficulties as more normal or to be expected in

recovery than when they were younger because their expectations became more nuanced. They had learned that what constitutes a right decision is highly subjective. They also learned that this was true not just for them or people with mental illnesses or addictions but for everyone. Alexis said: "everybody is different. I can't make the right choices for anybody except myself." She applied this same rule with professionals who tried to decide things for her and judged them accordingly. Brian used an example of deciding how to do yard work to emphasize the complexity of possible motivations behind making a right decision to a goal: "the first benefit is the clean yard, the second is the physical exercise, and the third is the sense of accomplishment. Therefore, someone could get the same results plus more by selecting 'how' they wish to [get the yard work done]."

A closely related but slightly different aspect of seeing choices and making the right decisions involved dilemmas. Dilemmas are defined here as situations where a difficult choice has to be made among two or more alternatives and where no one choice stands out as the best or most desirable. Dilemmas are often associated with feelings of ambivalence. Logical cognitive problem solving and decision making processes were found to be of limited utility for participants when they faced true dilemmas. Often emotions were important in dealing with these situations in CDs recovery. For example, prior to Carmen's more recent decision to reach out for help, she felt she had exhausted her own knowledge and skills to get well. She felt she needed help and support to survive but she had been abused, threatened, and depersonalized by many people, including some treatment

practitioners and programs. Thus asking for professional help represented a dilemma for her of the highest order. She subsequently, impulsively rather than thoughtfully or rationally, reached out for help at a time of crisis to the transportation coordinator in her new community. Indeed, her past negative treatment experiences would, arguably, have led her to logically decide not to engage in professional treatment again.

Colleen spoke of dilemmas as “crossroads.” She felt she had always been controlled as a child and youth, first by various family members who abused her and then by being a ward of the child welfare system. She said that she often feels that she is in a corner when facing choices in life: “I get to a corner. It is like, ‘ok, what do I do now? Which way do I go?’ You know there is a bad way and you know there is a good way but you don’t know which one to take – which one is the safest?” Colleen said that she can see choices more now but her lack of trust in herself to make “right” decisions remains her greatest struggle. Seeing more choices often is more of a struggle for her now than when she saw fewer alternatives – it was simpler when she perceived she had fewer choices. Overall, seeking help was often viewed as a dilemma rather than a solution due to services being hard to access, not knowing the kind of person you might meet, knowing abusive treatment experiences can occur, and being trapped in a system that was perceived as often not caring and often did not take into account participants’ individuality. Carmen stated:

Just because the treatment works for this person – that same treatment might be harmful to another. I can't stress to someone enough how much it takes to being yourself to go to those appointments. Just putting themselves out there. And for you to be put in a program that could possibly destroy you for the rest of your life. And that is more harmful than any drug.

While recovery was characterized by greater attention to the rational weighing of positives and negatives among choices; nevertheless, emotions were also incorporated, such as in dilemmas mentioned above. Also, sudden catalytic experiences associated with decisions to pursue recovery were not carefully thought out. Susan's impulsive decision to give custody of her children to her parents in the midst of a mental health crisis is another example of a "right" decision for her was made without using a rational problem solving approach:

I was pretty gone by then to really have any decisions – to make normal decisions. But I did make one that I was really proud of because it took a lot to say and that was I gave my mom custody, my parent custody of the [children]...It was one of the best decisions I had made in years.

Generally speaking, substance use/misuse or addiction-related behaviors were viewed as "right" decisions or at least neutral ones in CDs recovery. As already mentioned, substance use offered benefits to participants. Factors associated with decisions to address addiction have also been mentioned above. For example, deciding to address or stop substance use/addiction behaviors was "right" when the person self-determined that they had lost control of his or her self (and control was wanted back). Participants' descriptions of what constituted a "right" decision for them in their recovery with respect to use and/or abstinence from substances were highly diverse. Outside of impulsive acts, rationales

included: total abstinence from non-prescription substance use, abstinence from some non-prescription substances but the use of others, abstinence from all non-prescription and prescription substances, and/or the use of some prescriptions.

The influence of others in making “right” decisions was another important area of discussion in relation to SD in treatment and recovery. One aspect was balancing caring and compassion of others with caring about his or her self in relation to seeing choices and making “right” decisions. Generally, “right” decisions in recovery included thought being given to balancing how decisions the participant might make could negatively affect another person versus his or her self. Malcolm stated it as a case of: “if I do this, I blow it for me. If I don’t, I’m going to blow it for everyone else.”

Another aspect was in terms of the influence of treatment professionals. Again, trust was a key. For example, participants who were involved with professional services and supports that they trusted were generally appreciative of the professional’s participation in making “right” decisions. Sometimes, he or she actively sought out the influence of others in his or her self-determined decision making (i.e., they wanted to temporarily delegate decision making or collaborate in certain areas or moments of their life). Malcolm said that: “I’m leaving it to him [psychiatrist recommendations] because he hasn’t steered me wrong.” However, if trust was betrayed in some way then these participants would counteract or suspend the influence directly, if possible, or covertly if there was

no other option. Alexis spoke of a recent experience she had with a mental health counselor around trust that led her to make a treatment decision:

When I got out of the hospital in May they wanted me to [still] see this one mental health counselor and [also] a crisis counselor at the hospital just until I kind of got a little more stabilized... There was one thing in the 3 months that I said, 'ok, I don't want you telling her [the crisis counselor]'... she told me [later], 'I talked to your other counselor' and I said, 'did you tell her this?' She didn't lie to me about it, she said, 'you know what, I did'... it wasn't one of those [involving harm], no. After that... I said, 'you know I just kind of need a break from you to think about if I can still see you'... How am I supposed to trust her again with anything, you know?

4.5.3 Determining Processes: Summing Up

The determining component of SD meanings involved two key interrelated processes: knowledge building and decision making. Knowledge building was best described as a positive hermeneutic feedback loop behind participants developing a more nuanced sense of self, and, in turn, more nuanced SD meanings associated with CDs recovery. Seeing choices, patterns, and learning experientially to make "right" recovery decisions was important for participants in relation to making decisions. Again, regulating degrees of needed relative sense-of-self stability simultaneously with growth and change appeared to be an important theoretical consideration of these processes in relation to the overall role and purpose of SD meanings.

4.6 SD: Being Determined

As mentioned above, the *being determined* component is best understood in this grounded theory as a "power" that animated participants' meanings of SD (Figure 4.6). The term "power" can be used as a noun or a verb. General

meanings of “power” as a noun include the “ability to do something or act in a certain way [and]...the capacity to influence the behavior of others, the emotions, or the course of events” (Soanes & Stevenson, 2006, p. 1125). As a verb, “power” refers to a supply of energy or to “move or cause to move with speed or force” (p. 1125). As mentioned in Chapter Two, John Locke referred to SD as a de facto “power” of all human beings stemming from an innate capacity for free will (to choose to sin or not), Foucault argued power permeated all social relationships, and Friedrich Nietzsche promoted the idea that peoples “will” aspired to expand personal power – “the will to power” (Blackburn, 2005). In contrast to Nietzsche, this theory’s *being determined* reflects “the power to will.”

Being determined about someone (including the self) or something related to the conviction behind defending participants’ standpoint element “settings” as well as their motivation to grow and change. It also related to the conviction they held in their own decision making or the degree of confidence or trust he or she had in the decision making of another person or group. Finally, it related to the degree of confidence the person had in his or her personal knowledge of self generally, in relation to substances (including medications) or mental health. Words like “stubborn”, “dedication”, “persistence”, “loyalty”, and “commitment” referred to this SD component. There were no sub-categories. Participants described it as simply “there” to varying degrees (or not).

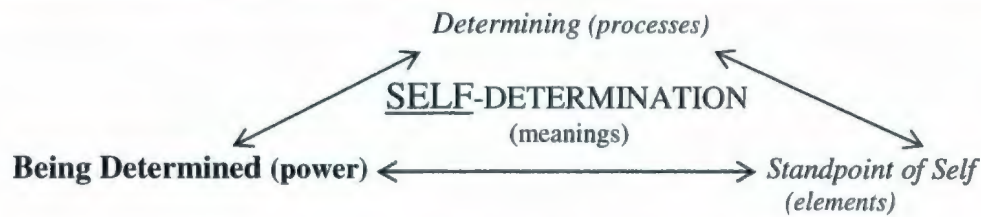


Figure 4.6: Self-Determination Meanings: Being determined

Carmen said that the first thing she thought of when asked what SD meant to her was: “My stubbornness. It is my survival tool. It means survival.” The absence of being determined about something or someone was often associated with crises (e.g., “giving up”) that included, for some, suicide ideation. In many ways, being determined in SD was spoken of as a fundamental force of life. It is interpreted as being rooted more in feeling sensations (e.g., emotion; mood) than with thoughts or behaviors. In this way, it was profoundly affected by some mental illness symptoms (e.g., depression, mania, and anxiety). Its absence was strongly associated with hopelessness. This weakening or loss of power was also often associated with participant’s descriptions of his or her survival being somehow in doubt. As with the other components of SD meanings, the trend in CDs recovery was to be determined in more situationally relativistic, compatible, and discerning ways than the primary sense of self’s experience of it as innate and absolutist (e.g., “good” or “bad”; “there” in terms of motivation or “not”).

Being determined was not present in relation to only “positive” aspirations. It was equally present in relation to participants’ self-determining to stay the way he or she was (e.g., being dependent on substances) as it was in

relation to overcoming tremendous obstacles associated with self-determined growth and change (e.g., CDs recovery). Colleen spoke of being determined to finish high school: "I would run away from group homes, I would be gone for like 3 weeks, I wouldn't get sleep, I would live on the street and I would still go to school." However, she also spoke of being determined to misuse substances in order to be "numb" in her twenties no matter what. Alexis also spoke of being determined to get drugs: "somehow I am going to make this much money so I could do this tonight. And then I would end up doing something stupid but, you know, I would get what I wanted." Susan spoke about being determined to not let other people, or her mental illness, control her: "I am just more determined to make sure that my life stays on track no matter if I am bi-polar or not. And I don't let bi-polar ruin my life. I rule it. I control myself, my guidelines...I don't let anybody else do it – or my illness."

Malcolm spoke of being determined to not use cocaine in recovery: "today, self-determination, what it means to me is that I have to make decisions and be very determined on my decisions to say, 'I'm not going to go and fill my nose full. I'm not going to end up with a nose bleed." Being determined was core to Carmen's early conviction to recover without professional treatment: "I did it all on my own. See, for me, the reason why I did my own self-diagnosis, and I do my own self-healing...because I am petrified of anybody institutionalizing me in any way." Her determination was also essential to her subsequently being able to reach out for professional help: "People have to understand how hard it is for

people like me to even go to the appointment. And how much determination it takes to go there, to get there. Just to go to a regular doctor's appointment. Just to go to...anything...it can be the scariest thing ever."

The primary sense of self was characterized by participants being determined without conscious awareness, or if they were aware, without critically questioning its presence or purpose. CDs recovery was associated with the participants' increased awareness of their power to be determined, and with their capacity to consciously discern between how exercising their determination could both help them and/or limit them in some way. For example, "stubbornness" could help them reach their goals, while "stupid stubbornness" might frustrate goal achievement or lose sight of aspirations. Ways that people tried to influence their power in CDs recovery included attempting to nurture it in areas that supported or enhanced recovery (e.g., consciously talking to oneself in ways that pushed them to keep going despite depression symptoms; developing different ways of interpreting its contribution to outcomes) and to cope with it when it was pushing the person in ways that were viewed as risky to recovery (e.g., urges to misuse substances; acting manically or impulsively in association with mental illness symptoms; suicide ideation). Colleen explained the challenge for her to try to understand it and work with it in recovery:

Sometimes when you are determined it is really, really good. When you have this kind of illness it is really, really good to be that way. But, on the other hand, you can be too determined because, ok, let's say you are determined to get to another town and be alone. Well, you worked towards that but when you get there then – is that what you really want?

People who were able to energize and channel their determination seemed to be empowered in treatment and advocacy. Being determined was also experienced as empowerment when participants joined with others in a shared quest to pursue certain aspirations (e.g., through shared church membership or mental health peer support involvement). At the same time, Brian and Sam also spoke of how other peoples' determination (including those embedded within social structures and institutions) could support, counter, or hinder their power of being determined. Brian stated: "it has prevented me being self determined if someone is equally as determined to quash me and my efforts at survival, let alone improvement of my situation." However, participants were relativistic, compatible, and discerning in this area as well. For example, although Brian emphasized the fewer the limits the better, he also believed that the freer that people were to be self-determined, the greater the potential for conflict that resulted in SD winners and losers. Finally, Alexis shared the following famous quote by Ralph Waldo Emerson. It is particularly prescient in regards to the importance of a power associated with being determined for her meaning of SD: "The task ahead of us is never as great as the power behind us. That to me – that would mean self-determination."

4.7 Theory Summary

Participants' SD meanings encompassed three interrelated components: the *standpoint* of self; the processes of *determining*; and a power associated with *being determined* about something (including the self) or someone. These

components contributed to subjective meanings of SD at a particular time and context. The standpoint had five key elements: beliefs and values; attitudes towards self; attitudes towards ecosystem; sense of control; and aspirations. There were two key processes of determining: knowledge building and decision making. Being determined animated the SD meanings (and self-direction).

The organizing concept of the grounded theory is the person's overall sense of self within his or her ecosystem. The sense of self is conceptualized as being fundamentally interrelated or integrated with facets of his or her dynamic ecosystem. The ecosystem includes physical, socio-cultural, psychological, and spiritual dimensions. Self-ecosystem differences were discernable by participants, but the self was never discussed in terms of being completely cut off or completely separated from each other in CDs recovery. Instead, differences or discernments were a matter of degree, such as balancing responsibilities to the self and others or the relationship between the sense of control and affecting an aspect of the ecosystem in some way. The interconnectedness incorporated structural issues where power was described as being supportive and/or oppressive to some people but not others in various ways, based on certain characteristics and contexts. In relation to this research's primary focus on CDs, one expression of oppression reported was how government health care and social service policies were written or interpreted in ways that empowered agents to deny services or benefits relating to their mental illness symptoms when an addiction was believed to be co-occurring. As mentioned above, their current or

even past addiction issues could “trump” their mental illnesses being seen in a less socially stigmatizing way.

Participants’ sense of self and SD meanings changed over time. Two discernable senses of self were associated with the shifts or changes in SD meanings. The two senses of self were not static stages but instead are artificial “snapshots” of a dynamic phenomenon. A primary sense of self was established in childhood, youth, and into early adulthood. A more “nuanced” sense of self emerged in association with participants pursuing CDs recovery. Figure 4.7 provides a visual representation of the components and relationships important to the primary sense of self and Figure 4.8 does the same for the more nuanced sense of self in CDs recovery. The primary sense of self’s SD components are characterized by largely ambient standpoint of self “settings”, determining processes, and power associated with being determined about someone (including the self) or something. Recovery was characterized by a greater attention to, and integration of, “nuances” of meaning of mental health, mental illness, substance use and misuse (including prescription medication), addiction-related behaviors, treatment, authorities/experts, and CDs recovery. This trend was towards greater situationally relativistic, compatible, and discerning views in recovery (in contrast to more absolutist and incompatible views of the primary sense of self). SD meanings and self-direction reflected participants’ respective sense of self within his or her ecosystem.

Knowledge building in the form of a positive (hermeneutic) feedback loop is interpreted as driving the overall trend towards more nuanced views and meanings in recovery. Shifts occurred gradually or suddenly. Sudden shifts are referred to as “catalytic self-ecosystem experiences” that unexpectedly impacted on participants’ sense of self. Some catalytic experiences were associated with the development of participant’s primary sense of self, such as SD standpoint of self “settings” relating to distrusting his or self and/or professionals. Others were associated with many participants later experiencing a kind of sudden “kick-start” towards greater awareness, questioning, and potential shifting of meanings associated with developing a more nuanced sense of self and SD meanings in recovery.

Finally, regulating degrees of relative “stability” of the sense of self simultaneously with growth and change appears to be an important consideration of the role and purpose of participants’ SD meanings (and self-direction). Regulating stability may be a function of SD meanings in relation to defending or protecting the primary sense of self, even if aspects of it such as negative attitudes towards one’s self, or a belief that it was wrong to care for one’s self, were deemed in hindsight to be faulty or harmful (i.e., negative feedback loops). However, the SD knowledge building positive (hermeneutic) feedback loop is a core feature of determining processes of participants’ SD meanings. More situationally relative, compatible, and discerning meanings in relation to the

nuanced sense of self appeared to help participants regulate degrees of relative self-stability in relation to recovery-oriented growth and change.

Participants saw their substance misuse or other addiction-related behaviors as either neutral or a “right” decision at the time, such as when they connected substance use with enhancing their sense of control in relation to mental illness symptoms. Substances were described as providing benefits to participants in terms of: helping people not care, helping people have fun, helping people simply function with effects of mental illness and/or traumatic experiences when they knew no other way (e.g., increase a sense of control), and/or helping people gain a sense of belonging with other people. The view of substance use or related behaviors changed as people became aware of various issues, especially in relation to negatively affecting their sense of control. For six participants, making self-determined decisions to change in relation to pursuing CDs recovery were catalytically experienced in association with:

- Being determined to maintain the primary sense of self wavered or “broke down.”
- Addictions were no longer seen as benign or helping the sense of control but were instead seen as now controlling the person, and the person wanted control back.
- The majority of participants were in a crisis, often associated with hopelessness, failure in relation to goals and aspirations, and a fear of dying.

- The majority of participants were coincidentally in a different physical/social space away from status quo influences (and often feeling betrayed or abandoned by these influences).
- At least one other human being was viewed as caring, trustworthy, and able to offer help in some way during these times.
- The participant wanted to connect with someone for help at that time.

