Order Number 9417480

Identity and recovery: Theoretical and empirical explorations

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City University of New York, 1994

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IDENTITY AND RECOVERY:

THEORETICAL AND EMPIRICAL EXPLORATIONS

by

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A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

1994

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

11/22/93
Date

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Abstract

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Scott Kellogg

Adviser: Professor Vera Paster

This dissertation examined, both theoretically and empirically, the role of identity in the recovery process from addiction. Using multiple identity theory (Deaux, 1991; Gara, Rosenberg, & Cohen, 1987; McCall & Simmons, 1978; Rosenberg & Gara, 1985; Stryker, 1968, 1981; Stryker & Serpe, 1982; Stryker & Statham, 1985) and the important theoretical and empirical work of Waldorf, Biernacki, and Stall (Biernacki, 1986; Stall & Biernacki, 1986; Waldorf, 1983; Waldorf & Biernacki, 1981), the process of identity transformation, reorganization, and creation was explored in natural or spontaneous recovery, the therapeutic community, the 12-Step programs, psychotherapy, and religious treatment programs. A core recovery model that emphasized the creation of an identity to compete with and replace the addict identity as a central self-concept was seen as a common process in these five healing approaches. The clinical utility of using identity theory in this way was also discussed.

The empirical section of the dissertation used the Social Identity Q-sort to test four hypotheses on the nature of the identity structures of recovering people with 63 alcoholic and/or addicted men in treatment. The findings showed the importance of the degree to which the subjects valued their addict and recovery identities.

A Q-factor analysis was also done to get a more subjective view of their identity structures. Two successful approaches emerged. The first emphasized a mixture of recovery and spiritual items, while the second emphasized recovery and family items. A core healing component, the Recovery Quartet, was found which emphasized the centrality and importance of sobriety and the connection to the treatment program and to the therapeutic experience.

The final area of discussion focused on the stages of change models of Schlesinger (1992) and Prochaska, DiClemente, and Norcross (1992) all of whom argued that the change or recovery process begins long before people enter formal treatment. Suggestions for further research were also discussed.

Acknowledgments

I would first like to thank my committee for all their help and support. Professor Vera Paster, my chair and mentor, has been a strong source of support and guidance throughout graduate school, and she was an inspiration in the design of the study. I am grateful for having had the opportunity to work with her. Professor Deaux's help was appreciated in my attempts to make a connection between social psychology and clinical practice, for providing me with a forum to discuss my work, and for her many helpful editorial comments concerning the dissertation text. Professor King's assistance was also valued both in the completion of this project and in my work as an adjunct lecturer.

Ilene Cohen, PhD, was both a reader for the dissertation and a clinical mentor for the past three years. Her guidance and supervision have been extremely valuable. Andrew Weintraub, PhD, was helpful as a reader, a clinical supervisor, and as the research sponsor at the Hospital.

A number of other people were quite crucial in the success of this venture, and I would like to acknowledge them as well. At the Hospital, Carmen Vasquez, PhD, Anatina Miescher, MD, Susan Egelko, PhD, Harry Breuer, PhD, and Harold Lifshutz, PhD, all gave generously of their time and expertise. At the Agency, Louise Teiga, RN, and

Mr. Eric Roth were both facilitators in the gathering of data at that site.

I received statistical help from Marc Glassman, PhD, Ora Ezrachi, PhD, and Hal Wilensky, PhD. Stephen Brown, PhD, was gracious enough to speak with me about Q methodology as was Dan Thomas, PhD. Crucial computer support and guidance was provided by Mr. John Atkinson, Mr. Sandy Fleischer, Mr. Evan Stark, Ms. Ann Reid, and Ms. Barbara Collins and her staff. The Identity Research Seminar and Ms. Iva Smith were both helpful in the development of the Q-sort.

Encouragement during difficult times came from Monty Cox, M. Div., and from Ana Ferreira, PhD, and their help was deeply appreciated. My family supported me completely throughout the dissertation experience, and I feel love and gratitude for my wife, Nadine Samanich Kellogg, my children, Chris and Noelle, my mother-in-law, Frances Samanich, and my stepmother, Barbara Kellogg.

Lastly, this dissertation is dedicated to the memory of my parents, Edward Cummings Kellogg and Nancy Kellogg Wyckoff, whose support was of vital importance during the graduate school process but who were, sadly, not alive to see its completion.

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Chapter one: Introduction and review of the literature

Introduction

This dissertation is both a theoretical and empirical exploration of the relationship between identity theory and recovery from drug and alcohol addiction through psychosocial methods. Building on the work of Waldorf, Biernacki, and Stall (Biernacki, 1986; Stall & Biernacki, 1986; Waldorf, 1983; Waldorf & Biernacki, 1981), the theory being promulgated here is that the experience of recovery is frequently and largely a process of identity creation and/or restructuring. The theoretical section begins with a discussion of the processes of recovery from addiction as seen through the lens of identity theory (Deaux, 1991; Gara, Rosenberg, & Cohen, 1987; McCall & Simmons, 1978; Rosenberg & Gara, 1985; Stryker, 1968, 1981; Stryker & Serpe, 1982; Stryker & Statham, 1985). Next, there is a review of Waldorf, Biernacki, and Stall's work on untreated recovery and Biernacki's (1986) examination of the therapeutic community (TC) (Deleon, 1989; Densen-Gerber, 1984). This is followed by an exploration of the change processes involved in 12-Step groups, psychotherapy with substance abusers, and religious treatment programs -- using identity theory as a guide. The hope is that this approach will reveal commonalities among seemingly disparate methods of treatment and will help to reduce ideological conflicts between methods -- most notably between individual psychotherapy and

participation in 12-Step groups (Clark, 1987).

The empirical section of the dissertation is an examination of the social identities of men in two full-time, outpatient alcoholism treatment programs -- one based in a large hospital in a major urban area on the East coast (the "Hospital") and the other in an agency (the "Agency") located in the same locale. The study looked at the identity structures of men who were in the beginning or orientation phase of treatment and compared them with the identity structures of those who were further along or in the program phase of treatment. The hypotheses, which were tested using a Q-sort, centered primarily on the differing positions of the addiction-based and recovery-based identities. In addition, a Q-sort factor analysis was done to further explicate the data.

Returning to the theoretical aspect of this work, while identity and addiction have been examined from sociological and social psychological perspectives, this dissertation (aside from a few suggestions from Biernacki [1986] and Stall and Biernacki [1986]) is perhaps among the first to look at the clinical utility of identity theory in helping people recover from drug and alcohol addiction and to propose that identity theory be given a central role in the psychosocial treatment of addiction.

Identity theory

Toward a definition

Identity theory (Deaux, 1991; Gara, Rosenberg, & Cohen, 1987; McCall & Simmons, 1978; Rosenberg & Gara, 1985; Stryker, 1968, 1981; Stryker & Serpe, 1982; Stryker & Statham, 1985), the theory underlying this dissertation, is a creative synthesis of social psychological and sociological work concerned with understanding the development and the nature of the self. The similarity of these two approaches has been in viewing this developmental process from a consistently social or group-based perspective. Identity theory is most immediately an outgrowth of role theory (Heiss, 1981; Stryker, 1981), and it emphasizes the more internal, the more psychological, aspect of role rather than its more external or structural aspect. In a broader sense, identity theory is part of the symbolic interactionist tradition (Blumer, 1970; Mead, 1964; Stryker, 1968, 1981; Stryker & Serpe, 1982; Stryker & Statham, 1985) with its emphasis on the reflective objectification of the self -- that is, the understanding that one can view one's own self as an object and that this self-as-object (or the "I" in a Meadean perspective) can be evaluated as one becomes an audience to one's self (McCall & Simmons, 1978). Finally, there seems to be an overlap between identity theory and reference group theory (Shibutani 1955/1968). The most striking communality here

is the shared emphasis on multiple group memberships and the importance of group ideology on individual belief, perspective, and action.

What is an identity? An identity is a self-conception, a self-definition, that develops out of "participation in structured role relationships" (Stryker & Serpe, 1982, p. 206). In contrast to Erikson's (1959/1980) work, which saw identity as a more unitary and global concept, identity theorists have emphasized the multiplicity of identity. Inasmuch as an identity develops out of membership in structured group relationships, an individual may have as many identities as they have group memberships (Stryker & Serpe, 1982). In the following discussion, the theory will be introduced in its complexity by examining: (a) the structure and organization of identities; (b) the social dynamic of identity; (c) the importance of belief and action; and (d) the process of identity change.

The structure and organization of identities

Two fundamental concepts of identity theory -- multiplicity and hierarchy -- were major areas of empirical interest in the study of the men at the Hospital and the Agency. Our understanding of multiplicity and hierarchy will draw largely on the work of McCall and Simmons (1978; McCall, 1977) and Stryker (1968, 1981; Stryker & Serpe, 1982; Stryker & Statham, 1985). These sociologists and social psychologists came to similar understandings of identities

independently and, seemingly, simultaneously (Stryker, 1981). McCall and Simmons emphasized that role-identities (their term for identities) were multiple because the individual has "one for each social position he occupies, aspires to occupy, or has imagined himself occupying" (McCall & Simmons, 1978, p. 73-74). Stryker and Serpe (1982) noted that "it is clear that persons may have as many identities as the number of distinct sets of structured relationships in which they are involved" (p. 206). In both cases, there seems to be a clear connection to the Meadean emphasis on multiplicity; as Mead (1964) himself commented, "a multiple personality is in a certain sense normal" (p. 207). The idea of structured relationships as a key component in identity formation has been central to the writings of other workers in identity theory. Thoits (1991) argued that "role identities are self-conceptions in terms of one's position in the social structure. . . . Specifically, role-identities are viewed here as self-conceptions based on enduring, normative, reciprocal relationships with other people. . . .that are ongoing. . . that are currently enacted. . .and that carry fairly clear rights and obligations in relation to others" (p. 103). The concept of structured relationships as a foundation for identity (as opposed to fantasied or "possible selves" (Markus & Nurius, 1986)) was important in the empirical study of identities.

Given the multiplicity of the self, the question that arises is how are these identities related to each other and how do they impact on cognition, affect, and behavior. Numerous writers have argued that identities are not random but are organized and that this organization, often in the form of a hierarchy, allots differing levels of importance to the identities in terms of their overall impact on behavior and perception (Burke, 1980; McCall, 1977; McCall & Simmons, 1978; Rosenberg, 1981; Rosenberg & Gara, 1985; Stryker 1968, 1981; Stryker & Serpe, 1982).

The identity hierarchy has been examined in different but overlapping ways by McCall & Simmons (1978) and Stryker (1968, 1981; Stryker and Serpe, 1982). McCall and Simmons have looked at the organization of identities in terms of two different hierarchies. The first is the prominence hierarchy (or "ideal self" [McCall & Simmons, 1978, p. 74]). This is the ordering of identities in terms of their overall importance to the individual. While this structure is amenable to change, all things being equal, the identities at the top will have the greatest impact on behavior and will be the guiding principles for the individual's life. This is because people seek to maintain their sense of self and self-esteem by supporting their identities and living life through them. In addition, the identities themselves help guide behavior.

The origin of the prominence hierarchy lies in

childhood. It develops "because parents and other important childhood audiences reward certain of the child's nascent role-identities with social approval and more or less discourage others" (McCall & Simmons, 1978, p. 216-217). However, as therapists have noted (Meador & Rogers, 1973; Sullivan, 1953), this process of reward and discouragement may not be attuned to the child's actual talents and weaknesses. While a child's ability to perform a social role may be a factor in gaining social support, it may not be necessary for the maintenance of the role. In addition, an ability in a particular area does not at all ensure support for that identity. The overall prominence hierarchy, pending changes due to later maturational experiences, will be a reflection of the general pattern of support and discouragement of the child's behavior.

Their second hierarchy, which will only be mentioned briefly, is the salience hierarchy. The salience hierarchy refers to the likelihood of any specific identity being called into play in a given situation. This is the result of the interplay between the demands of a given situation and social groups and the differing needs of the varying identities for validation. This means that those identities which are most prominent will not necessarily be invoked in a given situation. The focus of this dissertation and research, however, will not be on the more "situational self" but on the "ideal self" or prominence hierarchy.

While emphasizing the malleable nature of the prominence hierarchy, McCall and Simmons (1978) pointed out that "the over-all prominence of a given role-identity is, then, actually a weighted average of the average past levels of [experience with] several factors" (p. 77). The six factors they cited were self support, social support, intrinsic gratification, extrinsic gratification, commitment, and investment. Identities will also vary on the degree to which they are interrelated and cluster together.

Stryker (1968, 1981; Stryker & Serpe, 1982) examined the question of hierarchy primarily through the use of two factors -- identity salience and commitment. (In a potentially confusing choice of words, identity salience, as used by Stryker, was fairly synonymous with what McCall and Simmons called identity prominence. It was <u>not</u> similar to what McCall and Simmons called identity salience.) Stryker and Serpe (1982) wrote that identities may be organized

> into a salience hierarchy. This hierarchical organization of identities is defined by the probabilities of each of the various identities within it being brought into play in a given situation. Alternately, it is defined by the probabilities each of the identities have of being invoked across a variety of situations. The location of an identity in this hierarchy is, by definition, its salience (p. 206).

In addition, the position of one identity in the hierarchy will have an impact on the positions of the other identities (Stryker & Serpe, 1982) and "one can expect behavioral products [from a particular identity] to the degree that a given identity ranks high in this hierarchy" (Stryker, 1968, p. 560).

Reflecting Stryker's social emphasis, the position of a given identity in the salience hierarchy will be related to the level of identity commitment that exists. "Commitment is defined as the degree to which the person's relationships to specified sets of others depends on his or her being a particular kind of person, i.e., occupying a particular position in an organized structure of relationships and playing a particular role" (Stryker & Serpe, 1982, p. 207). Commitment itself can be seen as having two dimensions: (a) extensivity -- "the sheer number of relationships entered by virtue of an identity"; and (b) intensivity -- "the depth of the relationships entered by virtue of an identity" (Stryker, 1968, p. 561).

Stryker & Serpe (1982) developed a series of hypotheses to look at the interrelationship between salience and commitment. The core themes in these hypotheses appeared to be: (a) the greater the commitment to an identity, the greater its salience; (b) the more salient an identity, the more important to and the more positively valued by the individual; and (c) the greater the salience, the greater

its impact on behavior and self-esteem.

The social dynamics of identities

Identity theory continually promulgates the social nature of the self. The content of identity is certainly influenced by group membership. Breakwell (1986), in a passage that succinctly covered much of the terrain of identity theory, wrote:

> each individual is located within this matrix of networks, memberships and relationships. The content of identity will be assimilated from these structures in the social context. They each provide roles for the individual to adopt. They each generate systems of belief and value, which specify acceptable behaviours and attitudes. By establishing codes of value and morality, they also provide the criteria against which the evaluation process in identity must make its comparisons (p. 36).

This statement should be balanced, however, with the observation that identities are both dialectical and creative. That is, not only does the group have an impact on the individual, but also the individual has a role in determining what aspects of the group are internalized as well as having an impact on the group itself. He or she may change the group's beliefs, structure, or position, or he or she may leave the group altogether or start a new one. Backman and Secord (1968) have pointed out that people may

use "role selection" (p. 289) in their choice of roles or identities, and they sometimes have (or strive for) latitude in their "role portrayals" (p. 289) -- that is, the way they enact a particular identity may be quite unique.

Whatever the ratio of individual-group input into a given identity, identities need support. Deaux (1991) has suggested an ecological function for a group or series of groups in this regard. She feels that multiple memberships can provide "a system of support for particular identities" (p. 86). Building on this ecological construct, one can, perhaps, begin to speak about "identity niches" -- groups or psychosocial "spaces" that foster and develop particular identities -- perhaps in the face of a hostile environment (Levine & Perkins, 1987). This may well be a useful concept in an attempt to make therapeutic interventions based on identity theory. If recovery is a process of developing identities that will challenge and replace the addict or alcoholic identity, then the various forms of treatment under discussion -- therapeutic communities, 12-Step groups, psychotherapy, and religious treatment programs -- may each be seen as a niche for the development of a recovery identity. This niche idea is, perhaps, most starkly seen in programs working with "street" addicts who live much of their lives surrounded by other addicts. The structure of many therapeutic communities (i.e., with little or no contact with the outside world for the first month) may, in

fact, be an attempt to protect the niche and the fragile identities that are developing there. Similarly, Stryker and Statham (1985) (citing Dornbusch, 1955) wrote, "Changing self-concepts occurs through isolating persons from social relationships that validate and provide opportunities to cue behavior reflecting an 'old' self in some manner incompatible with a different self" (p. 327). In a related manner, the therapy hour, both with its nurturing of "possible" (Markus & Nurius, 1986) or "alternate" selves and its set structure (predetermined time and duration of session, confidentiality) may also serve to protect and accelerate identity development through the intensity of its process.