CDs recovery for all but Sam (who did not identify himself as having mental illness symptoms per se) included focusing on improving personal and social functioning in terms of balancing caring about and for one's self and about and for other important people in his or her life. Overall, recovery was viewed by participants in relative and compatible ways and was not absolutist in terms of focusing on cures, abstaining from all potentially problematic substances (some abstained from all substances and others abstained from some but not all), or taking prescribed psychiatric medications (some abstained from all prescription drugs while others used them). Participants discerned differences, patterns, and relationships involving his or her self and the surrounding ecosystem in relation to substance use/addiction problems, mental health, and mental illness symptoms in CDs recovery. Greater discernment appeared to help people to see different and more available choices to deal with addiction and/or mental health issues (and, in

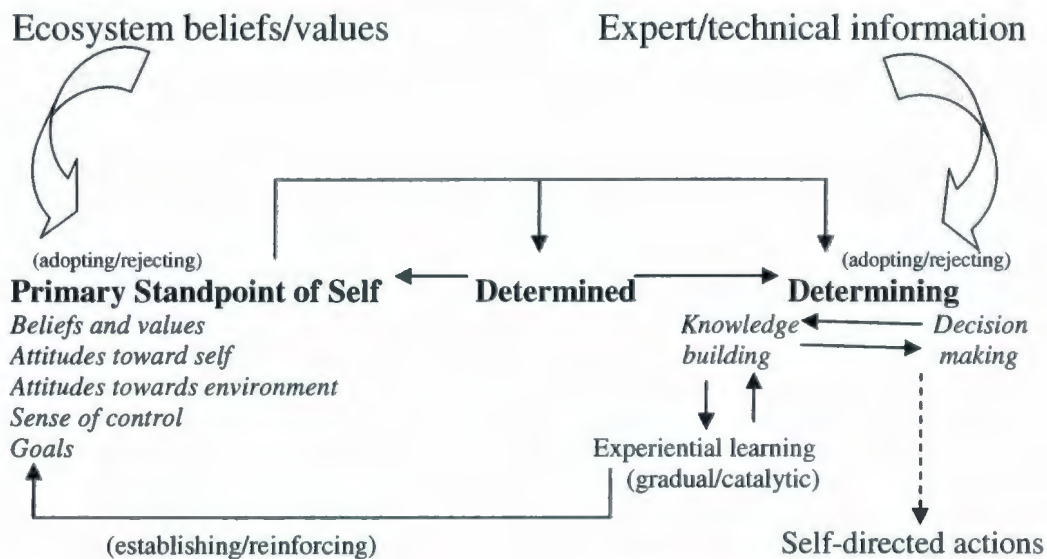


Figure 4.7: SD Meanings: Primary sense of self within the ecosystem.

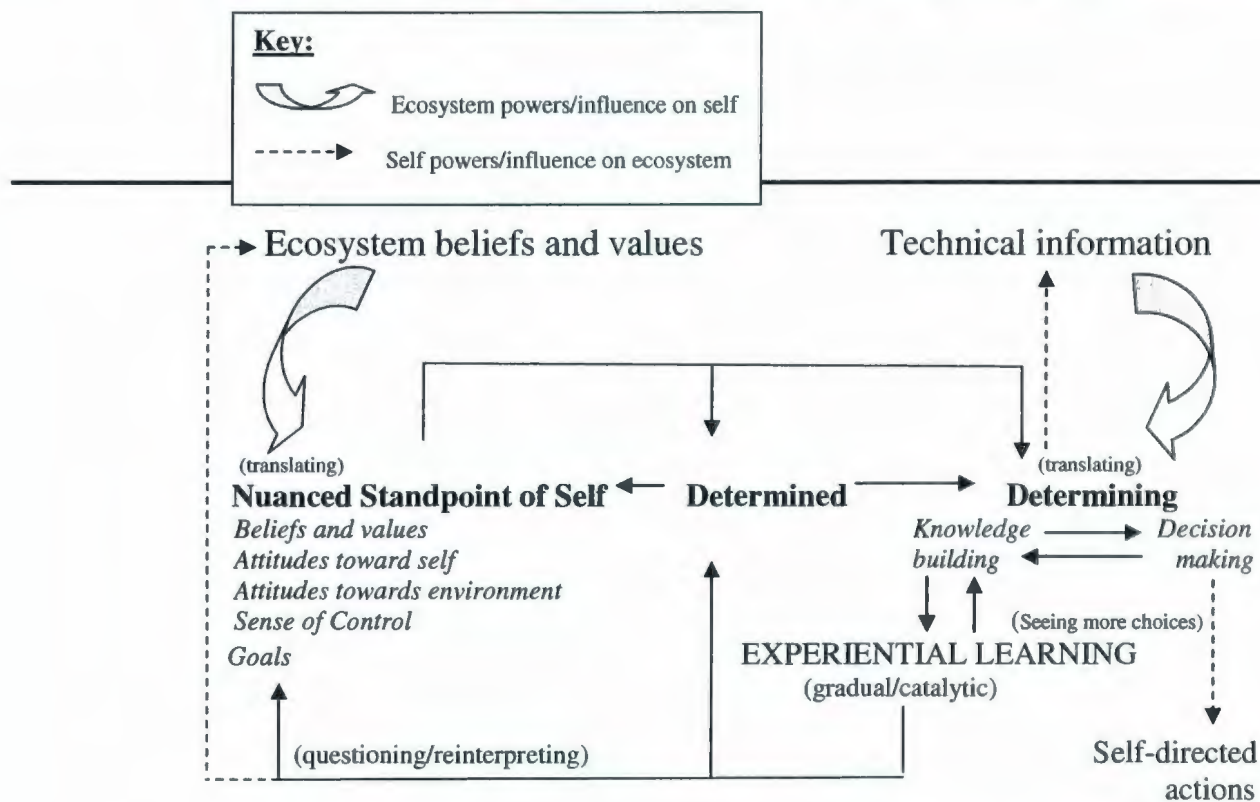


Figure 4.8: SD Meanings: More nuanced sense of self within the ecosystem, in association with CDs recovery

turn, feel more self-determining). Treatment that helped a person regulate his or her subjectively perceived need for relative stability of self (through process and effect) within recovery-oriented growth and change was highly valued in relation to participants' SD in CDs treatment and recovery. Limits to SD were accepted and even supported, at least in hindsight, when they were judged to be "fair", helped regulate self-stability, and were not perceived as being primarily punitive or in the best interest of those applying them.

Another important part of CDs recovery among participants in relation to sense of self and SD meanings involved participants translating externally-based values/beliefs and expert/technical information associated with mental illness and/or addiction into personal meanings that "made sense" to the person, particularly in relation to his or her self-standpoint, experiential knowledge, and personally meaningful aspirations. Similarly, they often reinterpreted certain subjective meanings of past experiences in recovery that had been banked into his or her personal knowledge in association with their primary sense of self's narrative. Participants valued working with professionals and programs that saw people as unique and shared their more nuanced views of CDs treatment and recovery. Those who were perceived as being absolutist in relation to treatment and CDs recovery were not highly trusted by participants.

CHAPTER FIVE

Discussion

5.1 Introduction

This chapter discusses the findings in relation to the grounded theory's organizing concept and the theory's key components of participants' SD meanings. The purpose of this study includes contributing to the systematic development of social work theory and practice knowledge that builds on understanding better the subjective meanings of SD for persons living with and recovering from CDs. One CDs practice consideration arising from this theory is discussed in more detail. It concerns the potential importance and role of SD meanings in relation to participants' uniquely seeking and maintaining or regulating degrees of sense-of-self stability simultaneously with experiencing if not pursuing growth and change, all within his or her dynamic ecosystem. It also concerns how regulating self-stability with growth and change relates to mental health and mental illness, substance use/misuse or addiction issues, and CDs recovery. Other practice implications and possible areas of future research are mentioned throughout the discussion. The chapter concludes with a look at limitations of the study and its findings.

5.2 The Sense of Self within His or Her Ecosystem

Meanings of SD in CDs treatment and recovery experiences were found to hinge on the participant's subjective sense of self, at a particular time and within a

particular context. As Carmen stated: "The key word is 'self', right?!?" The defining characteristics of this grounded theory's organizing concept include:

- It is subjective.
- It is located relationally.
- The self is neither Cartesian/Locke in nature (i.e., the conscious self is not independent of the body and its space-time context) nor is it simply a product or function of some process or system separate from the person (e.g., radical anti-Cartesian behaviorism).
- It is mutually interactive with the ecosystem at both the micro and the macro social/structural levels.
- An important part of self-ecosystem interactions involve asymmetrical powers and forces. For example, the individual can express his or her power or influence in ways that can have an effect on people or aspects of his or her ecosystem while, at the same time, the self can be impacted by asymmetrical powers, forces, controls, and limitations located in dimensions of the ecosystem (including socio-cultural structures and institutions).
- The initially established "primary" sense of self has the capacity for change.
- Hermeneutic knowledge building describes the process associated with changes in the sense of self over time associated with pursuing CDs recovery.

- Changes in the sense of self over time reflected a trend towards a greater awareness of, and attention to, nuances of subjective meanings, including SD meanings.
- The more nuanced sense of self associated with participants pursuing CDs recovery was characterized by more situationally relative, compatible, and discerning views of his or her self, environmental dimensions and forces, mental health, mental illness, addiction, and CDs recovery.
- SD meanings and self-direction are, at least partly, associated with participants' uniquely regulating the relative stability of the sense of self simultaneously with experiencing if not pursuing growth and change.

5.2.1 Edward Deci's SDT

SDT (Deci, 1980; Deci & Ryan, 2002) is perhaps the current most influential practice theory in mental health that is overtly related to notions of SD. Deci deduced an organic multi-dimensional view of the self and made it central to understanding SD (as a form of autonomy). This study's inductive grounded theory shares a number of similarities with SDT with respect to the self. For example, Deci identified trust as an important SD-related issue and an internal force or power – the will – as an important facet of the self in relation to SD. SDT also suggests that an environment perceived as more controlling or non-responsive to one's needs is less conducive to people being able to optimally trust, grow, and achieve in areas such as athletics, education, and illness recovery (including mental health or addiction). Finally, SDT includes an interactive

feedback loop between the self and the environment. Deci (1980) stated: “it is an ongoing interactive process between the person and the environment that affects their behavior and the adjustment of their internal states” (p. 213).

However, there are at least three significant differences between the deduced SDT and this study’s inductively developed grounded theory derived from participants’ responses and analysis. First, Deci does not refer to positive hermeneutic knowledge building as best describing the interactive feedback loop processes involving the self and the environment that lead to personal adjustments, growth, or change. Second, this study’s concept of a more “nuanced” sense of self in CDs recovery – characterized by more situationally relative, compatible, and discerning views of his or her self, ecosystem controls and powers, mental health, addictions, treatment, and recovery – does not easily match up with Deci’s internal causality orientation category. SDT implies that this category is most conducive to recovery. Instead, the more “nuanced” sense of self evident in this study appears to reflect more compatibility in terms of the majority of participants integrating or balancing all three of Deci’s loci of causality in their SD meanings in CDs recovery. Third, unpredictable catalytic self-ecosystem experiences found to be associated with significant shifts in participants’ sense of self, and, in turn, meanings of SD and self-direction, challenge SDT assumptions that the self and its loci of causality facet can be assumed to be stable. Deci (1980) acknowledged that his theory is challenged to be predictive of behavior because “to make accurate predictions about behavior and internal states, one

must utilize the person's orientation at that time and the characteristics of the environment at that time" (p. 313). However, he goes on to state that predicting is easier than it sounds because the person's causality orientation is relatively stable and any changes that occur do so fairly slowly. This study did find that participants tried to maintain the relative stability of both their primary and nuanced sense of self. It may also be true that gradual change in the sense of self is more typical. However, the findings of this study include participants' descriptions of sudden unexpected "catalytic" experiences which suggest that the sense of self is inherently more dynamic and less predictable than SDT assumes. Further, the grounded theory's knowledge building positive (hermeneutic) feedback loop appears to be related to growth and change. Consequently, participants' SD meanings appeared to integrate and regulate both change and stability.

Rather than assuming people have static self-stability states per se (inclusive of a loci of causality), participants are interpreted in this grounded theory as continually seeking and maintaining or "regulating" the relative stability of his or her self simultaneously with growth and change within a complex and somewhat unpredictable ecosystem and its dimensions. SD meanings are associated with, and may be critical to, this perceived need and/or goal of participants in relation to dynamic internal sensations, including those associated with mental illness and/or addiction. Simultaneously, participants are integrated with his or her dynamic ecosystem that may be influenced but not particularly

controlled. Consequently, it can unpredictably disrupt self-stability as much as support it.

One possible explanation for the difference between SDT and this theory is that the relative stability of the sense of self was more uncertain, and regulating sense-of-self stability was a more pronounced daily need, for this study's participants than for the hypothetical "norm" that SDT refers to and tests against. Perhaps many people who have not been challenged by CDs, addiction, or mental illness (nor related ecosystem dimensions and forces associated with coerced treatment, stigma, and prejudice in these areas) could maintain the relative stability of their primary sense of self with growth and change throughout their lifetime. As a result, their sense of self may traverse a different path, or the occurrence of a more "nuanced" sense of self over time is different somehow in nature. Perhaps this trend can also be discerned among other samples of people, but it occurs with more difficulty or more gradually and without sudden shifts in self-awareness and meanings. Participants' experiences of abuse and its traumatic effects, especially trust, may also be an important factor associated with SD meanings among this study's participants. One line of future investigation could explore this issue of sense-of-self stability among people with CDs versus comparative controls, such as: people without having experienced mental illness symptoms, addiction, or abuse; people without mental illnesses but with experiences with abuse or addiction; and/or people with mental illnesses but without having experienced addiction or abuse.

5.2.2 The Sense of Self and CSD

I analyzed over fifty social work journal articles and books that referred to CSD. The majority of texts over the past thirty years can best be described as implying that CSD referred to autonomy and hinged on an individual sense of self within brief idealistic statements about supporting clients' wishes, desires, rights, and decisions (McDermott, 1975; Reamer, 2006; Taylor 2006). The ecosystem was typically represented in these texts as a transactional factor associated with fostering, upholding, or, under certain broadly stated circumstances, limiting freedoms or the autonomy of individuals. The social worker is typically viewed as a part or agent of the ecosystem in relation to the client. A minority of texts argued for a CSD perspective that reflects a deeper synthesis of person(s) and ecosystem (e.g., Falck, 1988; Ramsay, 2003).

A small number of texts denoted more specific meanings of the self to CSD in social work ethics and/or practice. However, these notions of self in relation to CSD were not based on inductive empirical research and analysis. Instead, they were philosophical in nature or else they were deductively adopted or adapted from research studies and practice experience in other disciplines, especially sociology or psychology (e.g., Perlman, 1965; Abramson, 1985). Overall, the findings of this study suggest that inductively exploring client meanings of self in relation to SD is an underutilized research approach that could help social workers better understand and ethically operationalize CSD in practice.

5.2.3 Sense-of-Self Stability and SD in CDs practice

Regulating degrees of self-stability simultaneously with experiencing if not pursuing growth and change, vis-à-vis the role and importance of participants' SD meanings in CDs treatment and recovery, may be one of this theory's most promising conceptualizations for further enquiry. The idea that physiological and psychological homeostasis, equilibrium, or self-stability is important to people's health and wellbeing is not new to social work and is particularly important to general systems theory (Hearn, 1979), ecosystems theory (Germaine & Gitterman, 1980), and crisis theory (Roberts, 2006). Protecting relative self-stability related to participants' references to the importance of SD as an absolute right in terms of pure survival. It also is consistent with participants defending a self-standpoint in CDs recovery that, at least from my perspective when interviewing them, included lingering self-harming, self-limiting, or self-defeating attitudes, beliefs, and/or values.

However, general systems and ecosystems theories are criticized in social work for assuming that people mostly seek equilibrium, that life can be reduced to a series of steady or balanced states driven by negative feedback loops, and that the social worker, as an expert if not an authority, should direct clients towards balance or homeostasis (Green & Blundo, 1999). Christopher Hudson (2000) suggested that emphasizing negative feedback loops associated with homeostasis in systems theories leads to promoting normalization over growth and change (including normalizing social structures that perpetuate stigma and oppression).

He argued that deviation-amplifying positive feedback loops promote growth and change and that emphasizing subjectivity, non-linear development, and positive feedback loops moves social work models away from general or ecosystems theories and more towards complex or “chaos” systems theory.

Chaos theory emerged from developments in physics and mathematics, notably mathematical equations that are iterative in nature. Iterative equations continuously feed equation results back into the equation, which produces new and unpredictable results. In other words, they are unsolvable. Chaos theory’s major applications have been in understanding weather patterns, population growth, and astronomy. It is being considered in relation to psychology and social work, at least metaphorically without mathematical support (Ayers, 1997; Hudson, 2000). David Scharff (2000) outlined six important principles that characterize dynamic non-linear chaos theories: (1) continuous feedback; (2) small differences in initial conditions produce completely different and unpredictable effects (i.e., the butterfly effect); (3) details are inherently unpredictable but at the same time they are not purely random; (4) there is a tendency for such systems to self-organize into non-random trends and patterns (called fractals); (5) pattern boundaries vary with degrees of magnification and measurement sensitivity (an illustrative example often cited is the widely disparate quantitative results found when measuring the same shoreline with a yardstick versus a micrometer); and (6) “strange attractors” that act as focal points

of trends or patterns. These focal points are produced by the system, but they also may be the very thing that organizes the system.

Scharff discussed the sixth principle in relation to the human heartbeat. He cited studies that found that a chaotically irregular but not random heartbeat confers a greater potential for adaptability to changing needs of the body (e.g., rest versus exercise) and changing environments (e.g., threats). In contrast, the heartbeat's rhythm is most stable and quantitatively predictable in a diseased state.