Belief and action

Identities are cognitive, affective, and behavioral guides to the self and the world. It is in the nature of groups that "each. . .arises at an interpretation of reality which suits its own interests and intentions" (Breakwell, 1986, p. 37). Thus, each family, church, workplace, or political group has its own world view or "assumptive world" (Frank, 1974, p. 27). It is here that identity theory and reference group theory (Shibutani 1955/1968) meet. Identity involves the individual's internalization of group norms and practices. This is clearly a complex process -- especially in a world where multiple-group memberships are the norm. The depth of an individual's allegiance to different groups

may vary and their belief systems may be similar, be in opposition, or apply to different spheres of activity. The hierarchy will, of course, reflect their general overall weight.

In addition, the group's beliefs may only be accepted in part by the individual, and the groups themselves may differ in the degree to which they require complete acceptance of their ideologies. A.A., despite stereotypes about the inflexibility of some of its members, has a slogan -- "Take what you need and leave the rest" -- that surely signals philosophical flexibility.

Identities run deep. Thoits (1991) noted that "role-identities should give individuals a sense of meaning and purpose in life and should provide behavioral guidance" (pp. 104-105). Heiss (1981) felt that identities may be a "guiding principle, a gestalt, perhaps a 'deep structure'" (p. 96), and Rosenberg (1981) pointed out that people may feel that they really "are" their identities. Their group- and identity-related assumptions may be such a part of them that they are unaware of them. An important part of psychotherapy is bringing these beliefs into consciousness and examining their validity and their effect on the patient's past, present, and future functioning. In terms of treatment for addiction, adherence to group ideology has been an important factor in self-help groups (Antze, 1976), religious treatment programs, and therapeutic communities --

the last being especially known for their intense resocialization processes (Gecas, 1981).

Belief systems are related to perceptions. Indeed, we see much of the world through our identities (Rosenberg & Gara, 1985), and we define and act upon what we experience in terms of its relation to and meaning for our identities and our plans (McCall & Simmons, 1978). Shibutani (1955/1968) pointed out that as we begin to change our reference group memberships, we become aware of things that we had not noticed before and that which was familiar may begin to seem strange.

Action is the sine qua non of identity, and action and identity are fundamentally dialectical (Breakwell, 1986). In one of the classic papers on identity, Foote (1951) argued for the primacy of identity over drives as the motivating factor behind action. He stressed the importance of group identifications in explaining behavior -- especially behavior involving great self-sacrifice. McCall and Simmons (1978) wrote that "role-identities. . .[can] serve as perhaps the primary source of plans of action" (p. 67). Stryker (1981) argued that self-conceptions "are the best indexes of plans of action" (p. 11).

Identity is the source of action, and action is also the expression of identity. Burke (1980) felt that "the action implications are the meanings of an identity" (p. 22). Not only does action express identities, but it may

work to help maintain them as well. Turner (1968) proposed that action may be either task-directed, identity-directed, or some combination of the two. McCall and Simmons (1978), in their discussion of what they called the salience hierarchy, observed that identities that need support will have a greater likelihood of being acted on. They also pointed out that a particular action can be relevant to and have an impact on a number of identities simultaneously.

Action is also a factor in identity formation. Turner (1968) stressed that one develops a sense of one's self and one's capacities and weaknesses in active and vigorous interaction with others. This self-awareness is ongoing as we continue to learn about ourselves from our actions (Gergen, 1977). As Mead (1964) put it, "It is as we act that we are aware of ourselves" (p. 229). And, as a bridge between the individual and the group, it is through our actions that we identify ourselves as group members and internalize the group norms (Shibutani, 1955/1968).

Identity and change

The final area of identity theory to be looked at here is that concerning change. As one attempts to look at the clinical utility of identity theory, the whole question of identity change and creation takes on great import. As a way of examining some of the parameters of this issue, this discussion will include identity (or role) strain and conflict, the dynamics of conscious "identity work" (Deaux,

1991, p. 88), the differences between individual- and group-initiated change, and lastly, the important issue of resistance to change.

The identities that we have in our hierarchy may be subject to strain and/or conflict. These two ideas are somewhat overlapping, and both may play an important role in the decision to stop using drugs or alcohol (Stephens, 1985). Stephens (1985) has discussed how addicts may have difficulty meeting the requirements of the addiction without endangering themselves. Their addiction may also conflict with other relationships, obligations, and desires that they have. The pain of these experiences may be important factors in their taking steps to address the addiction. In a broader sense, Goode (1960) has described role strain as a "difficulty in meeting given role demands" (p. 485). He saw it occurring when there were contradictions between roles and within roles (i.e., there was a conflict among the various tasks of a given role or identity) as well as when the fulfilling of one role left others lacking.

Conflict between selves or identities is seen as deriving from memberships in different groups -- each with their own belief systems and behavioral prescriptions (Breakwell, 1986). The conflict is experienced when the individual is faced with "essentially alternative ways of defining the same situation, arising from several possible perspectives" (Shibutani, 1955/1968, p. 111). The outcome

in situations like these may initially be resolved by the prominence hierarchy (McCall & Simmons, 1978). In fact, it is in these potentially difficult moments of choice that we perhaps become most consciously aware of our multiple identities, and it is through our actions at these times that we may really experience what our values and priorities are. However, a situation of more chronic identity conflict or strain may require more complicated solutions -- perhaps involving identity reshuffling or creation.

Identities and identity structures change for different reasons and in different ways. Change can be initiated by the individual (in isolation or with a group) or by the group, and it can involve the reshuffling or discarding of identities in the hierarchy and/or the creation of new identities or the redefinition of existing ones. From the standpoint of the individual, identity change can be an active and creative process (Breakwell, 1986). Times of stress and challenge may lead the person to engage in "identity work" (Deaux, 1991) or "identity projects" (Harré, 1983). This may involve the jettisoning of a threatened identity in an effort to save the larger identity structure (McCall & Simmons, 1978); it may involve "the selection and construction of possible selves" (Markus & Nurius, 1986, p. 955) (or views of the self that guide the person's behavior toward the creation of a new or altered identity); or the person may create an "innovative role"

(Heiss, 1981, p. 115).

Heiss' (1981) discussion of the "innovative role" is an interesting and potentially useful idea in understanding identity change. Heiss, in common with McCall and Simmons (1978), believed that there is an "economic" aspect to each role or identity. That is, the individual makes an ongoing cost-benefit analysis of each of his or her roles or identities and of the identity structure as a whole. Costs and benefits may be measured in terms of tangibles or intangibles or some combination of the two. New roles or identities are sometimes created out of a sense that the overall role or identity set is not working. Heiss (1981) made the interesting point that in these kinds of situations, the "innovative role" or new identity will, at least initially, be located at the top of the prominence hierarchy (McCall & Simmons, 1978). This is because it is hoped that it will prove to be a more rewarding identity than the others (which are presumably being experienced as insufficient). Over time, the position in the hierarchy of the new identity may change. This theory has some relevance to an attempt to understand recovery (and relapse) in identity theory terms and it will be explored below.

Identity change and creation, from the standpoint of its origin with the individual, occurs both in- and outside of a group context. Gergen (1977) made a strong case for the latter when he wrote that the individual

> may be moved to engage in some form of symbolic functioning, the result of which may yield an altered conceptualization of who one is, of one's true identity or true feelings. Such processing may serve to strengthen or weaken already existing conceptual structures, or it may provide altogether novel constructions of one's identity (p. 156).

Identity changes in a group context may occur through the individual's initiative, the group's initiative, or a combination of the two. Deaux (1991), in her discussion of the "identity work" process, noted that the "characteristics associated with an identity" (p. 88) can change -- identities can move up and down the prominence hierarchy, identities can be "lost through external forces and events," and that people can make conscious choices to add on identities and that "possible selves" can be a vehicle for this (p. 89). Her thoughts on identity construction, however, most clearly elucidated the process of the individual actively attempting to create an identity in a group context. This work involves three factors: (a) a process of defining oneself in terms of memberships in a specific group; (b) acquiring "relevant information about [the] group characteristics"; and (c) the "public proclamation" of group membership (p. 90).

The intermediate space between individual- and group-initiated change is perhaps best seen through looking at the

role of relationships to others in this kind of change. McCall and Simmons (1978) maintained that significant identity changes usually commenced because one had developed a relationship with someone outside of his or her previous and primary groups. Shibutani (1955/1968) argued that our choice of reference group was predicated "upon personal loyalty to significant others of that social world" (p. 111). Once we begin the process of adding to or changing our group memberships, all or most of our identities are called into question (Breakwell, 1986) and, in turn, actual identity changes can have profound effects on relations with previously significant and insignificant others (McCall & Simmons, 1978).

Finally, group-induced identity changes can occur if the social group or context begins to redefine the individual (Gergen, 1977). Examples of this can be seen in labeling theory (Trice & Roman, 1970) and, in a related process, in family therapy theory (Satir, 1983). Trice and Roman (1970) have written about the processes involved in labeling deviance by socially designated "labelers" (p. 539) -- such as psychiatrists, psychologists, and social workers. They maintain that the label itself then guarantees its own process of disturbed behavior -- what they call "secondary deviance" (p. 539). In identity terms, they are arguing that the individual has been given a stigmatized identity by the group -- in this case, by the agents of the larger

society (see also Goffman, 1963). He or she may then be continually defined in terms of the stigmatized identity regardless of his or her protests or behavior. Biernacki (1986), in his discussion of the problems of recovering heroin addicts, emphasized the importance of "proof" in the recovering addicts' interaction with nonaddicted people. He mentioned the importance of keeping regular hours, having normal possessions (i.e., stereo and TV), and being able to support oneself financially, as common symbols that the addiction has been shaken. Stephens (1985) found that if significant others did not accept and support an addict's attempt to recover, the addict was more likely to relapse than if he or she did get that support. Putting all of this together, the group can both redefine a person into an undesirable or unwanted identity, and it can work to keep him or her in that identity by blocking his or her "identity work" (Deaux, 1991) or "identity projects" (Harré, 1983).

On a smaller scale but with very serious implications, these same processes can go on within a family. Satir (1983) has written about the complex use of the "identified patient" (p. 50) in dysfunctional families. Children can become locked into identities within a family. Whether they are scapegoated (which may eventually lead them into contact with socially sanctioned labelers) or are more "benignly" defined (i.e., "smart girl," "sexy boy," or "good girl"), the same rigid definition processes may be at work. Once

defined, the family as a group (with parental power predominating) can work to trap its members in their roles or identities. This can be done by ignoring behavior inconsistent with the identity. An example of this would be the punishing of the "bad" girl for staying out late but excusing the "good" boy when he does the same. While this process of categorization may take place in many families, it is perhaps the simplicity and rigidity (as well as the scapegoating) found in these identity assignments that are the hallmark of a dysfunctional family.

In a more general sense, these group-induced changes may affect the identity structure or the content of a given identity (i.e., from a success to a failure or vice-versa). In addition, some identity changes are programmed or encouraged by institutional agents (i.e., graduation) (Strauss, 1962). And, finally, identities may change because the groups to which the individuals are connected change overall status in society (Breakwell, 1986). A contemporary example of this would be the position of Communist Party members and functionaries in Eastern Europe and the former Soviet Union who, in some cases, are going from positions of power to potential outcast status and members of the Solidarity movement in Poland or Charter 77 in Czechoslovakia (who are moving in the opposite direction).

Although the processes of identity change may be abrupt

and radical, it is perhaps more commonly a gradual process (Bush & Simmons, 1981). There would seem to be a complex dynamic at work in many cases in which an increasing quantity of group- or identity-related involvement "suddenly" leads to a qualitatively different experience of the self. For the identity change that was desired or sought after, the person may have a sense that they have finally "become" that which they had hoped to be. Strauss (1962) has observed that "awareness of significant change is a symbolic matter" (p. 82). Stall and Biernacki (1986), in their discussion of people addicted to heroin, cigarettes, alcohol, or food, noted the importance of symbolic incidents in individuals' decisions to take steps about their addiction. These experiences perhaps symbolized the depths and/or dangers of their addict identity.

Finally, while "identity projects" (Harré, 1983) may be consciously undertaken, people are often resistant to changes in their identities or identity structures. People use a whole array of cognitive, behavioral, and emotional defenses to keep from having to change (Frank, 1974). In terms of addiction, a commonly used defense is denial. Markus and Sentis (1982), looking at the self in terms of information processing and Piagetian theory (Piaget, 1970/1983), maintained that humans have a bias toward assimilation over accommodation. That is, they seek to fit incoming information into already existing information

structures or they "bend" information to conform to their conceptions about the world and ourselves. It is when this fails to work that they "accommodate" -- they change the way they understand things to better fit the information they are receiving. In a clinical sense, it is difficult for individuals to give up a sense of self or an identity if they cannot see what they will replace it with (Guidano & Liotti, 1983).

Identity and natural recovery[1]

Heroin addiction and natural recovery

The understanding of the processes of recovery from addiction through the lens of multiple-identity theory is mainly built on the work of Waldorf, Biernacki, and Stall. Related work, using the role-identity model of McCall and Simmons (1978), was done by Stephens (1985), and earlier work was done by Foote (1951), who briefly mentioned identity factors in A.A. involvement, and by Ray (1961/1973), who discussed the role of identity in the cycles of abstinence and relapse among heroin addicts.

Waldorf, Biernacki, and Stall, who were initially interested in the processes of recovery in untreated heroin addicts, built their theory of recovery on the identity processes that have just been discussed. They viewed addicts as belonging to a variety of "social worlds" (Biernacki, 1986) -- each with its concomitant world view and behavioral implications. That is, each social world

contributes an identity and these are organized into a hierarchy.

What does this mean in terms of untreated cessation of drug use? Biernacki (1986) (referring also to the work of Broadhead, 1983) clarified this when he wrote:

> Natural recovery refers to the processes through which a new calculus or arrangement of identities and perspectives emerges and becomes relatively stabilized. This process entails a different articulation of identities in which the identity as an addict becomes deemphasized (symbolically and socially) relative to the other identities existing or emerging as part of the person's overall life arrangement (p. 25).

Biernacki was able to discern three different paths to this kind of identity restructuring. The path taken to the new identity structure, the transformative path, was often related to the depth of the individual's involvement in the drug culture and its impact on his or her nonusing social worlds and identities.

The first path to becoming an "ordinary" person was <u>identity reversion</u>. In this situation, the addict returned to a former identity that had been on hold during the addiction and which had not been impacted on by the addiction.

The second path was <u>identity extension</u>. This refers to the focusing of one's energies and attention on an identity

that was coexistent with the addict identity. This identity was either untouched by the addiction or not so badly damaged that it could not be salvaged.

One variant of identity extension was found among those who worked in areas where the addiction was not necessarily held against the individual. This world included such groups as jazz and rock musicians and "hip" writers. Here, both the addiction and the recovery from the addiction would appear to fit the lifestyle well. However, the more usual process of identity extension is probably based on compartmentalized identities.

The third path was identity emergence. In this case, the individual forged a new identity, an identity that was not related to his or her pre-addict or addict life. This process would be most applicable to those with the deepest involvement in the addictive process, those who had "burned their bridges" to such an extent that there was no available social world that could be used as a viable vehicle for identity transformation. Additionally, it would apply to those who had lived lives of such psychosocial paucity and abuse that there was little fertile ground for growth readily available.