Negative feedback loops associated with homeostasis are a part of this theory in relation to participants defending or protecting degrees of his or her sense-of-self stability. Nevertheless, knowledge building positive (hermeneutic) feedback looping is a core process of participants' SD meanings associated with CDs recovery. Further, the trend or pattern towards a more nuanced sense of self and associated meanings was evident (at a higher level of magnification) but individual "details" of subjective SD meanings were uniquely unpredictable. Consequently, the emphasis in this theory on SD meanings having a function in regulating self-stability simultaneously with growth and change shifts it towards a more complex or chaos systems perspective. One area of consideration that arises is whether subjective perceptions of treatment options as generally trustworthy, generally untrustworthy, or a more case-by-case nuanced view might represent different strange attractors that help provide insight into trends or shifts in peoples' SD meanings in CDs treatment over time?

For example, one SD-related pattern or trend could organize around attitudes towards treatment being assumed to be trustworthy as a strange attractor and another could organize around treatment as untrustworthy attitudes. Direct experience could reinforce or maintain the general pattern of either trend. Some contrasting experiences to either established trend could perhaps have a gradual effect but not dramatically shift the general pattern or the respective organizing strange attractor. However, other contrasting experiences could potentially cause a sudden shift or cascade (see below) such as where the pattern organized around the trustworthy strange attractor becomes organized around the untrustworthy strange attractor, or vice versa. Another pattern from either original trend could emerge that is organized around a third strange attractor that reflected more nuanced case-by-case or person-by-person evaluations of treatment trustworthiness. Quantitative methods could potentially be used to explore this conceptualization but it would require extensive sampling, plotting, and mathematical modeling.

One practice implication of an association between SD meanings and self-stability regulation is that social workers who assume rather than try to understand each client's subjective perception of SD may unnecessarily if not unethically undermine, interfere, or conflict with clients needs to maintain a degree of relative self-stability and/or undermine, interfere, stifle, or conflict with clients' recovery-oriented change and growth (if not be an outright risk to clients' safety). Risks could occur, for example, if client SD meanings lean towards autonomy and their

decision making was unnecessarily limited. At the same time, risks could also occur if client SD meanings lean towards wanting to share or delegate decision making to others (e.g., family members and/or professionals) and the client is left unnecessarily abandoned or directed to make autonomous decisions.

Better understanding clients' subjective SD meanings could help workers not only better uphold CSD values in practice but also help clarify decisions around ethically limiting it. Participants acknowledged the need for there to be limits to SD and self-direction under certain circumstances. However, descriptions of treatment experiences suggested that many interactions which interfered or conflicted with participants' SD meanings were not always necessary and may have contributed to worsening mental health symptoms, addiction relapses, and/or instilling/reinforcing mistrust of treatment and professionals. There may be important connections to investigate between CDs treatment, SD meanings, and client self-stability regulation within growth and change that could reduce harm to clients, improve client-worker experiences in terms of trust, and improve many client outcomes.

This grounded theory also suggests that there may be important linkages to further investigate in relation to people with CDs regulating sense-of-self stability, their SD meanings, prescription medication compliance, and decisions to use, misuse or abstain from other substances in treatment and recovery. Many participants' decisions to use/misuse substances and/or engage in non-substance addictive behaviors prior to pursuing CDs recovery was at least partly because

they perceived their use as either benign to their self-stability or it helped them defend or regulate it. Substance use helped regulate self-stability in ways that included numbing or minimizing issues associated with mental illness symptoms, aid managing issues associated with past trauma/abuse, defending his or her sense of control, and/or facilitating connections with others.

Addressing addiction issues appeared to be a priority for most participants in relation to wanting to regain a greater relative sense of control. This occurred when these participants experienced substance use/misuse or non-substance addictive behaviors as not only no longer helping them regulate their relative self-stability but becoming an outright risk to his or her life. In other words, addiction came to be perceived as gaining such a degree of control over the sense of self that it was a serious risk to his or her survival. An early decision to stop led seven to describe experiences that were characterized by greater immediate self-instability associated with lost social connections with “using” friends or acquaintances, worsening mental illness symptoms, and/or worsening after-effects of past trauma/abuse experiences such as flashbacks, self-loathing, or nightmares. All returned to using, perhaps in an effort to regain a degree of self-stability. However, these attempts still involved or integrated change, such as using different substances or attempts to use previous substances in a more self-limiting way. Unfortunately, people reported losing control again with old or new substances and people tried again to deal with the addiction and/or mental illness symptoms. Eventually, all but Sam either became determined to pursue

professional treatment or willingly participated with it when it was imposed in some way. This willingness to participate in professional treatment was typically associated with viewing it as a last resort when survival was at risk. Rather than seek assistance, Sam said he actively self-regulated his continued use of alcohol.

Recovery decisions associated with abstinence, the controlled use of some substances but not all, prescription medication use or avoidance, psychotherapy participation, peer supports, and using other services and supports also appeared to be subjectively evaluated by participants at least partly in relation to the perceived risks and benefits to their relative self-stability. All participants expressed concern about how simply being involved with professional treatment services might negatively affect his or her self-stability in terms of both the process of treatment (e.g., losing control of decision making) and any specific intervention's impact (e.g., physically/psychologically destabilizing side effects). However, all had idiosyncratic reasons in this regard, and SD meanings did not simply equal freedom or autonomy when making decisions. Instead, most participants wanted some external guidance or support and structure, albeit temporarily, if they felt hopeless, confused, or were in a state of crisis. Participants also reported times when they chose to share or delegate some aspect of their decision making in treatment with practitioners that they trusted. In recovery, if trust was broken then participants took back their decision making either overtly or covertly.

Outside of crises, most participants consciously chose to sometimes delegate or share making treatment decisions, and comply with professional recommendations, when they trusted the treatment program or practitioner(s). When trust was not there (either assumed prior to contact or not earned through their experience in interactions) all participants sought overtly or covertly to maximize their freedom and autonomy in treatment interactions and directions. The more experience participants had with treatment, the more trust needed to be “earned” by professionals and programs rather than it being assumed ahead of time.

The findings suggest that matching unique SD meanings in CDs recovery with degrees of autonomy, collaboration, and external guidance and structure may be critically important to helping many people with CDs recover. The findings support CSD practice models in social work that seek to match or “titrate” the effects of worker influence or external structure with client-directed self-regulation or self-direction specifically in relation to safety and trust issues (e.g., Murdach, 1996). However, to achieve any sort of appropriate and ethical matching then social workers must first seek to understand clients’ subjective meanings of SD rather than apply a personal and/or professional generalized assumption of what it is or should be. For example, some participants who wanted a high degree of external structure and guidance typically self-determined wanting less of it, less often, as they gained greater self-stability in recovery. Other participants who initially wanted a high degree of autonomy in association with a

high distrust of others often wanted to subsequently share more or temporarily delegate their decision making as they trusted more in nuanced ways in recovery. It bears repeating again that a key factor in the findings in relation to these SD changes was subjective perceptions of trust: being able to trust more his or her self, other people, social structures, and various dimensions and forces of the ecosystem. Findings suggest that social workers need to recognize the relationship between trust and CSD in therapeutic relationships and continue to recognize that this trust is something earned over time.

Understanding clients SD meanings in practice and upholding them, except under exceptional circumstances, appears to naturally fit with a CDs recovery process that focuses on people needing to regulate degrees of sense-of-self stability simultaneously with experiencing if not pursuing growth and change. CSD in this context refers to helping people find their unique recovery-oriented balance or equilibrium with their shared responsibilities, their autonomy, their delegations of decision making, their treatment collaborations, and their interrelationships with other people, structures, and dimensions of his or her ecosystem.

5.2.4 Regulating Self-Stability and CDs Etiology

All participants except Alexis said that substance use problems or addiction came after mental health issues, such as those arising from experiencing trauma and abuse, or mental illness symptoms. The majority had contact with a mental health professional prior to addiction issues developing. This pattern fits

with addiction-secondary CDs epidemiological theories. Most research suggests that this addiction-secondary onset pattern reflects the experience of the majority of people with CDs (Kessler et al, 1994; Rassool, 2001; Meuser et al, 2003).

The most inclusive addiction-secondary CDs theories are multiple risk or multiple factor theories. The multiple risk perspective can encompass most other addiction-secondary CDs theories that are more specific such as the *super-sensitivity* theory (Meuser et al, 2003), the psychodynamic self-medication theory (Khantzian, 1985; 1997), and negative reinforcement or behavioral self-medication theories (Eissenberg, 2004). As the name implies, the multiple risk perspective associates the development of addiction with a broad range of influential factors that could include the direct effects of mental illness symptoms (e.g., depressive moods or persistent debilitating anxiety), certain physiological sensitivities to the chemical effects of substances, and/or the effects of abuse, poverty, social isolation, and stigma – all of which are generally associated with mental illness. CDs multiple risk theories are concerned with how substance use/misuse or non-substance addiction behaviors may be an attempt to mitigate or mediate a broad range of potential direct and/or indirect effects associated with living with persisting mental health issues or mental illness symptoms.

I was unable to find any CDs theories that specifically linked notions of regulating sense-of-self stability among people with mental illness with the subsequent development of addictions. The closest example in the literature is perhaps Linda Najavits' work in the area of helping women with PTSD and

substance abuse issues that she organized around the concept of “seeking safety” (2002). Regulating self-stability may prove to be a useful concept to further investigate in relation to understanding CDs etiology and improving social work practice in this area.

5.2.5 Sense-of-Self Stability and Adaptability

This theory’s “primary” sense of self within his or her ecosystem and more “nuanced” one in CDs recovery are not static states. Instead, they are artificial “snapshots” of a dynamic phenomenon. Shifts in the perceived sense of self were described as non-linear. There is also no theoretical end-point to knowledge building (beyond death). Consequently, the sense of self would theoretically always be engaged in regulating self-stability with change that includes the potential for unpredictable shifts in any “direction.” Nevertheless, a more nuanced sense of self may have provided participants with greater degrees of adaptability or flexibility in their sense of self that was conducive to recovery-oriented growth and change.

Greater adaptability or flexibility would, arguably, help maintain needed degrees of relative stability of self in the context of uncertain obstacles and outcomes associated with CDs recovery (i.e., the nuanced self could better “bend” without “breaking”). The more nuanced sense of self may also have helped participants adapt, develop or maintain a more positive sense of self. Certainly, participants spoke of having a more positive sense of his or her self in relation to his or her recovery (e.g., Malcolm reaching his goal of being a “somebody” by

helping others with mental illness; Carmen being able to say she has so much about her self to be proud about). Mental health self-advocates often will identify a more positive sense of self as critical to recovery from mental illness (Ridgway, 2001).

In relation to chaos theory, the nuanced sense of self being more adaptable than the more absolutist primary self to dynamically changing internal/external sensations, contexts, challenges, and opportunities would be similar to the chaotic but not random pattern of the heartbeat and its benefits. However, a sense of self that is too flexible or has too much “give” could potentially fall into a more random or out of control pattern that would be highly disadvantageous to functioning. Consequently, a certain degree of continuity would have to be maintained or a new strange attractor would need to re-establish continuity. A line of inquiry could look at whether a relatively nuanced sense of self, regardless of how or when it is present, is particularly conducive in some way with CDs recovery.

5.3 Sense of Self, Coherence, Continuity, and Change

Characteristics of the sense of self in this grounded theory share similarities with some theories of the self that were mentioned in Chapter Two. For example, George Herbert Mead’s work (1913; 1934) has some important conceptual characteristics that are similar to this grounded theory’s organizing concept. Both conceptualizations locate the sense of self within relationships and both integrate a more conscious awareness of the self occurring over time that is

driven by these relationships. Both theories also see the self as socially constructing a temporal coherence for itself. Finally, the two see the awareness and meaning of self changing over time.

In terms of temporal change, Mead organized much of his view of the evolution of the self, self-awareness, and self-identity around notions of an organic "I" and the subsequent development of a conscious, learned sense of self. He called this conscious facet of the self the "me." Despite the emergence of the "me", the full extent of the "I" remains unknowable to the person and operates in the background. Mead thought this emergence of a conscious view of one's self involved learning to take on the beliefs, values, or attitudes of others in childhood. Through communicative processes, social relationships molded a person's sense experiences of the "I" into a socially-based early meaning of the "me." Meanings of others both individually and/or collectively (e.g., a generalized "other") became social "objects." Again, communicative processes translated socially-based meanings into internal ones, this time through the "inner speech" a person has with his or her self over time. Although Mead saw the self as socially constituted and, in turn, socially controlled; nevertheless, he also thought the self was simultaneously capable of unpredictable, independent, creative, personal initiative. This creative initiative stems from the socially-based "me" never being able to fully comprehend or control the "I", nor anticipate how the "I" might ultimately influence the self. Consequently, the unpredictable "I" can have an impact on ecosystem dimensions.

Mead also suggested that the “me” is involved in interpreting the past in such a way as to create a coherent continuity of the self in the present and the future (Maines, Sugrue, & Katovich, 1983). The formation of the primary standpoint elements in relation to SD meanings overlaps in a number of ways with Mead’s “I” developing an initial, conscious, socially-based identity of its self. Once the primary sense of self’s standpoint elements had settled then participants often defended the homeostasis of their primary sense of self in the face of disruptive external and internal events and communications. Descriptions of some of the benefits of substance use/misuse appeared to fit with protecting or defending the homeostasis of his or her primary self.

Mead also suggested that the past and future of the “me” are also continually subject to reinterpretation as new sense experiences occur in the present and are molded into substantive meanings that need to fit somehow with the self’s coherence and continuity. Consequently, either new sense experiences can only be interpreted in certain ways to fit with the existing continuity and coherence of the self, or else the past and future need to be reinterpreted or reconstituted to regain continuity and coherence with the substantive meanings of new non-conforming experiences. The knowledge building positive (hermeneutic) feedback loop appears to conceptually overlap with this facet of Mead’s theory. The more “nuanced” sense of self in CDs recovery also bears some similarities to Mead’s temporally changing perspective of self that implies that the “me” develops greater internal sources of meaning and reflection (although remaining

socially based). The nuanced sense of self in CDs recovery can be viewed in this light as an evolving form of the conscious “me” that participants found simply helped them better regain, maintain, or regulate needed degrees of continuity and coherence (i.e., stability) of the self simultaneously with recovery-oriented growth and change. This appears to be associated with developing more situationally relative, compatible, and discerning perspectives of his or her self, ecosystem dimensions (including the generalized other), mental health, mental illness, addictions, treatment, and CDs recovery – in the past, the present, and the future. SD meanings and self-direction, in turn, appear to fall into line with regulating the re-constructed or “renovated” coherence and continuity of the sense of self, with the ongoing potential for further growth and change.

Questioning and, at times, reinterpreting aspects of the sense of self that integrates the past (e.g., primary standpoint beliefs/values) and the future (e.g., the standpoint’s goals and aspirations) in relation to a present that consciously integrates mental health and substance use issues was associated with the majority of participants pursuing CDs recovery. However, regulating coherence and continuity or relative stability of the sense of self for participants was not as simple an experience as a theory such as Mead’s might imply; reinterpreting the past in relation to new events were described as sometimes profoundly traumatic and could at times put their very survival at risk. Mead (1934) suggested that attitudes adopted from others were the base of purposeful behavior, some were

easily reorganized via communication with the self and others, but other attitudes that were more fundamental to the self could only change with great difficulty.

As mentioned above, subjective SD meanings and self-direction may be intrinsically linked to the need for people to regulate the relative stability of their sense of self simultaneously with experiencing if not pursuing growth and change. Not understanding and, in turn, not respecting clients' subjective SD meanings whenever and wherever possible in CDs recovery may contribute to severe crises in terms of Mead's notion of the self's need for continuity and cohesion. Offering people opportunities to consider reinterpretations is one thing. However, the therapeutic potential of such opportunities may be compromised when professionals pre-determine and control what that reinterpretation should be. In such situations ethical statements that emphasize egalitarian relationships are compromised and the professional power, whether intentionally or unintentionally, is arguably abused. Similarly, when programs are structured in such a way that SD is compromised and client goals and experiences are not considered meaningful aspects of the treatment plan then the asymmetrical power differential is reinforced to the detriment of the client who has less power in the relationship and within the program. No matter how well meaning, the findings of this study suggest aggressively persuading or coercing people to face and change what appear to be incoherencies is potentially risky because they can precipitate crises with unpredictable outcomes. Further, they could create or reinforce distrustful attitudes that guide people to avoid accepting help in the future.

One major difference between Mead's work and this theory's conceptualization of the sense of self in relation to SD meanings is the fundamental integration of the power of being determined about someone (including the self) or something. Mead does not refer specifically to an internal force or power (e.g., will or willpower) in relation to the capacity of the "I" to be unpredictable, creative, and socially uncontrollable. However, Otto Rank's (1945) description of the creative "will" that was a focus of his applied therapeutic model is reminiscent of these qualities of Mead's "I." Mead also does not specify that a hermeneutic communicative process is behind the "I" developing an awareness of a part of the self in the form of the "me." In contrast, the findings interpret hermeneutic communicative processes being behind the primary sense of self moving to greater awareness of, and attention to, nuances of meaning of the self, ecosystem, mental health, addictions, CDs recovery, and, SD.

There is some support in the literature for integrating hermeneutic processes with self-awareness and consciousness, including Mead's conceptualization of the sense of self. For example, Douglas Ezzy (1998) argued that Mead's notion of the "me" as self-identity occurs specifically in a hermeneutic narrative configuration. Ezzy suggested that integrating Mead's social psychological conception of the self relationally and temporally with Paul Ricœur's philosophical hermeneutic theory of *narrative identity* "provides a subtle, sophisticated, and potent explanation of self-identity" (p. 239).

According to Ricœur's theory, "selfhood" is a form of being that is able to reflect upon itself, through internal communication and communication with others, while "identity" is a narrative construction resulting from the reflective processes (Ricœur, 1992). Consequently, the self as "me" becomes known through hermeneutic narrative activities in association with interactions with the world. Random events of the lived experience of the "I" are interpreted through language as episodes of an unfolding coherent story and synthesized into the continuous narrative in a way that Ricœur describes as "emplotment" (1992). The narrative processes are hermeneutic in essence; lived experiences are continually related to the narrative, in terms of their place in the overall plot of the story, and the overall plot of the story is continually related to meaningful events that randomly occur. Interpreting and reinterpreting of the random events and/or the unifying narrative can and do occur.