Typically, it was found that these former addicts had gone through a number of identity changes along the way, perhaps using different paths; however, they "typically emphasized or focused their accounts on a single identity

transformation" (Biernacki, 1986, p. 143). (And for some, this transformation process included a period of "identity hiatus" [p. 147] -- a period where the old identity had been given up but the new one had not yet appeared.) The common theme in all three of these approaches is the availability of what Biernacki (1986) called "identity materials."

> Identity materials are those features of social settings and relationships (e.g., vocabularies, social roles) that people can use to fashion new identities, reestablish old ones, or extend existing ones . . . .People selectively incorporate these aspects of their social relationships into a coherent arrangement of identities and thereby create a new sense of self (p. 144).

Recovery, from this perspective, is not something that people achieve by themselves. The addict often needs to find new social settings that will both supply role models and support their work at self-transformation. A common way is to form connections to existing institutions -- universities, religious organizations, businesses, political action groups (Biernacki, 1986; Waldorf, 1983) -- places where these transformations will be socially validated.

Whatever the course chosen, social validation and social acceptance of the new identity by nonaddicts (and often by other addicts as well) is crucial. The essential problem here is that the stigma of the addiction and the

common social perceptions that usually go along with it may lead to experiences of rejection for the addict and may lead him or her back to the world of other addicts where he or she is more easily accepted. The idea of "once an addict, always an addict" may plague an individual's attempt(s) at recovery and may be a serious roadblock to the necessary identity changes.

Stephens (1985) also supported this view. As mentioned above, he discussed a study in which it was found that if important social groups -- family, addict friends, and nonaddict friends -- continued to treat an abstinent person as if he or she were still an addict, then the abstainer was more likely to relapse than if his or her abstinence was supported. His formal hypothesis was "the greater the extent to which the person is cast into the role of street addict, the more likely the person is to relapse" (p. 442).

The degree to which recovering addicts can integrate themselves into nonaddict networks will be of valuable assistance in their battle with cravings and urges. This integration can help in three ways: (1) it helps to remove the individual from the temptations and old behavior patterns associated with addict friends; (2) it helps to redefine drug use in a negative context; and (3) it provides alternative behaviors and activities (Biernacki, 1986).

The transition to being a member of nonaddict social networks, which is so important, can also be quite

difficult. Many addicts fear rejection or social disapproval but they must overcome this if their sobriety is to last. Biernacki (1986) found three common approaches for the initial step of making new connections and dealing with the problem of stigma. Some addicts had nonaddict friends or networks who knew of their addiction and accepted them anyway. These also included religious and political organizations who accept people with histories of addiction because of their group ideologies. Some attempted to hide their drug histories and involvements, and some actively tried to change the opinions others had of them.

An interesting footnote to this study was that a number of subjects did try heroin once or twice after long periods of abstinence and after their identity transformations had been developing. A fascinating and common experience was that the ex-addicts found the use of the drug to be quite unpleasant, and the fact that they used it, did not like it, and did not return to active use, helped to symbolize to them the depths of change that they had gone through and how far removed they were from their previous lives (Biernacki, 1986; Waldorf, 1983).

Toward a model of spontaneous remission

Stall and Biernacki (1986) expanded the findings of their work with heroin addicts by comparing these findings with the literature on spontaneous remission from the "problematic use" of alcohol, tobacco, and food/obesity. By

"spontaneous remission" they meant "the continued cessation of the problematic use of a substance for at least one year without any formal or lay (such as Alcoholics Anonymous) interventions" (p. 3).

Their review of the literature reinforced their sense that there may be a consistent model at work in all "spontaneous remissions," a model that was essentially the same as the one they had found for heroin addicts. "The central process which underlies spontaneous remission is the successful public renegotiation and acceptance of the user's new, nonstigmatized identity" (p. 13). The essential features of this process were significant-other support and positive feedback mechanisms supporting the change.

Stall and Biernacki briefly discussed their findings in terms of formal treatment approaches. One major point they made was that if identity is a crucial factor in successful recovery, then there should not be an overemphasis on the "addict" identity in formal treatment. This is a point that will be returned to later.

Identity and motivation

Before looking at the role of identity theory in other forms of recovery, it might be useful to briefly examine its role in the cessation of substance abuse. In Biernacki's (1986) work on untreated heroin addicts, he felt that the recovery process usually began in one of three ways: (1) "Fortuitous circumstances" -- the individual underwent some kind of

existential crisis that was followed by a conversion experience (perhaps of a religious, political, or ideological nature); (2) the individual decided to stop "using" because of the negative consequences of the lifestyle (i.e., prison, health problems), and he or she took steps in a purposeful manner to change his or her life; and (3) the addict did not appear to make a decision at all but just seemed to drift away from the addiction to a more conventional way of living. This last group included, but was not limited to, those whose drug use was situational -- having to do with being involved with a person who was doing drugs or being in a particular place where drug use was common. When the relationship ended or the person moved on, the drug use ceased.

Identity processes run through these three patterns. In the first, the "conversion" experience certainly includes identity change; in the second, the addict identity is getting to be more than the individual can handle; and in the third, one sees that drug use can be tied to one identity and that this identity (and its concomitant substance use) can be compartmentalized and separated from the others and perhaps even jettisoned as circumstances change.

Stall and Biernacki (1986), in their more general model of spontaneous recovery, see the "building of resolve or 'motivation'" (p. 13) as taking place in a context in which

the "economic" (p. 13) costs (broadly defined) are getting too high. The person may be faced with financial difficulties, health problems, social and/or legal sanctions, and/or difficulties with significant others. The result is that the whole process of continuing just seems too difficult. Interestingly, they found that this was often brought home to the person in "significant accidents" (p. 12) Although this event may or may not be intrinsically important or meaningful when viewed from the outside, it is of great symbolic and internal importance to the addicted person. Although sometimes, but not always, a warning of an impending disaster, the accident served as a personal catalyst for change and a new identity.

One subject in the study described this kind of experience. He said that about a year earlier, after having been thrown out of a men's shelter earlier in the day, he had bought some alcohol and some "crack." Before using it, he turned to look down a major concourse, and suddenly everybody on the street seemed dead to him. At that moment he made a promise to God not to drink or use drugs, and at the time of his participation in the study, he had been clean and sober for over a year.

Stephens (1985) felt that role strain and role conflict were usually the two major forces that worked to end the addictive lifestyle. By role strain, he meant that the individual was no longer able to do all that was necessary

to maintain the addict role successfully (i.e., getting money, finding drugs, avoiding withdrawal, escaping arrest, and protecting him- or herself from other addicts). By role conflict, he meant that the addict was feeling the competing demands of other roles (or identities) that did not support further drug use (i.e., the mother addicted to "crack" who must either stop using drugs or lose custody of her baby; the worker who will be terminated from his job if he has one more "dirty urine" specimen). Either or both can be, and commonly are, at work in people who begin the process of recovery. What most of these observations share is a state of conflict and tension within an identity or among identities.

Identity and recovery: Formal, lay, and religious treatment programs

Identity and the therapeutic community

Although Biernacki (1986) focused primarily on the natural recovery experience, he also attempted to extend his findings to the healing properties of the therapeutic community (TC) (DeLeon, 1989; Densen-Gerber, 1984). Biernacki saw the TC process as a vehicle for identity transformations that had much in common with those found in natural recovery. These commonalities included:

> (1) an attempt to destroy existing identities rooted in the drug world; (2) the common structuring of exclusionary group membership during the initial stage

> of abstinence, even if it means breaking up couples; (3) the establishment of social networks to support the new identities, corresponding perspectives, and vocabularies that are being shaped and developed in the program in lieu of those related to the addict world; and (4) the provision of some social-psychological techniques that can be used to neutralize drug cravings when they appear (p. 193).

By doing this, Biernacki took the first step toward developing a theory of identity transformation as an essential component of all psychosocial recovery processes -- whether in terms of formal treatment or "natural" occurrence. It is the focus of the rest of this section to look at the implications of identity theory for understanding the 12-Step group approach, psychotherapy with substance abusers, and, more briefly, religious treatment programs.

Identity and the 12-Step programs

The 12-step programs are those programs of psychospiritual transformation that began with Alcoholics Anonymous (A.A.) (Alcoholics Anonymous, 1953, 1967, 1976; Bill W., N.D.) and which have grown, especially in recent years (Hoban, 1989), to include Narcotics Anonymous (N.A.) (Narcotics Anonymous, 1988), Cocaine Anonymous, Drugs Anonymous, etc. In terms of sheer numbers helped, these programs have clearly been the most effective form of treatment available.

When 12-Step groups are viewed through the lens of identity theory, one sees an ideological foundation that would allow for the provision of identity materials and enable the individual to work on his or her "identity projects" (Harré, 1983) while providing several overlapping identity images to be strived for.

A.A., the archetypal 12-Step group, originally focused its attention on the most "hardcore" alcoholics. With these "difficult cases," there was a feeling that halfway measures would not be sufficient and that a radical transformation of the self was required. It was felt that this process was so fundamentally challenging, that only the most desperate would be willing to try.

A.A. and N.A. both believe that a radical change, a "personal revolution" (Mahoney, 1980), is required. Bill W., the A.A. co-founder, wrote, "no true alky ever stops drinking permanently without undergoing a profound personality change" (Alcoholics Anonymous, 1967, p. 1). N.A. echoes this sentiment: "Personality change was what we really needed" (Narcotics Anonymous, 1988, p. 15). The end result was that "We become different people" (Narcotics Anonymous, 1988, p. 11), or, more profoundly, "We were reborn" (Alcoholics Anonymous, 1967, p. 104). These writings help provide an ideological foundation for the importance of identity change.

As was apparent in the work of Waldorf, Biernacki, and

Stall, the support of significant others in this transformation is essential. The 12-Step programs are a powerful group phenomenon and the importance of the group is central -- "most individuals cannot recover unless there is a group" (Alcoholics Anonymous, 1967, p. 9).

12-Step programs are psychospiritual programs, a synthesis of psychology, spirituality, and theology. In the A.A. conceptualization of the causes of alcoholism, several different models are presented. On one level, alcoholism is seen as both a disease or allergy and as a reflection of one's "personal shortcomings" (Alcoholics Anonymous, 1953; Beckman, 1980; Bill W., N.D.). More fundamentally, alcoholism and other addictions are seen as resulting from the individual being out of alignment with God's will or purpose for him or her. "At no time had we asked what God's will was for us; instead we had been telling Him what it ought to be" (Alcoholics Anonymous, 1953, p. 32). The fundamental solution is to "clean house" and then to try and effect a realignment. Humility, the process of making God's will one's own, is seen as an essential component of this work (Alcoholics Anonymous, 1953).

By following the 12 Steps and attending meetings, the recovering person begins to undergo "core change" (Mahoney, 1980, p. 177) or "deep structure" change (Arnkoff, 1980, p. 344). While this sometimes occurs dramatically, it is more often gradual (Alcoholics Anonymous, 1976), and it leads to

changing definitions of the self. "Practicing spiritual principles in our daily lives leads us to a new image of ourselves. . . .We learn to respect ourselves" (Narcotics Anonymous, 1988, pp. 50-51). In addition, it leads to the belief that "the central fact of our lives today is the absolute certainty that our Creator has entered into our hearts and lives" (Alcoholics Anonymous, 1976, p. 25).

The self that results from this "conversion" is potentially the antithesis of the street-addict and/or alcoholic self. As Tolstoy (quoted in Fosdick 1917/1982, p. 286) said, "I ceased desiring what I had wished before, and began to desire what I had not wished before" -- a feeling that the recovering person may share.

Two prayers have played important roles as orienting constructs for 12-Step groups as to the nature of being human. The first is The Prayer of St. Francis (Alcoholics Anonymous, 1953, 1976) and the second is The Serenity Prayer (Alcoholics Anonymous, 1967).[2] The first portrays the model of the ideal human being and the second seeks to strike a balance between the capability of humans for action and creativity (both for good and evil) and an inherent sense of ontological limitation that is the nature of a created being, a point that Kurtz (1988) stressed.

The images that were provided of the ideal identity in the A.A. and N.A. writings are overlapping and appear to be influenced by The Prayer of St. Francis. The prayer, as

variously translated, asks that we be made into "instruments" or "channels" of "Thy peace." N.A. advises, "When we share with someone new, we may ask to be used as a spiritual instrument of our Higher Power" (Narcotics Anonymous, 1988, p. 49). A.A. (1976) recommends meditating on the prayer with the hope that we would become "a channel of thy peace." In related imagery, perhaps reflecting the Biblical roots of the 12-Step programs, there is a call for service and servanthood: "service to others will get us out of ourselves" (Narcotics Anonymous, 1988, p. 54); and "we are living to learn, to serve, and to love" (Alcoholics Anonymous, 1967, p. 94).

Two other images run through the literature -- that of "agent" and of "example": "God was going to be our Director. He is the Principal; we are His agents" (Alcoholics Anonymous, 1976, p. 62); "we try to let Him demonstrate, through us, what He can do" (Alcoholics Anonymous, 1967, p. 129). In this way we have five overlapping images (instrument, channel, servant, agent, example) of the new self or new identity that will be the endpoint of the development of a healing relationship with a Higher Power.

Although it utilizes processes of mortification and confession (Donovan, 1984), 12-Step ideology sees all people as being of value in the eyes of God and encourages recovering people to shed negative images of themselves and

to not let others make them feel unworthy: "in God's sight all human beings are important" (Alcoholics Anonymous, 1953, p. 129); and "as God's people we stand on our feet" (Alcoholics Anonymous, 1976, p. 83).

The work that remains is to become socially useful and to reach out to other sufferers of alcoholism and addiction: "your job now is to be at the place where you may be of maximum helpfulness to others" (Alcoholics Anonymous, 1976, p. 102); and "nothing will so much insure immunity from drinking as intense work with other alcoholics" (Alcoholics Anonymous, 1976, p. 89). The development of these identities is an ongoing process that develops out of regular attendance at meetings, "working the Steps," studying the literature, and reaching out to other alcoholics.

Identity changes and self-definition

One of the more striking aspects of a 12-Step meeting is the ritual identification of each member in terms of his or her addiction ("I'm Bob. I'm an alcoholic." "I'm Susan. I'm a drug addict.") (Maxwell, 1984). This emphasis on the individual defining him- or herself in terms of the addiction has been found to be problematic by some clinicians. Marlatt and Gordon (1985) felt that it was therapeutic to help the patient distance him- or herself from the addictive practice and to increasingly de-identify with his or her past behavior.

Stall and Biernacki (1986), in their discussion of how to transfer their findings to other treatment modalities, wrote, "care should be taken during the intervention process that the identity of 'addict' does not become an indelible part of users' personal. . .[or] social identities" (p. 19). This conclusion is seemingly just the opposite of 12-Step practice.

A possible way of reconciling the differences between recovery based on developing nonaddict identities and recovery based on a constant self-definition as an alcoholic or drug addict lies in the contextual and constructivist (Berger & Luckmann, 1966) nature of this latter kind of identification. To say that one is an addict or an alcoholic at a 12-Step meeting is to gain acceptance into a large and highly supportive network (Maxwell, 1984). It also means that one has defined oneself in terms of a process toward recovery, regardless of where one is or the speed at which one is travelling along that road (Maxwell, 1984). It is a radically different self-definition and it is done in a social world that provides ample identity materials and that is highly accepting and supporting of the individual. A revealing moment of identity transformation for one addict is nicely captured in a N.A. testimonial:

> I remember seeing people at meetings. It sounds corny, but I wanted what they had. I wanted to be able to say, "My name is Bill and I am an addict. And I am

> doing something about my life!" I used to think that the people there were conning. That's what my head was saying, but deep in my heart I knew what they were saying was true (Narcotics Anonymous, 1988, p. 194).

If we understand the admission of alcoholism and/or addiction in this context, then we can see it as a paradigm shift that is in keeping with identity theory.

There are other pressures at work in the 12-Step program that have ramifications for identity change as well. Sarbin (1968), writing in the language of role theory, pointed out that the social networks of socially degraded individuals usually have few opportunities for roles by choice or achieved statuses. Achieved statuses are roles or identities that are not "given" but are ones which must be aspired to and, if performed successfully, bring social support and rewards. As one goes deeper into the addictive process, these "achieved" experiences are likely to become increasingly unavailable from the "mainstream" world. For the addict, this can mean that he or she has little choice but to be an "addict." The surrounding social worlds will not allow him or her to try to claim a different identity and, in addition, the individual will be subject to the negative social consequences of a stigmatized identity.