In terms of this study's grounded theory and Ezzy's thesis, SD and self-direction would, by extension, be a natural, coherent, but changeable expression of the sense of self that is grounded in real world experience but subjectively interpreted. Hermeneutic processes are constructing and reconstructing a coherent and continuous narrative identity. Ezzy's blending of ideas associated with Mead and Ricœur shares some strong conceptual similarities with this study's self-standpoint, determining processes, and their interactions in meanings of SD. Although Mead did not speak of the importance of a power such as "will" or "being determined" within his conceptualization of self, Ricœur does in his

“philosophy of the will” (1965). Ricœur related “will” or “willing” to decisions that lead to actions in the world. However, he suggested that the act of willing is inherently subjective and is a form of “being” that involves participating in social situations with other beings. In contrast, this study’s conceptualization of being determined appears to be more omnipresent than Ricœur’s view of will and more along the lines of Rank in psychology. Overall, this grounded theory’s defining characteristics of the sense of self in relation to SD meanings appears to overlap in a number of ways with an amalgam of the work of Mead, Rank, and Ricœur.

5.4 Sense of Self, Self-Stability, and Social Work

As mentioned in Chapter Two, Howard Goldstein (1981) argued that the “self” in social work is best understood in terms of “states” and “processes” and is comprehensible only within its environmental context, rather than it being a “static entity” unto itself (p. 111). This study’s findings share much with this view. However, this study’s theory sees the sense of self, at least in relation to SD meanings and self-direction, as best understood in dynamic terms that involve not only states and processes but also forces or powers – the power associated with being determined as well as asymmetrical forces operating within both discrete and generalized self-ecosystem interactions and relationships. Another important similarity between Goldstein’s view of the self and this theory’s is in relation to the self and “stability.” Goldstein cites the work of psychologist Gordon Allport (1955) when he stated that the self is best seen as a multidimensional “proprium” or composite. Goldstein discussed three “vital operations” of the self: (1) “[it]

involves adaptation and takes account of the self as both constant and variant in its commerce with reality”; (2) “[it] is intentional, future oriented, and in pursuit of meaning”; and (3) “[it is] a system that strives for stability although undergoing change, maintaining balance while experiencing tension” (p. 111-12).

Goldstein’s inclusion of “striving for stability although undergoing change” as a “vital operation” of the self appears to conceptually overlap with this grounded theory’s interest in the role of SD meanings and self-direction in regulating sense-of-self stability with growth and change in relation to CDs treatment and recovery. Further, Goldstein’s view of the self suggests that regulating degrees of self-stability with change in relation to SD and self-direction may have some relevance to social work practice and CSD beyond this study’s focus on participants’ experiences in CDs treatment and recovery.

The grounded theory also shares some qualities with Sharon Berlin’s constructivist cognitive-integrative view of the self (1996; 2002). For example, her conceptualization of subjective memory-based narrative self-schema patterns constructing personally coherent meanings of the self relate to this theory’s temporal development of self-knowledge and the standpoint elements’ initial set-points and subsequent adjustments. Like Ricœur’s narrative identity theory in philosophy, Berlin’s social work practice model also conceptually overlaps with this grounded theory’s interest in SD, regulating self-stability, and change in terms of the self’s narrative coherence and continuity. Berlin (2002) also speaks to “back and forth” interactions of the person with his or her environment and the

importance of experiential learning in therapeutic practice; however, she does not refer to the self-ecosystem interactions or the processes of experiential learning, knowledge building, and subsequent adjustments to narrative self schemas as hermeneutic in nature. She also does not integrate an internal force or power associated with being determined, as is highlighted in this study. Finally, she does not relate her view of the self to the role and purpose of CSD in social work.

Berlin (2002) does make reference to “empowerment” and that asymmetrical powers associated with individuals and social structures (including social workers) can often negatively impact on peoples’ constructions of self-schemas and mental health recovery. Participants spoke of the negative impact of authorities/experts at a person-by-person level as well as at more macro levels such as through mental health and/or addiction treatment systems/structures or social benefit programs. At the same time, participants acknowledged a role for experts and authorities and that limits on peoples’ SD are necessary to lessen or channel inevitable conflicts stemming from subjective and idiosyncratic needs and wants of individuals and groups. Most acknowledged times when their determination harmed others in some way. Nevertheless, many structural powers of the ecosystem were reported by participants to be a verifiable source of danger to their physical safety, sense-of-self stability, and personal growth, whether well-meaning, impersonal, or malicious. This finding supports the role of CSD in social work in relation to protecting clients from potential harm.

Finally, Dennis Kimberley and Louise Osmond (2003) referred to the “stability of self” as an important theoretical dimension to understanding and better assisting people with CDs from an ecological social work perspective. The authors did not define this self-stability reference in detail or relate it to the role and importance of CSD in social work practice. Still, it provides further theoretical support for this theory’s interest in the role SD meanings may play in relation to regulating sense-of-self stability with change and growth in CDs treatment and recovery (although this study’s theory moves towards complex chaos systems theory rather than reflecting a strictly ecological perspective).

5.5 SD, CDs, and Stigma

This study did not focus specifically on issues of SD meanings and CDs in relation to stigma and such differences as gender, ethnicity, and age. However, at least one open-ended question relating to stigma and CDs was posed to each participant. SD differences in meanings associated specifically with gender were mentioned by a number of female participants as views they held more in the past (i.e., associated with their primary standpoint). When interviewed, they did not believe that gender differences in terms of stigma were fundamental to their essential meanings of SD but were more associated with social constructions of meanings about gender that they had uncritically adopted and that they, and society as a whole, were changing. However, one important gender-related area of interest might be in relation to subjective SD meanings associated with caring for others. For example, some participants mentioned biological differences

associated with pregnancy that they did not relate specifically to stigma issues. However, they also believed these could be relevant to meanings of SD for women, but different for men. This finding, as well as my male social location in relation to interviewing and analysis, suggests that further investigation into SD meanings associated with gender could enhance understanding of the concept and the applicability of the grounded theory.

Understanding SD meanings in relation to various age groups is also important given how social structures asymmetrically assess risk, delegate, or expect people to accept and exercise different degrees of external direction with individual freedoms or autonomy based on age (Staller & Kirk, 1997). Also important to consider are the different beliefs, values, and attitudes that are in play in relation to parental roles and responsibilities cross-culturally and how beliefs and values are internalized as a part of a youth's view of self. Exploring SD meanings and issues in relation to children and youth may be particularly important to CDs prevention, treatment, and recovery because important epidemiological studies are finding, like the majority of this study's participants, that most substance use issues among people with mental health disorders occurred years after the first emergence of mental health symptoms or first experiencing the effects of trauma/abuse in childhood, youth, or early adulthood (Kessler et al., 1994; Kessler et al., 1996; Rassool, 2001). As mentioned above, some CDs etiological theories, such as multiple risk theories, include the potential

stigma and social marginalization associated with being a victim of trauma and/or having a mental illness with a greater vulnerability to addiction.

Participants spoke of how they thought mental illness was becoming a less stigmatizing issue for them generally. However, there was a strong shared perspective that having an addiction remained more stigmatizing than having a mental illness, having a co-occurring addiction often “trumped” improvements in the way their mental illness was viewed by others, and having a co-occurring addiction did lead to some discriminating practices among social institutions (e.g., disability benefits criteria), some mental health treatment programs, and some treatment professionals. Participants’ attitudes towards treatment professionals reflected these experiences. Although the primary sense of self was more generalized about attitudes such as those associated with distrusting all professional help, these attitudes were still integrated into their more “nuanced” sense of self in CDs recovery. The difference in recovery was that the distrust was more selectively incorporated into attitudes and self-directed avoidance behaviors.

Steven Wineman’s (1984) model of multiple, intersecting, and mutually reinforcing forms of oppression and the prevalence of CDs suggests that investigations into stigma and mental illness need to consider issues of addiction and CDs. I did not find any specific references to conflicting, interacting, or reinforcing issues of stigma associated with having a mental illness and having an addiction in relation to CDs recovery and CSD in social work texts.

One recent social work text does identify the lack of a social work perspective on addiction generally (Csiernik & Rowe, 2003). The authors proposed a "biopsychosocial" framework that considered addiction in terms of the "pharmacological" of the substance, the "individual characteristics" of the user, and also the "social context of use" (p. 12-13). The authors argued that understanding addiction within a social work perspective naturally incorporates social context issues of "oppression" and "social marginality" vis-à-vis the person and the addiction (p. 13). Consequently, such a social work perspective on CDs prevention, treatment, and recovery would seek to better understand oppression, social marginality, and stigma associated with having mental illness and addiction issues (as well as other potentially interlocking qualities or characteristics such as age, gender, sexual orientation, race/ethnicity/culture, geographical location, and other forms of disability). Examples of studies could include surveys that compare and contrast stigmatizing values and beliefs of mental illnesses, substance use problems or addictions, and CDs that are held by social workers. Using case vignettes that distinguish between issues associated with mental illness, addictions, and CDs in ways that reveal potential differences in social workers' degree of directiveness, along the lines of the study done by Rothman et al (1996), could be illuminating.

Notions of false consciousness, consciousness-raising, and critical consciousness are important aspects of many conceptualizations of anti-oppressive practice. Critical consciousness seems to be somewhat similar

conceptually to this theory's "nuanced" sense of self in CDs recovery (e.g., notions of greater awareness and "insight," critically questioning socio-cultural beliefs/values and expert/technical information, and questioning and adjusting negative self-attitudes associated with social expressions of stigma and prejudice). Stephen Quintana and Theresa Segura-Herrera (2003) looked at the development of a state of false consciousness and the subsequent shift towards people achieving a less internally oppressive state of critical consciousness about their selves individually and collectively among a racially oppressed Mayan group in Guatemala. They refer to the shift as a "transformation of self" (p. 274). The authors proposed that the shift towards critical consciousness involved "questioning the legitimacy of outgroup dominance and increasing ingroup cohesion without reifying negative ingroup stereotypes" (p. 275).

Some anti-oppressive texts may imply that clinicians should promote a greater awareness of "false consciousness" held among clients and help them shift towards a more "critical consciousness." Consequently, one consideration that seems to naturally arise from this study is whether social workers in CDs treatment and recovery should somehow arbitrarily promote or facilitate clients shifting from a primary sense of self to a more "nuanced" one. However, a trap may lie in inadvertently or non-critically examining whether CSD in social work points to a theoretically preferred state of consciousness, sense of self, or meaning of SD whether it is associated with an anti-oppressive, cognitive, medical, or some other intervention framework. Specifically, notions of "false" consciousness

add a judgmental quality to discussions of the sense of self. As mentioned above, the self appears to be engaged in regulating stability with growth and change and SD/self-direction appears to be important in this regard. Actively disrupting clients' relative sense-of-self stability for reasons such as diagnosing that they hold a form of false consciousness may be inherently dangerous to the person and can create/reinforce distrust of people trying to help, at least in relation to this study's participants who were pursuing CDs recovery.

Anne Wilson and Peter Beresford (2000) suggested that there are some aspects of authoritative anti-oppressive practice in social work that violate social work's CSD values for people with mental illness and may even inadvertently perpetuate structural problems associated with expert-judgments and expert-prescribed interventions. For example, they discuss the risk that some practitioners may not respect the psychiatric client's own knowledge and meanings but instead "diagnose" a person as having a false consciousness and then arbitrarily pre-determine treatment goals and prescribe interventions (e.g., developing a critical consciousness). This authoritative anti-oppressive approach appears to fall into the same utilitarian trap in relation to CSD that concerns many critical/anti-oppressive theorists around traditional authorities or experts diagnosing a client with mental health and/or substance use disorders that negatively labels the person and then arbitrarily prescribing treatment to achieve pre-determined treatment goals (e.g., absolute abstinence with non-prescribed substances and absolute compliance with prescribed medications). Similarly, it

seems possible that judging a primary sense of self as needing to be arbitrarily changed or shifted towards a more nuanced sense of self in CDs treatment could arise for some people from reading this study, especially if the findings are supported in some way by future investigation. However, no matter how well meaning, arbitrarily trying to “force” a shift from a primary sense of self to a more nuanced one in CDs treatment would run the risk of having a disdain or disregard for the client’s personal knowledge, meanings of self, SD, and self-direction. Further, an arbitrary approach to transforming a person’s self in such a way is subject to being questionable in relation to workers’ social location and abuses of power in relation to the client. Finally, an arbitrary approach could, arguably, unnecessarily interfere with a person needing to regulate degrees of sense-of-self stability and risk mobilizing the client’s “being determined” component of SD to maintain or defend the way he or she is even more, both in the moment and with future attempts by others to help the person grow and change in relation to recovery.

The findings of this study suggest that the shift towards a more nuanced sense of self in CDs recovery was best described as hermeneutic in nature. Further study may find that it is a somewhat natural process for many people, including those with CDs vis-à-vis recovery (e.g., associated with notions of “maturity” or gaining “wisdom” with knowledge and experience). The challenge for clinicians would then be how to best nurture what might be a natural process of change in the sense of self, rather than either focusing exclusively on static states of stability

alone which runs the risk of stifling growth, or trying to force the dynamic process to occur in ways that interfere in the person's need to regulate degrees of self-stability with change. Outside of a highly directive temporary approach associated with crisis interventions and/or circumstances where immediate harm to self or others is imminent, one approach arising from this study could involve workers nurturing a hermeneutic circle between themselves and the person(s) they trying to help. An anti-oppressive hermeneutic approach in practice would not view any self-standpoint as inherently "false." It would guide the worker to bracket or be critically reflexive to his or her own beliefs/values and remain open to their own potential self-standpoint adjustments in a reciprocal therapeutic relationship with each client. Simultaneously, the worker can offer but not force on clients opportunities to: consider more critically nuanced or alternative anti-oppressive interpretations of past events; question their attitudes towards self and/or others; increase their awareness of the utility of their beliefs and values; join with the worker in more empowering ways; and explore self-advocacy individually and collectively. Ultimately, this worker-client hermeneutic circle could be helpful whether a worker holds a critical standpoint or some other perspective under-riding treatment interventions. It could also blend with hermeneutic experiential learning in other areas, support clients regulating sense-of-self stability simultaneously with growth and change, and, in turn, foster/uphold clients' subjective SD meanings in CDs treatment and recovery.

5.6 The Ecosystem and Sense of Self

The dimensions of the ecosystem were described by participants as an abstract whole at times (e.g., “the world”) and at times they were highly specific in participants’ texts in relation to SD. Generally speaking, dimensions were never viewed as separate entities but different aspects of them became more discernable in recovery (similar, for example, to the greater discernments of the self within his or her ecosystem). The biological or physical dimension of the ecosystem was occasionally mentioned but, other than in relation to Carmen’s spirituality, it was not generally an area of focus. Instead, people spoke more of “fused” physical/social spaces in relation to SD and CDs treatment and recovery. Being in a different social/physical space was sometimes associated with crises among many of the participants and the subsequent decision to pursue CDs recovery. However, consistent with other cautions about arbitrarily creating instabilities of self in treatment, forcing or directing people to be in a different physical/social space and thereby experience self-instability appears to carry a high degree of potential risk. This finding does suggest that having voluntary residential treatment options available for people with CDs is warranted (i.e., choices for people to place themselves in therapeutic physical/social spaces). Both Alexis and Susan spoke highly of residential programs that integrated addiction and mental illness treatment when they chose to attend. Unfortunately, integrated CDs residential treatment programs are few in Ontario as services associated with both the mental health and addiction treatment systems have moved towards primarily

community-based services. Voluntary therapeutic hospital stays appear to be increasingly rare. There is currently no fully publicly-funded voluntary hospital or non-medical residential programs that I know of as a practitioner with a waiting list of less than six to twelve months, in Ontario, that provide integrated intensive residential treatment (rather than just stabilization or withdrawal) for most co-occurring presentations of severe mental illness and addiction.

Finally, as mentioned in Chapter Two, critical/anti-oppressive theorists in social work may challenge the use of “ecosystem” as under-representing the fundamental integration and interactions of people in social relationships, especially in terms of overlooking asymmetrical structural power and control issues faced by some people but not others (e.g., based on gender, age, ethnicity/race, sexual orientation, and/or disability). The notion of ecosystem in the context of this grounded theory metaphorically refers to the broadest inclusion of physical, psychological, social, and spiritual worlds that the self is integrated with and reciprocally interacting with. One benefit of using this broad view allows for the theory to remain as conceptually flexible, inclusive, or trans-theoretical as possible. Nevertheless, the interpretation of the self and the ecosystem being separate and transactional rather than fundamentally integrated and interactive, as well as blurring asymmetrical structural power and control issues between the self and the ecosystem, are dangers associated with the presentation of the organizing concept as “the sense of self within his or her ecosystem.” A final risk may be that readers will assume that the grounded theory

is located within ecosystems theory overall, rather than within a more complex chaos systems perspective.

5.7 Standpoint of the Self

The use of the term “standpoint” in the theory reflects a participant’s subjective perspective associated with a position in time and space from which the self and participants’ relationships with aspects of his or her ecosystem are viewed and understood. The standpoint encompasses the past (e.g., memories and their meanings in relation to beliefs, values, and attitudes), present (e.g., sense of control), and future (e.g., expectations and aspirations). As mentioned above, the SD standpoint shares many qualities with social constructivist theories and practice models in psychology and social work. The standpoint is grounded in the unique perspective of the person at any moment in time and context. It shares a relativistic view with critical *feminist standpoint* theories (e.g., Harding, 1991) and is inclusive of many critical theory principles; however, it is not specifically organized around critical theory. Using the term “standpoint” emphasizes subjective personal viewpoints and their associated interpretations of meanings.