The 12-Step world, however, provides a way out. As long as one is "clean and sober," then all of one's roles or statuses are treated as achieved statuses. That is,

positive accomplishments in any area, even the most mundane, are supported and reinforced. This support comes, perhaps, out of a sense of how impossible this kind of behavior might have been when the individual was in the throes of addiction or alcoholism and also because even the smallest gesture can be interpreted as reflecting an underlying process of self-change.

Another factor at work in these programs that may help strengthen the new identity process is what Riessman (1965) called "the 'helper' therapy principle." By this he meant the traditional folk therapeutic approach of having people with a problem help those who have a more serious version of it. He points out that while the person receiving help may or may not profit from the experience, the person doing the helping is quite likely to benefit. A.A.'s emphasis on members helping those who are still actively drinking reflects this principle. The process of helping works to change the self-image, especially as the individual is involved in a worthwhile activity, and strengthen the commitment to the recovering identity (Riessman, 1965).

Identity and denial

Returning to the issue of defining oneself as an "alcoholic" or "addict," an intriguing question is if, how, and when a patient should be encouraged to admit that he or she is an "addict" or an "alcoholic." It is not uncommon for a patient to point to the fact that he or she has a job or is

married and has a family as proof that he or she does not have a drug or alcohol problem. To deny the validity of these potential self-definitions is perhaps to lose an avenue of recovery. In turn, to accept them too easily may allow the patient to continue in a state of potentially highly destructive denial. Navigating between Scylla and Charybdis calls for creative and innovative work, work that may save the therapy from getting mired down in battles over whether one is an "addict" or "alcoholic." A working agreement that there is a problem with substance or alcohol use may be sufficient.

A.A., N.A., and the identity hierarchy

By accepting that 12-Step group membership provides an identity (Maxwell, 1984), one can begin to see the processes of more formal recovery as being similar to those proposed for natural recovery (Biernacki, 1986). The individual who becomes an active A.A. or N.A. member is engaged in a process of restructuring his or her identity hierarchy. The recovery-oriented identity, one hopes, is going to the top of the hierarchy, and the addiction-based one is, perhaps gradually, declining in prominence (McCall & Simmons, 1978). Heiss' (1981) concept of the "innovative role," which was mentioned above, may also shed some light on this process. Using an "economic" model, he made the point that new roles or identities are sometimes created when there is a sense that the overall role set, or identity hierarchy, is not

working -- an experience that is not foreign to at least some of those who reach a decision that they have to do something about their addictions. In these kinds of situations, the "innovative role" or new identity may go immediately to the top of the hierarchy in the hope that it will prove to be a more rewarding identity than the others (which are presumably being experienced as insufficient). This perspective may help shed some light on both the "fanaticism" of some 12-Step group members and the problem of relapse. The person who seriously joins a group is, in a sense, gambling with his or her life and is likely to be quite invested in the outcome. This may well be a factor in the intensity of the allegiance of some 12-Step group members. Relapse, in turn, can perhaps be understood as the result of a conflict between the old and new identities. A person with a serious addiction is a person with an addict identity that, if not at the top of, is quite high on his or her identity hierarchy. That is, many of his or her thoughts, feelings, behaviors, and social interactions will be directly or indirectly related to or concerned with his or her addiction to drugs or alcohol. When joining a 12-Step group or entering into any program of recovery (whether formal, lay, or "natural"), the individual is attempting to put a new identity in the place of the addict identity at the top of the hierarchy. This means that the person may enter into a prolonged period of identity conflict between

the important but developing recovery identity and the unsatisfactory but entrenched addict identity. A slip or relapse would most likely occur when the addict identity momentarily dominates the hierarchy. Situations in which this would be likely to occur would probably be those of internal or external distress and/or those involving social pressures or a return to environments associated with the addiction (Marlatt & Gordon, 1985). Marlatt and Gordon (1985) recommended vigilant self-monitoring, and 12-Step groups commonly encourage newcomers to attend "90 meetings in 90 days" to help break the old patterns and strengthen the new identity. If the individual in early recovery, then, is frequently confronted with "essentially alternative ways of defining the same situation" (Shibutani, 1955/1968, p. 111) -- one promoting recovery and one furthering the addiction -- then it is not surprising that people slip even when they approach recovery with honesty and the best of intentions.

Identity, addiction, and psychotherapy

A psychotherapeutic approach to the problem of addiction that seeks to use the principles of identity theory can work in two nonexclusive ways. The first approach is to use the therapy to support the development of identities that are antithetical to the addict identity. The second approach is to use the therapeutic relationship itself as a kind of transitional identity to challenge the addict identity.

Zweben (1986, 1987) described a therapy for addiction that is centered on helping the patient make a connection to a 12-Step group. The therapist provides encouragement as well as a place for the patient to air his or her ambivalence about, or difficulties with, the program. In identity terms, the therapist is attempting to strengthen the connection to the group that has the necessary materials for identity creation or restructuring. This process can also take place in TCs or outpatient treatment programs where much of the therapy may be focused, especially in the early days, on keeping the client connected to the program.

On the other hand, the therapeutic relationship itself may help foster a kind of "therapy identity" that will be useful to clients in their attempts to regain their freedom. Frank (1974) has pointed out that one of the functions of a therapist is to help patients make changes in their "assumptive systems" -- that is, in their beliefs about themselves and the world that stem from their membership in various reference groups. This takes place in the context of a relationship with a socially sanctioned healer. Adler and Hammett (1973), in an article looking at the similarities among A.A., the TC, and psychoanalysis, pointed out that successful therapy involves a strong emotional bond with the therapist and an acceptance of the therapist's ideology or belief system. Put more mildly, this means that if addicts can form an emotional connection or bond to their

therapists, they can perhaps begin to internalize a belief in alternate or "possible selves" (Markus & Nurius, 1986). That is, they may begin to gain an experience of hope that things can change. Through this work, a new sense of self or "identity" may develop that helps them begin to combat their addict identity and which will help them begin to develop other more positive identities -- be they specifically related to recovery or not.

In a similar vein, Mahoney (1980), in his writing about profound change or "personal revolution," argues that "two of the primary functions of the therapist may be to (1) assist the client in perceiving or developing an alternate paradigm, and (2) guide the client through experiences that challenge the old paradigm" (p. 176). The first function would certainly mesh with the concepts of identity reversion, extension, or emergence (Biernacki, 1986), and the portrayal of the therapist as guide emphasizes both the emotional bond that is formed and the need for and importance of information (or ideology) for the recovering person.

It is quite likely that both of these processes are going on in most successful therapeutic work with addicted persons. To see these approaches in terms of identity creation and/or restructuring helps to reveal their commonalities with other treatment approaches. This, in turn, one hopes, would lead to more integrated and more

effective treatment.

Identity and religious treatment programs

In his autobiography, Malcolm X (Malcolm X & Haley, 1964) described the therapeutic method of the Black Muslims for helping heroin addicts to become free of their addiction. In this account, one can see processes at work that are similar to those of A.A. and that provide identity materials. As Malcolm X described the Muslim six-point therapeutic process, the individual who would recover must go through the following steps:

> The addict was first brought to admit to himself that he was an addict. Secondly, he was taught why he used narcotics. Third, he was shown that there was a way to stop addiction. Fourth, the addict's shattered self-image, and ego, were built up until the addict realized that he had, within, the self-power to end his addiction. Fifth, the addict voluntarily underwent a cold turkey break with drugs. Sixth, finally cured, now an ex-addict completes the cycle by "fishing" up other addicts whom he knows, and supervising their salvaging (p. 260).

Both in this passage and in ones that follow it, one can see several identity mechanisms at work. Former addicts "fish" for current addicts -- a process that helps increase the possibility of identification and bonding, and the addictive process is seen as an outgrowth of the racist nature of the

society which corresponds to the necessity of a group or social world viewpoint that works to define self and others. It also supports Antze's (1976) work on the importance of ideology in recovery. Malcolm X goes on to note that the addict is slowly introduced to Muslim circles where

> for the first time in years, the addict hears himself called, genuinely, 'Brother,' 'Sir,' and 'Mr.' No one cares about his past. His addiction may casually be mentioned, but if so, it is spoken of as merely an especially tough challenge that he must face. Everyone whom this addict meets is confident that he will kick his habit (p. 261).