In addition to standpoint, other theoretical terms were considered such as *identity* and *personality*. However, the grounded theory is, arguably, conceptually inclusive and flexible or trans-theoretical and both terms are closely associated with constructs of discrete predictive theories such as *identity theory* in sociology and *social identity theory* or *personality trait* theories in psychology. Identity theory in sociology holds a more environmentally deterministic or absolutist view

than this grounded theory. It suggests that society defines the individual person in terms of social roles, the roles provide individuals with self-meaning, and influences their behaviors through these roles (Hogg, Terry & White, 1995). Role positions are often hypothesized as being hierarchical in nature and people are more committed to some of their roles than others (Stryker, 2007, p. 1092). Social identity theories in social psychology are based more on socio-cognitive processes of individuals and groups. They focus mostly on trying to explain group processes and “inter-group” relationships through social factors determining peoples’ perceptions and actions (e.g., Tajfel & Turner, 1979; Hogg, Terry & White, 1995). For example, these theories share assumptions that people fall into, and feel they belong to, various social categories (e.g., gender; class). Category memberships provide a self-definition of who one is and set normative expectations as to how members should think, feel, and act. Perceptions of other members are “stereotypical and normative” while those who are not included become “others” who are stereotyped in ways that can contribute to, among other things, stigma and discrimination (Hogg, Terry & White, p. 260).

In contrast, personality theories suggest that identity and self-concepts are related to “dispositional structures of traits” internal to individuals (Stryker, 2007). According to Sheldon Stryker (2007), traits are considered to be relatively stable across time and context and encompass an individual’s patterns of emotions, thoughts, and behaviors. A “big five” set of traits are often studied:

openness, conscientiousness, extraversion, agreeableness, and neuroticism (e.g., McCrae & Costa, 1994).

The above theories have a number of facets that overlap somewhat with this study's standpoint component of SD meanings (e.g., development and role of attitudes towards self and ecosystem). However, the overlaps appear to fit better with participants' primary sense of self. At least partly, they may reflect socio-cultural contexts in which many of the models mentioned above were developed. Historically, a Western sense of self would have been, arguably, more subject to social forces and structures that expected, facilitated, enforced, and reinforced a potentially more static sense of self throughout one's lifetime. This included leading psychological assumptions of the day that were, and continue to be, challenged (e.g., Gilligan, 1982).

One of the strengths of this grounded theory is that it provides a more holistic framework for helping understand SD meanings. However, it does not assume what subjective individual standpoints or, in turn, SD meanings should or would be, outside of the suggested trend towards becoming more nuanced over time. Consequently, the theory does not appear to exclude other self-standpoints than what was found among participants, such as those more fundamentally based within a family, tribe, clan, cultural group or other community found among various meanings of selfhood across different cultures (Bukobza, 2007). As a result, the grounded theory does not appear to exclude more group-oriented or social "membership" meanings of SD that may be found (e.g., Falck, 1988;

Ramsay, 2003). Similarly, the theory does not appear to exclude self-standpoints different than those found in this study, such as those organized more around social roles, age, gender, class, sexual orientation, race/ethnicity/culture, geographical location, and other forms of disability.

5.8 Determining Processes: Decision Making

Decision making and knowledge building are the two categories of the *determining* component of SD meanings. Making “right” decisions in recovery was of utmost concern to participants. People believed that one must learn for his or her self how to make their own “right” decisions in their recovery, and that it was impossible for them to always know ahead of time what was the right thing to do. These references place experiential learning ultimately at the heart of people being able to self-determine what “right” decisions are for them.

Participants acknowledged that there is a need for collectively set and enforced limits, directives, controls, and boundaries to help regulate the effects of people being self-determining and self-directing on each other. Further, all viewed the need to set controls and enforce limits as legitimate in situations of severe crises or when people were in immediate harm, provided these measures were temporary and took into account the context. Most external limits or controls on their decision making were viewed as being legitimate in relation to subjective notions of “fairness.” Greater understanding of meanings of “fairness” in relation to limits or controls on SD meanings and self-direction may help inform practice further in this area.

Participants thought that a key for them was to learn to make their own “right” decisions in relation to CDs recovery and that actually making decisions and learning from outcomes was the optimal way that they gained knowledge and experience in this area. This also facilitated protecting themselves from others, including professionals, when they are uncaring, biased, or outright malicious in intervening with them. The findings support social work’s CSD meanings in terms of upholding or fostering clients’ experiential learning through self-determined decision making (e.g., Soyer, 1963).

At the same time, all participants except Sam spoke at length of the difficulties they had in the past with making right or “good” decisions. This issue remained Colleen’s most difficult challenge in her recovery. She spoke of continuing to feel overwhelmed, confused, and frightened of making decisions in her life and would often delegate her decision making to others. She also used to resent the people that she automatically delegated to more in the past – now she sees this as part of a major pattern she continues to struggle with. This issue of being overwhelmed and confused by having so much autonomy or freedom and, in turn, choices was a main point of American psychologist Barry Schwartz’s notable critique, *Self-determination: The tyranny of freedom* (2000). However, as Colleen exemplified, participants’ meanings of SD were not simply synonymous with, as Schwartz assumed, autonomy or freedom. Understanding clients’ subjective SD meanings, rather than make such assumptions, would, arguably, help workers more ethically and effectively match their influence and activities

vis-à-vis helping clients such as Colleen with decision making processes in recovery, both in the present and with experiential knowledge building in mind.

Finally, making “right” decisions is not just an issue for people with CDs. It is also a key issue for professionals in making mental health and substance use diagnoses and treatment decisions. For example, Howard Garb (2005) reviewed three problem areas in making “right” psychiatric diagnoses and treatment recommendations: (1) using an “affect heuristic” process that involves emotionally-based automatic shortcuts in reasoning that may be positively associated with clinical intuition, but may also be associated with biases; (2) making diagnoses by comparing unique individuals to “hypothetical prototypes”; and (3) making diagnostic decisions underpinned by clinicians’ ambient preferred causal theories. Making “right” decisions appears to be a challenge for all people at different times and to varying degrees, including professionals. Social workers who are critically reflexive to, but not paralyzed by, their own difficulties in making “right” decisions may have more empathy for CDs clients’ struggles in this area, give them more opportunities to collaboratively practice, and more safely help clients evaluate outcomes in the spirit of promoting and upholding their meanings of SD.

5.8.1 Rational Decision Making

The function of emotions/moods in decision making and problem solving has long been an area of debate and discussion in philosophy and psychology (e.g., Plato’s thesis that reason needs to harness desire). For example, *Subjective*

Expected Utility (SEU) theory is the basis of most theoretically prescriptive approaches to applied decision making and problem solving in Western society (Simon et al, 1986). SEU theory assumes that conditions are ideal in terms of maximizing rational or logical decision making and involves heuristic searches for information that start out wide and then cuts problems down in size through using some sort of means-ends or cost-benefit analyses. Simon et al (1986) suggested that empirical research on decision making shows that we cannot rely on ideal generalized assumptions in a real world. The authors noted how studies were showing that dynamic micro-contexts of perceived risk and uncertainty or high ambiguity result in decisions that do not follow SEU predictions (e.g., “dilemmas”). They argued that feedback was essential to learning and that feedback and learning were keys for understanding decision making that is required for continuous adaptations to dynamic, risky, and ambiguous real-world environments. Oliver John and James Gross (2004) suggested that emotions/moods are viewed in Western society as either irrational forces that are destructive or else they are a repository of “wisdom” that functionally help us negotiate life’s myriad of challenges and dilemmas (p. 1302). The emphasis on rational or cognitive problem solving over emotional sensations in problem solving and decision making is found throughout mental health and addiction theories and practice models (e.g., Wills & Holmes-Rovner, 2006). Problem solving and decision making difficulties among people with more cognitive than emotionally-based problems, such as those associated with symptoms of dementia

or psychosis, are dramatic. However, Antoine Bechera (2004) argued that people make decisions among choices not just by cognitively attending to consequences and probabilities but also “primarily at a gut or emotional level” (p. 30). He supported this opinion with studies of people with certain brain lesions that damaged their emotional processing but not their basic cognitive functioning centers. These studies found that such people who must rely on cognitions have impaired day-to-day decision making capacities. Bechera believed that emotional processing is strongly associated with memory. Thus, it provides an important experiential learning and self-knowledge component necessary for optimal decision making and problem solving, especially when preferred or expected outcomes are highly uncertain or ambiguous.

As mentioned in the literature review, patient and/or professional decision making has been of utmost interest in current medical ethics and operationalizing patient SD or autonomy (Kaplan & Frosch, 2005). Euthanasia/end-of-life debates and decision-making processes, including advance directives and living wills, were mentioned in the literature review as operationally important to notions of patient SD in health care. Limiting the SD of people in these cases is often associated with professional judgments of the “capacity” of clients to make decisions based on a rational or logical standard. However, evaluating such decision making is rife with dilemmas associated with the perspective of the decision maker (e.g., the affect heuristic mentioned above) and subjective interpretations by some as to a patient’s process behind making a particular

decision or the overall rational capacity of the person to make decisions in the first place.

The findings of this study illustrated a number of examples of such dilemmas. For example, Carmen's decisions as an adult, until her thirties, to avoid treatment may have appeared to be irrational until one learned of the abuse she experienced when she was young at the hands of a psychiatrist. Many of the right decisions people made were very spontaneous and appeared to be based as much on a gut feeling, instinct, or emotion associated with past experiences as they were to any rational cognitive deliberations. Most of the catalytic self-ecosystem experiences appeared to be associated with non-rational based decisions, including protecting children or pursuing treatment for addiction. Perhaps there needs to be a greater discussion in the CDs treatment literature in relation to how dangerous it is to trust an initial impression that a person's decision making is "dysfunctional" if it is not obviously rationally based. For example, there may be a generalized bias in relation to non-rationally based decisions as always a pathological expression of an addiction. The findings do not support such an absolutist assumption despite the fact that participants identified addiction and/or mental health symptoms often did play a "nefarious" role in their decision making. Not assuming that clients' self-determined decision making was dysfunctional if not immediately understood was an important facet of the writings of Carl Rogers (1961) and the humanism movement in psychology and social work. This view continues today with many clinical frameworks such as

those associated with constructivism (Berlin, 2002), motivational interviewing (Miller & Rollnick, 2002), and strengths-based practice (Brun & Rapp, 2001). Perhaps regulating self-stability simultaneously with experiencing if not pursuing growth and change plays a functional role in CDs clients' decision making that appears superficially illogical, paradoxical, or self-defeating to others?

Nevertheless, the nuanced sense of self in CDs recovery was found to be associated with a greater use of cost-benefit analyses and other rational decision-making strategies and a greater balance between, or integration of, both cognitions and emotion/mood in problem solving and decision making. Greater balancing also is suggested in recovery in relation to reactive and reflective decision making. The primary sense of self among most participants appeared to lean more toward being reactive (e.g., automatic decisions to avoid, escape, or run from serious problems) in terms of basing "right" decisions on their own cognitions, emotions, or others' influences. Some emotionally based decisions to run or avoid appear functional and rational given their development as part of the primary self when young (e.g., less socially-designated powers given to them to advocate for themselves and fewer skills experientially learned to do so). Still, the majority of participants spoke of avoidance or "running", for example, as a pattern into adulthood that no longer was seen as necessary or functional in recovery as it might have been in the past. More situationally relative, compatible, and discerning views of both their own thoughts and feelings, as well as the influence of others, seemed to help participants see more choices, fear mistakes or

uncontrollable outcomes less, and better balance their cognitions, emotions, and the influence of others in their problem solving and decision making overall.

Many people with mental health issues that involve intense, unpredictable feeling states, arguably, face a great challenge with balancing feeling states and cognitive processes in decision making. It appears that treating CDs may need to specifically incorporate helping people to better understand, manage, or regulate his or her feeling states (i.e., emotion/mood literacy or emotional intelligence) in relation to SD and decision making, but not to reject them outright.

There is a trend in therapy to re-evaluate the role and benefits of emotions/moods in day-to-day functioning (e.g., Greenberg, 2004). Some psychosocial programs for people with borderline personality disorders also focus more on the condition as a spectrum emotion management issue and treatment involves helping people better regulate feeling states in concert with their cognitive processes and behaviors (e.g., Linehan, 1993; Blum, Pfohl, John, Monahan & Black, 2002). CDs treatment that seeks to help people gain greater self-understanding and self-management of emotions/moods in concert with rationale decision making processes, in relation to both their mental health and substance use issues, appears to be a rich area to explore more in terms of integrated CDs treatment.

5.9 Determining Processes: Knowledge Building

Hermeneutics has its origins in Biblical studies (Flew & Priest, 2002). As opposed to God speaking directly to people without interpretation (i.e., divine

revelation), early Biblical scholars looked to meanings of scripture to emerge more fully over time through repeated reviews of the Bible interspersed with periods of reflection and periods of focusing on day-to-day tasks (Kezar, 2000). In the twentieth century, the philosopher Martin Heidegger (1889-1976) adapted the hermeneutic process to the task of gaining greater understanding of phenomena. Heidegger suggested that all meaning and shared understanding hinged on language and interpretation occurring in a circular process of pre-judgments, corrections, new questions, new pre-judgments, corrections, and so forth (i.e., the hermeneutic circle). Hans-George Gadamer (1989) emphasized hermeneutics in phenomenology research methodology, describing it as a never-ending spiral of greater understandings. Heidegger built his perspective on the work of Edmund Husserl's descriptive phenomenology. Husserl (1859-1938) viewed reality as not completely separate from a person's perceptions. One critical feature of Husserl's work is the idea of bracketing or suspending temporarily one's own beliefs, biases, assumptions, and/or theories of the physical world in order to better describe essences of phenomenon as unique from others (Lavery, 2003). Hermeneutics has since been used to explain a number of processes of the human condition, including the self (e.g., Ricœur's theory of narrative identity mentioned above) and the occurrence of mental health problems. For example, Guy Widdershoven and Ron Berghmans (2006) refer to hermeneutics as a way of understanding how we learn, how we make sense of our lives, how we make decisions, and, consequently, how it is fundamental to our mental health overall.

They refer to mental health “breakdowns” as a sudden shattering of a person’s presuppositions or current hermeneutic pre-understandings of self and the world because of some critical failure to make sense of an experience or circumstance that he or she is in. Developing a more “nuanced” sense of self may be one outcome of new understandings arising from the pieces of the shattered pre-understandings, which hermeneutics suggests will occur and which “saves” or reconstitutes the continuity and coherence of the sense of self.

This grounded theory suggests that the primary sense of self is characterized by mostly ambient SD-related processes, being determined power, and largely unquestioned standpoint of self elements. The hermeneutic positive feedback loop that banks self-knowledge is assumed to be occurring at all times, both gradually and/or suddenly. The more nuanced sense of self in CDs recovery is characterized by more consciously self-directed hermeneutic knowledge building through greater awareness and reflection of self-standpoint elements (e.g., greater awareness and questioning of internalized beliefs/values about addiction and mental health), potentially reinterpreting meanings, pursuing targeted external technical information, further reflection, questioning and potentially translating technical information into personal meanings that is banked as self-knowledge, and so on. The hermeneutic circle with respect to participants’ SD meanings in CDs recovery is particularly interesting in terms of most participants’ references to addictions. For example, participants saw their addiction-related substance use or behaviors as helping in some way, such as

enhancing their sense of control and/or facilitating belonging. Later, most described their addictions as gaining control over his or her self and becoming a threat to his or her stability or survival. This change in perspective contributed to decisions to address addictions and/or persisting mental health/mental illness issues.

Widdershoven and Berghmans' (2006) view of mental health crises as a "break" in a person's hermeneutic circle appears to fit particularly with Teresa's description of how she followed the "rules" as a child ward of CAS, succeeding in achieving her aspirations of having a home and family by following these rules, but losing it all when her marriage ended and she could not "fix" it. She believed that this experience was critical to her "breakdown" in her late thirties that was associated with being hospitalized for the first time for mental health reasons and subsequently developing a drinking problem. She spoke of looking back at her childhood and deciding that she missed something as a teen by adopting and pursuing her goals and aspirations the way she did. Identifying that she had been missing something was important in terms of picking of the pieces of her life and making her own sense of how the rules failed her, how her aspirations were lost, and how she struggled to adjust her view of her self and others in ways that could be more conducive to improving her quality of life. Susan's crisis, hospitalization, and diagnosis of differential identity disorder could also be viewed, in this light, as an even greater fragmentation in her self's stable hermeneutic-based narrative coherence and continuity.

5.9.1 Catalytic Self-Ecosystem Experiences

Studies of natural change for people in terms of recovery from illnesses, including mental illnesses and addictions, make reference to sudden recovery-oriented shifts. These references could be in terms of “spontaneous remission” of symptoms or problem behaviors (e.g., Melfi et al, 1998; Walters, 2000), “epiphanies”, or “turning points” associated with narrative meanings of illness and the self in relation to the past, future goals, relationships with others, treatment, and recovery (e.g., Charmaz, 1991; Frank, 1993; Verghese, 2001). Twelve step programs such as Alcoholics Anonymous (AA), Narcotics Anonymous, and recent “double trouble” groups that have emerged for people with CDs also incorporate a similar notion of catalytic self-ecosystem experiences in their references to people hitting a subjectively perceived “rock bottom.” The experience of hitting this rock bottom is considered by many to be essential for people who have the “disease” of alcoholism or addiction to decide to reach out for help and pursue recovery through the 12 steps (Morjaria & Orford, 2002).

Change is often described in ecological terms as occurring in two ways. One form of change is slow and gradual and the other is sudden. The two are interrelated. For example, *ecological discontinuities* are defined as sudden changes in any property of a dynamic ecological system that occurs as a result of smooth and continuous change in an independent variable. If the pressure associated with the gradual change suddenly passes critical values that are called *ecological thresholds*, then the system will quickly shift from one stable state to

another (Muradian, 2001). This ecological view of both gradual and sudden change fits well with this grounded study's view of the sense of self as regulating relative self-stability and hermeneutic knowledge building associated with growth and change occurring simultaneously. Chaos theories also incorporate sudden unpredictable shifts occurring in patterns or fractals. Rory Remer (2006) referred to "bifurcation" as a splitting in two of the established pattern. If splitting happens slow enough or within the pattern's boundary limits then the system resources can accommodate the new conditions and the relative stability of the trend is maintained. However, if conditions are not met then a "bifurcation cascade" occurs. In the event of a cascade, then the system reorganizes into a different, although sometimes similar, pattern around a different strange attractor. According to Remer, an alternative outcome of such a cascade is the system becoming truly random and out of control in terms of any pattern or trend.

In relation to this study, a participant's narrative coherence and continuity might be protected in order to maintain relative sense-of-self stability. SD meanings and self-direction would reflect this need or goal. New experiences that are continually occurring could then be interpreted to fit the established narrative in relation to maintaining self-stability. However, if an accumulation of experiences that somehow pressured the established primary narrative build up (such as around attitudes of trust towards others), then a threshold could be passed, a cascade could occur, and the person will need, instead, to adjust the subjective past and future narrative as a whole in order to regain a new relative

degree of self-stability (organized around a new strange attractor such as trusting others more, less, or in a more nuanced way depending on the respective initial pattern or trend). A single event would then be experienced as “the straw that broke the camel’s back” even though it may be associated with a cumulative buildup. Consistent with chaos theory, these apparently sudden pattern shifts could happen in any direction. Whatever subjectively works for the person in terms of regulating or regaining degrees of self-stability, simultaneously with experiencing if not pursuing growth and change, would appear to be the outcome of such “grand” rather than “petite” shifts. A random, out-of-control, pattern “breakdown” or “fragmentation” could also conceivably occur without regaining a degree of relative self-stability, such as through reconstituting a coherent and continuous narrative. Arguably, another possible outcome for participants at many such complex, uncertain, and often shocking times was considering ending the self.

The catalytic self-ecosystem experiences, as recounted by participants in this study, overlap somewhat with this conceptualization of sudden discontinuities or cascades. Pressures that are building towards some threshold could be associated with the unique internal state, processes, and power of the self and/or factors or forces located within the person’s ecosystem. However, the grounded theory does not conceptualize the primary or nuance senses of self as objectively stable states per se in reality. As mentioned above, they represent artificial “snapshots” of a dynamic phenomenon and so perhaps better reflect relatively

stable phases of chaotic but not random trends associated with his or her sense of self.

Many participants had catalytic experiences that were not associated with dangerous crises (e.g., Brian's realization people would not always be so hostile to others who are different, when he first went to college), and also were associated with many participants' decisions to pursue CDs recovery.

Nevertheless, there were other catalytic experiences that were associated with life-threatening crises and suicide ideation. The findings of this study suggest that CDs treatment should endeavor whenever possible to support clients needing to regulate self-stability simultaneously with growth and change. Consequently, gradual or petite change appears to be safest because of the unpredictable nature of the outcomes of self-ecosystem catalytic experiences. This study suggests that understanding and integrating clients' SD meanings and self-direction in treatment through the collaborative matching of freedoms and structure or directiveness, except under exceptional circumstances, may be critical to regulating self-stability simultaneously with growth and change. Non-life threatening catalytic self-ecosystem experiences could still occur within this approach along the lines of Brian's suddenly feeling less marginalized at college or Susan's experience of needing to end her relationship with a substance-abusing boyfriend when she was at the intensive treatment program. It also means that crisis-associated catalytic experiences could still occur, such as when a client faces fairly applied authoritative limits based on safety issues. However, the

association with life-threatening destabilizations could, arguably, be lessened and certainly not be promoted as necessary for CDs recovery. The findings suggest that professionals could contribute to experiences that orient people towards CDs recovery by acting in caring, trustworthy ways and hermeneutically assisting in stability-regulation simultaneously with facilitating recovery-oriented activities.

5.10 Being Determined

The third component of the grounded theory's model of SD meanings in CDs treatment and recovery experiences is *being determined*. The pervasive nature and role of being determined in relation to this grounded theory's SD meanings is not inconsistent with Foucault's notion of power pervading all relationships. As mentioned in Chapter Two, Foucault's non-committal stance towards ideals of power in relationships argued that people have and exercise innate creative or "productive" power individually and collectively, but it cannot be objectively discerned as legitimate or illegitimate outside of the power-knowledge nexus underpinning such perceptions. Nevertheless, the findings are also not inconsistent with aspects of critical theory as participants did perceive legitimate and illegitimate uses of their own power associated with being determined, the power of other people they directly interacted with, and/or social system or structural powers. Other peoples' individual and collective determination in an interactive world was sometimes experienced by participants as being a source of mutual support and action. At other times the determination of others was an obstacle to recovery or even a threat to a participant's life.

Participants in recovery appeared to recognize in recovery more relative, compatible, and discerning ways in which other peoples' determination (e.g., in terms of other individuals', groups', and/or structures' power associated with their stubbornness, persistence, or dedication) could work collaboratively with them, be indifferent to them, or purposively work against them. Perhaps most important to SD meanings in relation to empowering practice, survival, and CDs recovery involve participants' descriptions of experiences associated with their power of being determined being somehow weakened, destroyed, or "lost."

The power associated with being determined also appears to overlap with notions of human will and willpower. Otto Rank's will therapy (1945) and the will's organizing function as the key to innate motivation in SDT were previously mentioned. There are many other views of will. For example, Mathew Gailliot and Roy Baumeister (2007) hypothesized that blood glucose is a physiological source of energy for the "will." Lower blood glucose levels are suggested as one important factor impacting on notions of low "will power" and, in turn, low self-control. It may be that the power associated with being determined is best understood in terms of an integrated multi-dimensional construct that integrates emotions, cognitions, spirituality (e.g., faith, hope), relationships (e.g., empowering communities) and physiology (e.g., oxygen, glucose). Participants' descriptions brought to my mind a form of "life force."

Professional terms such as "denial", treatment "resistance" or "non-compliance" may refer to issues associated with participants being uniquely

determined in treatment interactions. Miller and Rollnick (2002) state in relation to motivational interviewing that: "what fewer people appreciate is the extent to which change talk and resistance are substantially influenced by counseling style. Counsel in a directive, confrontational manner and client resistance goes up. Counsel in a reflective, supportive manner, and resistance goes down while change talk increases" (p. 9). Miller and Rollnick emphasized a blending or joining approach that does not give a client a need to mobilize their determination to fight against the counselor while simultaneously motivating and supporting the client's self-determined and self-directed change. The findings of this study support treatment approaches that do not automatically try to confront a person's power of being determined except under exceptional circumstances associated with crises involving risks of harm to the client and/or others. Instead, joining with a client's determination with respect to his or her goals and aspirations, along the lines of motivational interviewing, appears to be an appropriate initial stance, especially if regulating sense-of-self stability through SD meanings and self-direction is as important as this grounded theory suggests.

5.11 Recovery, CDs, and Substance Abstinence

Participants' notions of recovery focused more on improving his or her experience of living or quality of life than on finding cures for CDs or being completely abstinent from all substances that are often associated with addictions. Their view of recovery was largely congruent with recovery meanings associated with the mental health consumer/recovery movement that were reviewed in

Chapter Two. Some participants may have been influenced by the literature on consumer/survivor vision of recovery through their peer support involvement or they may have been influenced by my reference to mental health self-advocates' meanings of recovery in the Participant Explanatory Letter (Appendix I). However, Carmen never connected with peer support and she immediately assumed I meant "cure" when I first asked what recovery meant to her.

Participants' meanings of CDs recovery were not limited to abstinence from non-prescription psychoactive substances or to complete compliance with the use of prescription medications. The findings suggest that expert/authority expectations of absolute abstinence versus clients' relative, compatible, and discerning views of self-determined use/non-use of substances (that could include decisions to abstain and also could include prescription medication within the meaning of potentially problematic substances) may represent a potentially divisive or "wedge" issue in the development of integrated CDs treatment and recovery. For example, at the U.S. Center for Substance Abuse Treatment (2007) "National Summit on Recovery" in 2005, a working definition of recovery that could be used across systems, programs, and stakeholders (including CDs) was proposed: "recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life" (p. 6). Twelve guiding principles sought to clarify and operationalize the definition. One principle stated: "recovery is self-directed and empowering" (p. 7). The working definition appears to suggest that being self-

directing does not include self-determined decisions around continued use of substances associated in the past with problems and/or substance use that is perceived by others as an addiction risk in the future. The working definition's abstinence-only directive does not appear to conceptually fit with the more nuanced views found among participants or the SD/self-direction themes associated with the mental health consumer/survivor movement.

Not recommending abstinence may be viewed as tantamount to encouraging the use of potentially harmful substances among people already struggling with mental illness symptoms. Not recommending abstinence may also be seen as buying in to a person's subjective view of his or her use of substances that underestimates the potential risks of continued use or the seriousness of problems already occurring and/or being insensitive to the negative impact of continued use on society, family members, or loved ones (especially those who may be vulnerable such as children) (Marlatt, 1996; Marlatt & Witkiewitz, 2002). However, notions of personal responsibility that balances caring for self and for others found in both the findings of this study and mental health self-advocates' notions of recovery does, arguably, cover addressing self-determined controlled or moderate use of non-prescription psychoactive substances that are beginning to cause harm to self and/or others. This is an area that needs further examination. How the abstinence/compliance issue plays out may have a major impact on the development of integrated CDs treatment and rehabilitation theory and practice.

Harm reduction (Marlatt & Witkiewitz, 2002) is a more nuanced treatment stance than pre-determined abstinence/compliance-only ones. It typically includes abstinence/compliance recommendations but the approach does not expect an *a priori* commitment to it in order to begin to work with the client. Harm reduction in relation to CDs appears to have the potential to be congruent with mental health self-advocates' vision of a recovery that emphasizes SD and self-directed pursuit of improved quality of life. Harm reduction is supported by a relatively strong base of research evidence and it has been relatively well-accepted and practiced over the past fifteen years among community-based addiction treatment providers in Ontario (Hobden & Cunningham, 2006).

Alan Marlatt and Katie Witkiewitz (2002) suggested that abstinence-only goals continue to be pushed by U.S. institutional views of addiction treatment. To be sure, the possible risks associated with harm reduction and client-directed attempts to control his or her use of substances may be frightening if not excruciating in a variety of ways for workers, family, and/or loved ones. However, many of the difficulties associated with harm reduction and CDs, as suggested by the findings, may also have a lot to do with structural power/control issues, socio-economic agendas associated with managed care, and/or some absolutist views of addictions and mental health among practitioners. Canadian studies of harm reduction versus abstinence approaches specific to CDs recovery are needed given that much of American theory, research, and practice in this area appear to be out of step with many Canadian practice contexts.

5.12 Trust: Professional Diagnoses and Treatments

Participants referred to many experiences where they encountered mental health or addiction treatment deliverers as malicious, indifferent, out of their realm of knowledge or expertise, or else well-meaning but still not trustworthy in a variety of other ways. However, having participants maintain a healthy dose of distrust of professional services in CDs recovery is also well-founded in terms of the lack of trustworthiness, validity, or reliability of mental health and/or addiction diagnoses and treatments (Basco et al., 2000; Nath & Marcus, 2006). Whether problems with mental health and substance use disorder diagnoses and treatment are viewed from a critical/anti-oppressive standpoint (e.g., labeling and stigma) or from a positivist one (e.g., validity and reliability), the fact remains that they are rife with problems and risks for people seeking help. One area of concern is whether the validity of diagnoses is better found through seeing symptoms in functional or dimensional terms that can better take into account their heterogeneity rather than the current categorical approach (e.g., Muthen, 2006). Another concern is the degree of subjectivity in the interpretations of categorical criteria found in the DSM (Garb, 2005). Concerns associated with the influence of the affect heuristic, theoretical prototypes, and preferred causal theories in clinical assessment and treatment decision making were mentioned above (Garb, 2005). In essence, categorical psychiatric diagnoses are qualitative and are open to the same critiques as qualitative research findings such as those in this study. Categorical diagnoses are based on the subjective self-reports of people

experiencing problems, as subjectively interpreted against standardized criteria or methodology by trained and accredited professionals (this can include specialized social workers in the U.S and U.K.; it is restricted to physicians, especially psychiatrists, and some clinical psychologists in Canada).

In practice, psychiatric symptoms are well accepted as often cutting across categorical criteria and they are not amenable to technology-based diagnostic procedures such as x-rays and various blood tests that have helped advance physical health care diagnostics. However, psychiatric diagnostic validity and reliability is an essential component to treatment in the current managed health care environment. Managed care depends on cost-saving measures that include quick and accurate diagnoses in order to fulfill its promise of efficiently prescribing or recommending evidence-based treatment interventions as soon as possible (Basco et al, 2000; Shear et al, 2000). Clinically significant co-morbidity (e.g., CDs) adds significant tension to managed care's treatment planning tendencies because efficient algorithmic treatment planning naturally seeks to link treatment linearly with one discrete disorder (Shear et al, 2000).

Fortunately, research and discussion is focusing more on understanding problems with mental health and addiction diagnosis and treatment trustworthiness. For example, Shear et al (2000) examined the degree of agreement between psychiatric diagnoses through "routine" unstructured assessments by an experienced and accredited psychiatrist and diagnoses for the same people that were obtained using a structured standardized format for the

DSM-III (the Structured Clinical Interview or SCI). Participants were in the community and sampled from both an urban and rural location. They found that only 51% of the SCI and the routine diagnoses were in agreement for a mood disorder and this was the highest degree of agreement found among all disorders diagnosed. In terms of co-morbidity, they found that 53% of the participants had two or more current Axis I diagnoses identified by the SCI and 29% met the criteria for three or more. The formal study did not include common Axis II disorders such as personality disorders. However, the authors did use a standardized tool to estimate the prevalence among participants. They found that 77% of all participants and 91% of those with two or more Axis I diagnoses scored in the range that suggested they could also be given an Axis II personality disorder diagnosis. Finally, the study looked at substance use disorders. The SCI found 17 substance use disorders and the routine assessments identified 23. Among the same group, 14 of the 23 routine diagnoses were for alcohol but the SCI identified only 3 for alcohol among the same group. The SCI and routine diagnoses agreed on only six of the substance diagnoses.

Participants' experiences with being diagnosed reflected the confusion and disagreement involved in psychiatric diagnoses that the study above suggests. Such confusion among participants contributed to distrustful attitudes towards experts, especially when an expert's absolutist views were just the latest in a long line of previous, often conflicting, absolutist expert views. People eventually

translated the technical information into their own meanings that made sense to them and facilitated their own recovery goals and aspirations.

Increased diagnostic triangulation that included clients could, arguably, improve diagnostic validity and reliability for CDs. Basco et al (2000) studied diagnostic stability or reliability by using triangulated stepped approach The triangulated steps were: (1) routine diagnoses among 200 severely mentally ill outpatients; (2) interviewing the patients using the SCI; (3) the subsequent review of each person's medical records by a research nurse and potentially amending the diagnosis; and (4) a second interview by a research psychologist or psychiatrist who had reviewed the diagnostic data gathered in steps 1,2, and 3. They found that diagnostic reliability improved with each additional step and also was the most effective at identifying clinically significant co-morbidity.

Basco et al (2000) suggested that system-imposed and/or context-specific time limitations are major impediments to using proven ways to increase diagnostic accuracy. However, their study did not include clients or other important stakeholders such as family members being included in the triangulation process. Many argue that people receiving services hold important personal knowledge and should be routinely involved in developing and reviewing their psychiatric assessments (Sadler & Fulford, 2004; Flanagan, Davidson, & Strauss, 2007). Studies suggest that there may be some risks associated with confidentiality and potentially increasing confusion or worry for some clients or loved ones with increased triangulation, but overall the adverse

effects are minimal, increases in accuracy are gained, and the approach helps develop treatment partnerships (Cimino, Patel, & Kushniruk, 2002; Flanagan, Davidson, & Strauss, 2007).

A number of participants accessed some of their assessments. They found agreement with much of the content of the assessments they were able to read, found some errors of basic facts such as important dates, and also discovered some significant interpretative differences that could be associated with practitioner bias or stigma. For example, after Alexis' first hospitalization she was involved with another treatment agency. The agency helped her gain access to her hospital records which stated that she compulsively lied about her mental health symptoms because she was an addict. All participants said that they wanted and needed the option of accessing the technical record of their symptoms, potential diagnoses, and treatment options when they had self-determined to pursue CDs recovery; however, they were not willing to accept without question professionals' interpretations even when there was trust in the relationship. Bringing caregivers/loved ones into assessment and treatment planning (e.g., whenever possible, appropriate, and ethical vis-à-vis SD meanings) could also increase the rigor of clinical judgments and the coordination of collaboratively developed treatment plans.

Sara Nath and Steven Marcus (2006) suggested that research on the nature and impact of medical errors in psychiatry still lags behind most other medical and surgical specialties. Findings of this study, in light of diagnostic validity and

reliability problems reported in the literature, supports participants' distrust of treatment generally, his or her need for cautiousness when working with even trusted professionals, and the client safety dimension of upholding SD in CDs treatment and recovery activities even further. One way of operationalizing CSD in CDs practice as well as improve diagnostic trustworthiness could involve social workers writing CDs assessments in such a way as to fit the needs of the agency or interdisciplinary treatment team, but at the same time also write it for the client to read and provide opportunities for their contribution. Other than in exceptional cases, a focus on the client as the primary audience of, and important contributor to assessments, arguably, could: attune framing mental health and substance use issues in texts in ways that are sensitive to treatment collaboration and client dignity and respect; potentially increase rigor through client-worker triangulation; help people make better narrative sense of their mental health issues or symptoms of mental illness; facilitate a hermeneutic circle in terms of collaborative assessments, treatment planning, evaluations, and adjustments; and promote and uphold SD meanings and self-direction. Longitudinal studies are needed to confirm that greater diagnostic rigor and, in turn, improved outcomes are achieved through greater assessment triangulation that routinely includes clients – as well as potential difficulties that may arise and how to address them.

5.13 Support for CSD in Social Work

The findings support a number of historical arguments in support of CSD as a core concept in social work ethics and practice. Points mentioned above

include: (1) restraining social workers from arbitrarily limiting client freedoms in ways that risk harming the client or interfering in clients' abilities to protect themselves from risks associated with treatment; (2) restraining social workers from unnecessarily normalizing directive behaviors in client-worker interactions; (3) supporting client empowerment in CDs recovery, including individual and collective self-advocacy; and (4) upholding and fostering experiential learning and knowledge building (except in circumstances associated with crisis and obvious risk of harm occurring to self and/or others).

Participants' meanings of SD did not conform to any particular absolutist professional or philosophical perspective associated with individual autonomy, positive or negative freedom, or social communitarianism. Participants of this study held unique meanings of SD that ranged from generally emphasizing autonomy to more situationally relative meanings that reflected balancing SD rights and responsibilities in relation to his or her self and to other people, both specifically and generally in terms of "the world" or "society." Participants' SD meanings in recovery also typically balanced SD as defending their autonomy in relation to basic "survival" and SD as conditional or subject to limits in relation to self-growth or safely "living", which includes with others in a social world. Participants also reported that there were discrete times associated with risks and self-instability when they supported greater worker or social directiveness (as long as it was "fairly" applied) or they wanted the option of sharing their decision making with professionals, peers, family members or loved ones (as long as they

were trustworthy). Finally, participants said that their SD meanings in recovery shifted from their meanings in the past. The grounded theory conceptualized shifts in relation to the sense of self, regulating self-stability simultaneously with growth and change, and hermeneutic knowledge building.

Although further study that builds on these findings is needed; nevertheless, CSD in social work may be advanced in practice by placing an emphasis on understanding each and every clients' subjective and dynamic meanings of SD (e.g., as part of a generalist social work assessment), rather than trying to arbitrarily deduce and operationalize ideal, vague professional value statements that assume meanings of SD for clients. Taking this approach may identify and make use of a potential nexus around social work's concept of CSD and the mental health self-advocacy movement's vision of recovery which includes respecting service-recipients' subjective SD meanings and is inclusive of CDs. From this perspective, CSD in social work needs to focus more on how we work with clients' SD meanings and self-direction ethically and therapeutically. The grounded theory arising from the findings suggests that a social work focus on clients' SD meanings needs to include clearer statements about how the self is being viewed. Finally, this study suggests that it is feasible and worthwhile for there to be more of a research emphasis in social work into the concept of SD and CSD. A number of possible research avenues have already been suggested. This study's findings could also be built upon through exploring the subjective meanings SD among social workers working in the fields of mental health and

addiction, and the subjective meanings of stakeholders such as family members and loved ones of people with CDs.

5.14 SD Meanings in CDs Recovery: Policy and Practice

Policy and practice are interrelated. For example, as discussed above, mental health policy that privileges public and/or private managed health care values and principles has significant implications for diagnosis and direct treatment of mental illness, addiction, and CDs. Front-line service delivery through to regional and system programming and also research activities are ideally coordinated, evaluated, and improved through the platform and framework of mental health and addiction policy. The findings of this qualitative grounded theory study offer some potential considerations for CDs policy and practice.

5.14.1 Policy Implications: Mental health policy seeks over time to improve mental health overall and reduce the burden of mental health disorders in a population (World Health Organization, 2004). It sets out values, principles, goals, and a plan for action to achieve both an overall vision of the future and specific benchmarks. Two general trends have been mentioned in relation to recent mental health policy developments: (1) a greater integration and coordination of treatment and support among and between addiction and mental health systems and programs across Canada; and (2) more privilege being given to the perspectives and experiences of consumers of mental health and/or addiction treatment services and supports. Evolving traditional mental health and/or addiction policy that emphasizes treatment objectives of cure and acute

care to one that reflects a longer-term client-centered vision of recovery that is inclusive of CDs and respects subjective meanings of SD is complex to say the least. Nevertheless, it appears to be occurring in various ways and to various degrees across Canada.

A number of possible implications arise from this study that could be important in the current evolution of mental health and addiction policy. One involves recognizing that widely-held stigmatizing beliefs and values about people with addiction may undermine improving the overall burden of prejudice and stigma for the majority of people with mental illness, who appear to be at risk for developing CDs. Such beliefs and values are potentially also held by a number of treatment program developers and practitioners in mental health. It may also be found that there is a greater degree of stigma for some or all mental illnesses among addiction providers. Such beliefs within and between the two systems could sabotage overall policy evolution or lead to a selective approach to implementing a recovery vision that sidelines people with CDs or further marginalizes people dealing solely with addiction issues.

The findings also suggest that participants will ultimately make self-determined decisions about abstinence and use of various substances in recovery. These decisions are not restricted to substances normally associated with addiction, but include prescription drug use. A harm reduction approach to addiction issues is not inconsistent with policy values and principles that privilege SD within a client-centered recovery approach for people with CDs, as well as for

people dealing solely with mental illness issues. Similar policy values and principles of meeting the client where he or she is “at” in relation to SD meanings could also be applied to prescription medication compliance concerns within mental illness/CDs recovery.

A third policy implication is perhaps the most critical. Mental health policy may need to address what may be widespread distrustful attitudes towards treatment programs, services, and professionals. This distrust among participants was possibly associated with certain beliefs and values. More importantly, such distrust was often reinforced if not established by real-life experiences. Further data needs to be gathered in this area to inform policy and action needed to be taken, including whether this distrust is more prevalent among people with CDs than people with mental illness (e.g., there may be a relationship with the CDs stigma issue discussed above). Regardless, policy would need to address this obstacle if it is found to be widespread. Policy that guides practice to seek to understand client meanings of SD, work collaboratively with them as much as possible, help people make sense of expert/technical information regarding mental illness and addictions due to diagnostic and treatment validity/reliability issues, and be mindful of notions of “fairness” when applying limits to SD meanings could, arguably over time, help address this risk to people trusting reaching out for help.

5.14.2 Practice Implications: A number of practice implications have been mentioned throughout the discussion above. They include the possibility that

recovery-oriented CDs practice that is inclusive of peoples' SD meanings may need to focus more on the sense of self, in particular the self-standpoint elements, in relation to motivation, determination, decision making, knowledge, and experience (i.e., rather than focus solely on determination-related issues and processes such as motivation and decision making). A second implication is that CDs practice that attempts to work with or match with SD meanings among different clients may also need to adjust over time with changes in SD meanings. The grounded theory suggests that the changes will be towards more "nuanced" meanings. Thirdly, CDs assessment and treatment planning could potentially benefit from exploring substance use issues in relation to the aspirations and the sense of control elements of SD meanings. Practitioners could try to help clients discern differences and connections between their mental illness symptoms and substance use/misuse. Such discernments could help people see more recovery-oriented strategies to address addiction issues and mental illness symptoms separately and together. Finally, programs and practitioners might assume that the "normal" and potentially healthy attitude of clients towards them is one of distrust. Adopting this initial stance would hopefully lead practitioners to be mindful of the trust issue in relation to fostering, upholding, or "fairly" applying limits to peoples' SD and self-direction (after first understanding what they actually are). One question that might be helpful for practitioners to continually ask themselves in relation to trust, SD, and their clients' CDs recovery is: "How

do I want to be remembered by this client in his or her continuing story of living with and recovering from CDs?”

5.14.3 A Social Work Practice Model?: Although more thought, reflection, and investigation is needed; nevertheless, it may be possible that a social work practice model in mental health that is inclusive of CDs and is organized around SD-related principles and concepts could arise from this study's grounded theory. The theory's emphasis on subjectively-perceived dynamic states, processes, and powers associated with individual points of view would lead such a model to be primarily complementary to other treatment models and of heuristic rather than predictive value. The utility of such a model would also have to be carefully considered in relation to group and community development “client” modalities in social work. Still, key features of such a model could include:

- Viewing SD as a dynamic fusion of the subjective standpoint of self, determining processes, and the power associated with being determined about someone (including the self) or something.
- Recognizing the importance of understanding clients' subjective meanings of SD and self-direction in CDs treatment.
- Seeking to understand and respect, if not always agree with or uphold a client's subjective meaning of SD within his or her vision of recovery.
- Recognizing that clients' sense of self may be discernable from but is still

relatively integrated with their ecosystem and its dimensions.

- Recognizing that client SD meanings and self-direction may be involved in simultaneously regulating a need for degrees of relative self-stability with experiencing if not pursuing growth and change. Consequently, workers would need to understand clients' subjective SD meanings in order to consider the impact of upholding clients' SD meanings, fostering them, or limiting them within the dynamic context of CDs recovery.
- Recognizing that a subjective primary sense of self, and its expression through the components of SD meanings, can adjust over time gradually and/or suddenly.
- Recognizing that sudden adjustments in the sense of self may be associated with recovery-oriented self-determined change but they may also be equally associated with significant risks and dangers associated with severe sense-of-self instability. Consequently, gradual change is preferred whenever possible.
- Recognizing that the sense of self may shift in association with CDs recovery towards a greater attention to, and integration of, "nuances" of meaning of the self, dimensions of the ecosystem (and its relationships with the self), SD, mental health and mental illness, addiction, treatment, and recovery.
- Recognizing how much trust affects clients' SD meanings and

self-direction in treatment and how being trustworthy may facilitate the person self-determining to seek, accept, and collaborate with help in the future even if not immediately.

- Recognizing it is important for clients to potentially maintain a level of distrust of treatment and professionals, and to be able to be self-determining whenever possible, given systemic/structural risks to clients associated with asymmetrical powers in therapeutic relationships, the stigma associated with CDs, and the reliability/validity problems with mental health and substance use disorders' diagnoses and treatments.
- Not assuming that any individual client, regardless of cultural background, gender, age, sexual orientation, race/ethnicity, geographical location, other forms of disability and so forth holds to some theoretical or heuristic prototype vis-à-vis absolutist or relativistic views of SD, free will, determinism, individualism, or social membership.
- Ideal CSD statements of support for clients' wishes, desires, rights, and decisions being extended in practice to include wishes and desires vis-à-vis clients' unique and subjective meaning(s) of SD.
- Workers being critically reflexive to their own absolutist/relativist views and how these views may reflect their social location and influence the use of their powers in relation to CDs etiology, treatment, and clients' recovery goals and aspirations.

- Whenever possible, workers facilitating a reciprocal hermeneutic knowledge building circle between themselves and clients in relation to clients' SD meanings and their relationship to assessments, treatment options, evaluating treatment outcomes, and CDs recovery.
- Worker directiveness being applied transparently, temporarily, with attention paid to clients' perceptions of "fairness," and reflexively in relation to professional CSD values and CDs clients' recovery-oriented goals and aspirations.

5.15 Study Limitations

Epistemologically, the inability to generalize from the findings of qualitative grounded theory studies is not a limitation per se (Pidgeon & Henwood, 1997). The purpose of this study is not to suggest that the eight participants are representative of the millions of people living with and recovering from CDs across North America. Instead, the study sought to inductively explore in-depth the meanings of SD among a select group of people living with and recovering from CDs. This study's grounded theory seeks to provide a stimulating and disciplined inductive conceptual frame that is grounded in participant perspectives and is conducive to further reflection and systematic investigation.

Methods of enhancing the study's research rigor were outlined in Chapter 3. Methods included closely following research procedures as outlined by Strauss and Corbin (1998) and Charmaz (2006). Nevertheless, the study could have benefited from a greater variety of data gathering approaches or procedures (i.e.,

greater triangulation). One example would have been to ask participants to share any meaningful poems, prose, artwork, or other materials that could have been included in analysis (Appendix VIII is a poem spontaneously offered by the seventh participant sampled).

The study explored participants' understandings and the retrospective nature of their stories reflects how they have made meanings of experiences that informed their understanding of SD over time. Consequently, their recall potentially containing significant gaps, being significantly affected over time, and/or retrospectively reinterpreted is not so much a limitation as a part of the findings and the grounded theory. Finally, the small sample size represents another potential limitation as it was due partly to feasibility issues. However, grounded theory guides the researcher to sample until reaching theoretical saturation, which was considered to have been achieved.

CHAPTER SIX

Conclusion

I would like to conclude by stating that the experience of doing this study with the participants has affected me in ways I never could have anticipated. I have been focused over the past six years on working closely with people with CDs; however, doing the study took me somehow deeper into appreciating the courage and the challenges facing people living with and recovering from CDs. Perhaps this difference was associated with me not feeling I had a specific clinical role to play and I was there simply to listen and try my best to understand. Perhaps it was also associated with participants not seeing me as a clinician or that they were not talking with me within a clinical context. Regardless, I know it has made me a better social worker, counselor, and person. My acknowledgement of them at the beginning of this dissertation does not do them justice. I consider it a great privilege and honor that the participants shared with me their meanings and experiences. It is an understatement to say how much I respect their courage, wisdom, and SD.

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APPENDIX I

Participant Explanatory Letter

Dear _____,

Thank you for agreeing to participate in my study exploring the meanings of self-determination in treatment among people in recovery from co-occurring symptoms of mental illness and substance use problems. I am a Ph.D. candidate at Memorial University of Newfoundland, through the School of Social Work. For my dissertation, I am studying the meanings of self-determination in treatment and recovery experiences for people who have had to deal with both mental illness and substance use disorders (that is, concurrent disorders). I will also be exploring how these meanings may be similar or different from ideas of client self-determination in social work.

Self-determination can mean different things to different people. Many advocates in mental health promote a person-centered, person-driven recovery that includes treatment and support services respecting the person's own need and right for self-determination. This idea of recovery does not mean "cure," "fixing," or "controlling" people and symptoms. Instead, it is about finding personal hope, meaning, supports, and skills to improve one's quality of life despite the challenges of mental health or mental illness.

Each person is unique and will have a personal sense of what self-determination means for them and their own sense of recovery. For some it may mean having more control or power over treatment choices and treatment decisions. It may also mean feelings of being empowered and respected as an individual with respect to professional supports and services, from planning and developing policies and systems to fighting stigma to evaluating local programs and direct services. It could also mean something else entirely to others. I hope that through this study we can begin to develop a better understanding of the meanings of self-determination in treatment among people who are in recovery not just from mental health challenges but from concurrent disorders. It is my hope that this study will contribute to better understandings and collaborations between persons who are seeking recovery from concurrent disorders challenges, social workers, and other members of their professional support and treatment network.

As a valued participant in this qualitative research study, you are asked to take part in two audio-taped interviews conducted by myself. The first interview is anticipated to last about one and one-half hours long. The second interview is expected to occur shortly after the first and last about one hour to an hour and a half. In the first interview, I plan to ask a few questions about you living and recovering from concurrent disorders and how self-determination has meaning for

you through your personal experiences with treatment and support services. For the most part, I plan to leave the discussion very open and encourage you to share simply what you think is most important for me to know. In the second interview, I will share with you the information that I have drawn from your interview and ensure with you that it is accurate. I may ask some follow-up questions to clarify anything I may not be sure about or to understand more certain significant themes. You may also wish to add anything further that you feel is important but did not come up in the first interview. I will also offer at that time to arrange to meet with you once more to share with you the understandings arising for me from your interviews and the interviews of other participants. This will again give you a chance to give me your valuable comments and feedback as to its accuracy.

I have attached a consent form which outlines some of the precautions I have taken to ensure the respectful use of the information you share with me. The audio-tapes of interviews and their transcripts will be assigned a unique code number. Names and any other identifying features will be altered in the numbered transcripts, the thesis or any other written material arising from the study. As the researcher, only I will have the list of participant names and their identifying numbers. I will be the only person transcribing the audiotapes into written text. My three-member thesis committee through Memorial University will be the only persons other than myself with authority to access the audiotapes. They require this authority to access tapes to ensure the integrity and quality of the research project and the written thesis.

An advisory committee consisting of a maximum of 3 members will have access to the anonymity-protected numbered transcripts but not the audiotapes, participants' names, or any other identifying information. The advisory committee members are mental health peer support workers in another region of Ontario. The advisory committee will provide a peer/consumer support perspective that oversees and advises me on the research process, in terms of maintaining a respectful and ethical approach to the research process with participants, provide advice on relevant issues that may arise through data collection, and provide a check on potential biases of my interpretation.

The audio-tapes and transcripts will be used solely for research and will be kept locked in my home office. One year after the completion of the research, names, identifying information, audio-tapes, and other related research materials will be destroyed. As mentioned above, any participant information that is in the thesis text will be altered to remove any identifying features. Participation in this study is entirely voluntary. You are free to withdraw at any time during the research process and any information you provide may be removed up to the point that the thesis is approved for defense.

Although no harm is anticipated from your participation, it is possible that during the interviews some emotional distress may arise for you due to past experiences. Consequently, we will discuss a plan to ensure you are safe before and after the interviews. You are encouraged to stop the interview or move to another area of discussion if you feel the need to.

If you share with me that you were a victim of criminal or unethical behavior then we will discuss your options with respect to possibly addressing this unfortunate experience. I will support your decision-making control over what action, if any, you may wish to take. If there is a clear and present continuing danger to others, then I will collaborate with you to develop a plan that protects your anonymity.

If you should express concern about your immediate safety, such as suicide, or concerns about harming others then I will have a legal and professional responsibility to ensure you and/or others will be ok. I will discuss with you any concerns or responsibilities that I might have and try to come up with a plan with you. For example, this could involve me going with you to the nearest hospital's emergency ward. However, I may have an obligation to take action and this may involve me acting independent of your wishes, to ensure safety.

You may withdraw at any time from participating in the research project and if you wish, all information that pertains to you up to and including the time that my research is approved for defense will be destroyed.

Your participation in this study is greatly appreciated. You are the central contributor and I would be pleased to provide you with a copy of its findings if you wish. Professional supports and services for people recovering from not only mental health challenges but also from concurrent substance use issues have much to learn from the individual and collective experiences and meanings of all the people who share their knowledge with me.

Please feel free to call me should you need to discuss more details about any of the information give above. I can be reached at () _____. You may also discuss this research project with my thesis supervisor, Professor Dennis Kimberley. You can reach him at () _____ or by e-mail at _____.

The proposal for this research has been approved by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) at Memorial University. If you should have any ethical concerns about the research (such as the way you have been treated or participants' rights), you may contact the Chairperson of the ICEHR at _____ or by telephone at () _____.

As we discussed on the phone, I will be meeting with you in city on
date at
time at participant's preferred place to meet for our first interview.

I look forward to seeing you then.

Sincerely,

John Ostrander MSW Ph.D. (candidate).

APPENDIX II

Participant Statement of Informed Consent

I, _____ consent to participate in the research project exploring the meanings of self-determination in treatment among people in recovery from co-occurring symptoms of mental illness and substance use problems (that is, concurrent disorders). I understand the nature and the purpose of this project being conducted by John Ostrander is as a doctoral dissertation at Memorial University of Newfoundland, through the School of Social Work. I also understand that the purpose of this study is to expand the existing knowledge of the experience of self-determination in treatment for people recovering from concurrent disorders.

I understand that the interviews will be tape recorded and will be solely used for research purposes. I also understand that the audio-tapes and identifying information will be stored in a secure manner that protects my confidentiality and that of the other participants. I am aware that John Ostrander will solely transcribe the audio-tapes and that only anonymity-protected numbered transcripts will be shared with the peer advisory committee. I understand that John Ostrander guarantees that my identity will be disguised in any written materials originating from the study. Names, identifying information, and audiotapes will be destroyed one year following successful completion of the research. Anonymity-protected numbered transcripts will be destroyed after five years.

I have been informed that participation in this study is voluntary. I am aware that questions regarding the research process are welcomed. I am also aware that I can refuse to answer or participate in any portion of the research process. I understand that I can withdraw consent and stop my participation at any point in the research project and should I choose to do so, all information pertaining to me will be destroyed.

I have been informed that there is the possibility that I might experience some distress as a result of exploring past professional/personal experiences. I am aware that a safety plan will be discussed with me before and after interviews to ensure my wellbeing. I am also aware that the researcher may offer referrals for further support should the need arise.

I am aware that in exceptional circumstances such as if I become suicidal or intent on harming others in some way then John Ostrander has a legal and professional responsibility to ensure that I and/or others are ok. I understand John Ostrander will try to work with me to ensure safety but could also involve him acting independently. I am also aware that if I share being the victim of criminal and/or unethical behavior then John Ostrander will discuss with me my possible options

to address it. If there is a clear and present continuing risk to others then John Ostrander will collaborate with me to address the situation in a way that, if I wish, protects my anonymity.

I understand that the proposal for this research has been approved by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) at Memorial University. I also understand that if I have any ethical concerns about the research (such as the way I have been treated or participants' rights), that I may contact the Chairperson of the ICEHR at _____ or by telephone at (709) _____.

I acknowledge that I have read and fully understand the consent form. My signature indicates my agreement to voluntarily participate in this research. A copy of this consent agreement has been given to me.

Participant Signature

Researcher

Date

APPENDIX III

First Interview Guide: Question Pool

Self-determination (general):

- Does self-determination mean anything in particular for you?
- How would you define self-determination?
- How might it be similar or different to ideas about freedom or being free?
- How might it be similar or different to having control over choices and decisions in your life?
- Do you think it is a right? Can you tell me more about that? A responsibility? Can you give me an example? Is it an expectation you have of yourself or others have of you? Any examples?
- Is it a need in some way for all people?
- Are there ways in which we are mostly always self-determining, no matter what?
- Are there ways in which we are almost never self-determining, no matter what?

Mental health:

- Tell me about your struggles with your mental health?
- When did you first find yourself struggling?
- What happened?
- Tell me about your experiences with professionals?
- What did they do?
- Were you forced in any way to accept treatment? Can you give me an example?
- Do you feel you were ever tricked or manipulated? Can you tell me more about that?
- Were you ever not directed, guided, or even pushed in terms of treatment? What did you think of that?
- Were you diagnosed? If so, how many different diagnoses have you had?
- Were you informed and educated about any diagnoses?
- How do you feel about being diagnosed? Did it help in some way? Has it caused you problems?
- Were you ever given any choices about treatments?
- Does anything or anyone stand out for you as being particularly respectful of your choices? Can you tell me more about them?
- Were you able to make some decisions in your treatment experiences?

- Did you feel you had power or control over your life in terms of your mental health symptoms? In terms of treatment? In terms of dealing with professionals? Any specific examples?
- How do you define recovery in terms of your mental health?
- How does self-determination fit for helping you in your treatment and recovery experiences?
- Have there been times when your being, or trying to be, self-determining has caused you problems? In your interactions with treatment professionals? Can you give any examples?
- Has self-determination ever been a problem in your recovery in any other way?

Substance use:

- Tell me about your challenges with substance use problems? Can you give me some examples?
- When did you first begin to use substances?
- Was there a relationship for you between your mental health and substance use? Can you tell me more about that?
- Did you try to get any help for substances use problems? Examples?
- If you asked for help, how were you treated by professionals?
- What did they do? Examples?
- Were you forced in any way to accept treatment?
- Do you feel you were tricked or manipulated? If so, in what way? Examples?
- Were you ever not directed, guided, or even pushed to get help?
- Have you been diagnosed in terms of substance use problems? If so, what sort of diagnosis was it? Do you agree with it? Has it helped you in some way? Has it caused you any problems?
- Were you informed and/or educated about any diagnoses?
- How do you feel about being diagnosed? Did it help in some way? Has it caused you problems?
- Were you able to make some decisions in your treatment experiences?
- Does anything or anyone stand out for you as being particularly respectful of your choices? Can you tell me more about them?
- Did you feel you had power and control over your life in terms of your substance use? In terms of treatment? In terms of dealing with professionals?
- How do you define recovery in terms of your substance use problems?
- How does self-determination best fit for helping you in your treatment and recovery experiences?

- Have there been times when your being, or trying to be, self-determining has caused you problems? In your interactions with treatment providers? Can you give me any examples?
- Has self-determination ever been a problem in your recovery in any other way?

Co-occurring substance use and mental health disorders:

- What has been your overall experience with professionals, programs, services and so forth in terms of needing help for both substance use or addiction issues and your mental health concerns?
- Are there any similarities or differences between your recovery experiences with mental illness and with substance use problems?
- Are there differences between being self-determining in the treatment and recovery from mental illness and being self-determining in the treatment and recovery from addictions? Any examples?
- Are there similarities? Again, could you give me any examples?
- Are there differences or similarities in terms of mental health and addiction professionals and treatment services supporting, enhancing, or negating your ability to be self-determining? Can you tell me more about these?
- To what degree have you felt able to be self-determining while dealing with both mental health and addiction problems?
- To what degree have the combined problems created barriers to you being self-determining?

Gender and relationships:

- Are there any issues associated with being a [woman/man] that are important to you in terms of self-determination in your treatment experiences? Can you give me examples?
- Have relationships with friends, family, or loved ones affected your experiences of self-determination in treatment and recovery in any way? Can you tell me more about that?
- To what degree have these close personal relationships supported you in, or created barriers for you in some way, to you being self-determining in your treatment and recovery experiences?

Age, geographical location, social and cultural considerations:

- Do you have any feelings or thoughts about self-determination and the different ages you were when experiencing problems with symptoms of mental illness? Substance problems or addictions? Co-occurring mental health and substance use issues?
- Have you lived in many different locations? Have you any comments about the differences in where you have lived and your experiences with self-determination in your treatment and recovery experiences?
- Have you had treatment experiences with rural or city treatment services? Both? Are there any benefits or barriers in terms of self-determination in treatment between rural or city treatment services?
- Are there any cultural issues important to you in terms of your treatment experiences? How might they relate to self-determination for co-occurring disorders?
- What about any other areas affecting your treatment and recovery such as housing or employment and being self-determining?
- To what degree has housing and employment supported you in, or created barriers for you in some way, to you being self-determining in your treatment and recovery experiences?

Conclusion:

- Do you have anything else you would like to share with me about this topic of self-determination in your treatment and recovery experience?
- How has this interview experience been for you?
- Are you feeling any distress or concern about what we have talked about? About your confidentiality and anonymity? About the research project? About yourself?
- Are you ok? If later on, tonight or tomorrow, you are bothered in some way by some of the things we talked about or some of the memories from our discussion are there things you can do or people you can reach out to in order to help you feel better?
- Let's review your safety plan. Is there anyone else we could add? May I refer you to _____?
- You have my phone number? You can call me anytime if you have any further questions or concerns.
- Can we set up another time in the next two weeks to meet again so I can share with you the transcript of our interview and my initial analysis of this interview?

THANK YOU!

APPENDIX IV

Memorial

University of Newfoundland

Office of Research

November 20, 2006

ICEHR No. 2006/07-015-SW

Mr. John Ostrander
School of Social Work
Memorial University of Newfoundland

Dear Mr. Ostrander:

Thank you for your correspondence of November 9, 2006 addressing the issues raised by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) concerning your research project *"Self-determination meanings in concurrent disorders treatment and recovery experiences."*

ICEHR has examined the proposal and the revisions, and is satisfied that concerns raised by the Committee have been adequately addressed. In accordance with the Tri-Council Policy Statement (TCPS), the project has been granted full approval for one year from the date of this letter.

If you intend to make changes during the course of the project which may give rise to ethical concerns, please forward a description of these changes to ICEHR for consideration.

If you have any questions concerning this review you may contact the Co-ordinator for ICEHR, Ms. Eleanor Butler, at ebutler@mun.ca. We wish you success with your research.

The TCPS requires that you submit an annual status report to ICEHR on your project, should the research carry on beyond November 2007. Also, to comply with the TCPS, please notify ICEHR upon completion of your project.

Yours sincerely,

T. Seifert, Ph.D.
Chair, Interdisciplinary Committee on
Ethics in Human Research

TS/bl

St. John's, NL, Canada A1C 5S7 • Tel.: (709) 737-8251 • Fax: (709) 737-4612 • <http://www.mun.ca/research>

APPENDIX V

Review Prior to Beginning First Interview

Introduction:

Thank you for agreeing to participate in my study exploring the meaning and experiences of self-determination in treatment among people in recovery from co-occurring symptoms of mental illness and substance use problems.

- I am a Ph.D. candidate at Memorial University of Newfoundland, through the School of Social Work.
- I am also a clinical social worker working with people dealing with mental health and substance use issues through both an addiction agency and a mental health agency in another part of Ontario.
- For my dissertation, I am studying the meanings of self-determination in treatment and recovery experiences for people who have had to deal with both mental illness and substance use problems (that is, concurrent disorders).
- I will also be exploring how these meanings may be similar or different from ideas of client self-determination in social work.
- I am interested in how better understanding what self-determination in treatment means for people who have experiences living with and recovering from co-occurring mental health and substance use challenges, and how this understanding can help improve social work practice in this area.

All information you provide is confidential and your participation will be anonymous:

- Your participation is voluntary and you may withdraw at any time.
- You will be assigned a code number and this code number will identify any reference to information provided by you.
- Your names and/or identifying data will not appear in any part of the numbered transcripts.
- Only the thesis committee has authority to access audio-tapes to ensure research integrity/quality.
- The Peer Support Advisory Committee will only see the anonymity-protected numbered transcripts.
- No audio taping will be conducted without your expressed written consent [written consent signed and agreement to audio tape interview requested – if participant wishes not to be audio-taped than permission sought to take written notes during interview].
- Audio-tapes, face sheets, and other identifying information will be destroyed one year after successful completion of the study.

- Audio-tapes and written transcripts of interviews will be kept locked in John Ostrander's home office and your anonymity will be protected in any written reports and the dissertation thesis.

You may at times find some of the questions I ask farfetched, perhaps even silly, or perhaps difficult to answer:

- This is because ideas about self-determination may mean different things to different people or be appropriate for some but not others.
- There are no right or wrong answers. I am most interested in what you feel is important to share with me. I am only interested in your opinions, personal experiences, and what they mean to you.
- Feel free to interrupt me, ask me to be clearer or explain what I mean, criticize my questioning and so forth.

You may find some of the professional/personal experiences we discuss could upset you:

- If you share being the victim of criminal and/or unethical behavior then I will discuss with you your possible options to address it.
- I will respect your decision-making control.
- If there is a clear and present continuing risk to others than I will collaborate with you to find a way to address it while, if you wish, protecting your anonymity.
- If you become suicidal or intent on harming others I have a legal and professional responsibility to ensure you and/or others will be ok.
- I will discuss with you my concerns and responsibilities and try to work collaboratively with you to ensure safety.
- However, I could act independently to ensure safety.

Do you have any concerns about this?

- I have a safety plan form I would like to fill out with you.
- We can stop at any time to take a break or end the interview. Just let me know.
- Do you have somebody we could call if you feel you need some support after we finish?
- Is there anything else I might need to know to help make sure you are ok if you are in some distress from the questioning or the memories?

Given what we have discussed, do you still wish to continue?

<p>With permission, begin audio-taping and turn to Face Sheet</p>

APPENDIX VI

Participant Safety Plan

Some people interviewed may become distressed from being interviewed about their experiences with recovery and self-determination from concurrent disorders. Consequently, this form is intended only to help ensure that you are not left without any supports or people to reach out to, should your participation in this study cause you any difficulties immediately following the interview or even sometime later.

- Are you "ok"?
- Has being interviewed caused you any problems or distress in any way?

(Even if you haven't expressed any concerns, it might be best if we have a safety plan in place just in case some issues do come up for you later. I really want to be sure that you are going to be ok?).

1. _____ County Community Crisis Support: Phone number: _____
Address: _____

2. _____ Distress Line: Phone number: _____
Address: _____

Participant's Professional Treatment and Support Team:

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

Participant's Peer Supports (e.g., AA member/sponsor; mental health peer support, etc.):

1. Name (first only): _____ Phone: _____

2. Name (first only): _____ Phone: _____

Friends and/or Family Supports:

Referral to therapist/concurrent disorders worker requested?

If you have any questions or concerns about the study, do not hesitate to contact me at () _____. The proposal for this research has been approved by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) at Memorial University. If you have any ethical concerns about the research (such as the way you have been treated or participants' rights), you may contact the Chairperson of the ICEHR at _____ or by telephone at () _____.

Appendix VII

Peer Support Advisory Committee Consent to Participate & Agreement to Maintain Confidentiality

I, _____, consent to participate as an Advisory Committee member in the research project exploring the meaning of self-determination in treatment among people in recovery from co-occurring symptoms of mental illness and substance use problems (that is, concurrent disorders). I understand the nature and the purpose of this project being conducted by John Ostrander is as a doctoral dissertation at Memorial University of Newfoundland, through the School of Social Work. I also understand that the purpose of this study is to expand the existing knowledge of the meanings of self-determination in treatment for people who are recovering from concurrent disorders.

I understand that my role on the committee is to provide an advisory consumer/peer perspective to the research project. The three members of the committee will oversee and advise John Ostrander with respect to such areas as his maintenance of a respectful and ethical approach to the research process with participants, providing him with advice on relevant issues that may arise through data collection, and providing him with a consumer/peer support check on his potential biases in interpretation.

I am aware that John Ostrander will code transcripts and the information they contain, and that he guarantees that participant identity will be kept confidential and will not appear in any written materials originating from the study. I am aware that transcripts will be given a unique identifying code and that transcript identifying details will be adjusted to help disguise participants. I am also aware that participants are not from the area in which I work as a peer support worker. All names, identifying information, audiotapes and related research notes and materials, including those of the Advisory Committee, will be destroyed one year following successful completion of the research.

I understand that my participation is voluntary and that I may withdraw at anytime. I am aware that all transcript-related written materials are to be returned to John Ostrander at the end of any Advisory Committee meetings. I am also aware that I will be asked for my written notes, memos, or other written texts that I may have made during these meetings to become part of the research audit trail. I understand that these materials will be preserved and stored in a secure manner that protects the confidentiality of the participants while remaining part of the audit trail.

I understand that participant names will not be disclosed to me and that protecting the confidentiality and anonymity of participants is critical. I

agree that I will not share in any way information associated with participants, or any of the interview information shared with me as part of my Advisory Committee role, with anyone other than privately with John Ostrander, the two other members of the Committee, or the members of the Thesis Committee.

I also understand that the proposal for this research has been approved by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) at Memorial University. If I have any ethical concerns about the research (such as the way I have been treated or participants' rights), then I may contact the Chairperson of the ICEHR at _____ or by telephone at () _____.

I acknowledge that I have read and fully understand the consent form. My signature indicates my agreement to voluntarily participate in this research. A copy of this consent has been given to me.

Participant Signature

Researcher

Date: _____

APPENDIX VIII

Dear Crack

I hate you.
You are evil.
Now I finally see how you ruined so many lives,
caused such misery.

At first you were a game,
something I did for fun.
But I didn't realize,
the nightmare had just begun.

I'd smoke your sweet rocks,
exhale the smoke through my nose.
Every minute of every day,
on my life you imposed.

You took away all my pain,
at least that is what I thought.
When really it was my mind and my soul,
that you got.

I thought the 5 minute high,
with each hit I take,
was the best thing by far,
but that was such a mistake.

You took over my life,
you were everything to me.
I didn't care about anything else,
you never set me free.

I walked the streets all alone,
night after night,
making money for you,
each day was a fight.

You took me to places,
I never imagined I'd go.
Because you had me in your grip,
I hit an all time low.

Now that you are out of my life,
I don't miss you one bit.
You will never see me again.
You mean less to me now than shit

(Alexis)