This last passage also reflects several identity processes. In being called "Sir," the addict is immediately redefined as someone worthy of respect. That no one cares about his past means that he does not have to be chained to the addict identity. By defining the addiction as a challenge that he can face and conquer, the group is emphasizing that the individual is more (and other) than his addiction. The group is also distancing him from the addiction -- an approach that was echoed in the work of Marlatt and Gordon (1985). That the addict must admit that he is an addict is the first phase of the process. Concurrent with it, he is given a taste of an experience that leads him to understand that he does not have to remain one. As the process goes on, the addict experiences hope and becomes ready for a

"cold turkey detox." The detoxification takes place with Muslims helping, supporting, and encouraging the addict around the clock. When the detoxification is finished, he is nursed back to wholeness by the Muslims. This is a powerful bonding experience for the individual and the group. When well, the new Muslim goes out to help other addicts, which is another example of the "helper therapy principle" (Riessman, 1965). The result of this painful and highly emotional experience is the creation of a new identity or identity emergence.

The theoretical and therapeutic value of identity theory

By viewing the different methods of recovery from addiction through the lens of identity theory, it is to be hoped that the common features and processes may become more salient. The value of this approach could be to help facilitate the coordination of individual psychotherapy with involvement in lay and formal treatment programs. Identity theory could help reduce philosophical conflicts that may exist between different approaches (Clark, 1987). For example, psychotherapy has traditionally struggled to increase the autonomy of individuals. The 12-Step programs, in turn, have a basic emphasis on "powerlessness," at least in terms of addiction. This clash over the issue of control, a point that Marlatt and Gordon (1985) have discussed, can now be reframed as varying ways of defining the self -- each effective with different kinds of patients.

Identity theory also opens up a variety of methods for change. For patients who cannot or will not engage in 12-Step groups, there may be other natural groups or potential relationships existing in their lives or community that could help them in this process. If this were the case, it would fit into a more general concept of "identity niche" -- that is, that the individual needs to find some kind of interpersonal, psychosocial "space" that will nurture and protect some or all of his identities. In a sense, all the approaches we have discussed, including the therapist's hour, are potential "niches" (Levine & Perkins, 1987) each in their own way serving the same function.

A third point, which echoes Biernacki's (1986) work, is that patients differ in terms of their potential identity materials and that these should be assessed carefully before a treatment program is designed so that potentially healing resources are not overlooked.

Toward a research paradigm

Introduction to the research

Biernacki's (1986) work was centered on an empirical study of identity change in recovering or "recovered" heroin addicts. Although identity theory is certainly theoretically and clinically compelling, it needs to be further grounded in empirical work. It was to that end that this research project was undertaken. The hypotheses of the study and how they relate to identity theory will first be

discussed, and then Q methodology and technique will be introduced and its potential as a highly useful tool in identity research will be explored. After this, the research methodology, the results, and the implications of the data will be analyzed.

The research being examined here involved looking at the identity hierarchies of men at the Hospital and the Agency. Originally, the study was planned for the Hospital men only. Because of changed conditions at the Hospital between the time the proposal was written and the time the research could be carried out, there were some slight modifications in the methodology. The additional Agency subjects helped to confirm the findings and strengthen the overall validity of the project (see Appendix A for a discussion of this issue).

The hypotheses that were developed represent an interface between the identity theory that was explored here and the structure of the two programs. The two groups studied consisted of men who were just beginning treatment (or the orientation group) and men who had been in treatment longer (or the program group).

Identity hypotheses

The research focused on the following four hypotheses:

1. In the identity hierarchies of those who are in the orientation group, the addict identity will be more prominent than among those who are in the program group.

2. In the identity hierarchies of those who are in the program group, the recovery identity will have greater prominence than in those who are in the orientation group.

3. Among those who are in the program group, both the recovery and the addict identities will be at the top of their hierarchies.

4. Since the experience of addiction is often incompatible with the maintenance of nonaddict identities (Waldorf, 1983), those who are in the program group will have richer and fuller nonaddict identities than those who are in the orientation group.

Hypothesis 1 reflects the idea that being an alcoholic or addict means that one has an identity based on one's substance use (Biernacki, 1986; Stephens, 1985) and that this is central to one's life. In other words, an addiction-based identity will be at the top of one's hierarchy. This will more likely be the case for those who are beginning treatment than for those who are further along.

Hypothesis 2, on the surface, appears to be the reverse side of Hypothesis 1. However, there is more to it than that. As the review of the work of Waldorf, Biernacki, and Stall (Biernacki, 1986; Stall & Biernacki, 1986; Waldorf, 1983; Waldorf & Biernacki, 1981) revealed, people recover without the use of a specifically recovery-based identity. It was proposed here that the Hospital and Agency program

men would, most likely, be relying on the recovery-based identity that is potentially provided by the Hospital and the Agency programs and, for some, 12-Step group attendance and membership. The fact that many of these men lived in shelters, welfare hotels, or "flop houses," would appear to support the belief that they were relatively cut off from situations and opportunities that would allow them to fully develop or maintain their other identities. In a more general sense, it reflected the belief that the dominant identity will have the greatest impact on behavior and therefore the recovery identity would be higher in the hierarchy for those who were in the program group than for those who were in the orientation group.

Hypothesis 3 was a test of Heiss' (1981) concept of the "innovative role" -- a concept that, perhaps, captures the experience of struggle that is the hallmark, for some, of early recovery. As was discussed earlier, even for those who are doing well, the "pull" to go back to one's old ways may be quite strong. This hypothesis did not contradict the previous two. In terms of hypothesis 1, it meant that the orientation group members would have the addict identity at the top of their hierarchies while those who were in the program group would have it as their second most prominent identity. In terms of hypothesis 2, one might have expected to find the recovery identity more toward the middle or the bottom of the beginner's hierarchies as this was a group

that was contemplating recovery but had not, as yet, really made a full (or perhaps even serious) commitment.

Hypothesis 4 referred to the fact that even under the best of circumstances, addiction has an impact on one's behavior, interactions, and relationships in most or all of one's social worlds (Waldorf, 1983). In turn, this means that one's identities are being damaged. An example of this would be that while the alcoholic may continue to have relations with his or her family, these relations may well be increasingly marked by tension, mistrust, and anger. Similarly at work, as the alcoholic is increasingly seen as unreliable, unpredictable, and/or unproductive, he or she, if not fired or demoted, may be put in increasingly peripheral positions. Recovery is more than just not drinking or using drugs. It means that one is regaining or re-creating one's life. For example, the Ninth Step (Alcoholics Anonymous, 1953, 1976) of the 12 Steps encourages the recovering person to make amends to those who have been hurt or damaged through his or her addiction. In addition, treatment programs encourage vocational training, educational enhancement, and general involvement in situations that do not include people who are still actively drinking or using drugs. It seems logical, then, that those who are doing well, even if in early recovery, could have begun the process of re-integrating themselves into the societal mainstream and will, therefore, have richer non-

addict identities than those who are closer to the addictive experience.

Chapter two: Methodology

Methodology

Introduction

The testing of these hypotheses was done primarily through the use of a Q-sort that was designed to reflect five major identities -- addiction, recovery, work, family, and religion. The following section is a discussion of Q methodology and technique, the experimental models that guided this research, and the specific methodology of the study.

Identity and Q methodology

Inasmuch as the Q-sort was the instrument used to examine the identity hierarchies of the recovering subjects, it would, perhaps, be helpful to explore the technique and its underlying methodology to see how it can be a particularly useful tool for the exploration of multiple identity theory. Stephenson (1953), the originator and foremost proponent of what he called Q methodology, felt that it represented a kind of revolution in experimental method. Instead of being forced to choose between an "external" view of behavior (that is, behavior as seen through the eyes of the researcher) that did not necessarily capture the personal experience of the subject, or the difficult-to-quantify reports that came from introspection or psychotherapeutic case studies, Stephenson (1953) felt that he had found a solution that would allow the researcher to scientifically

explore subjects' inner experience and behavior. As he put it, "Q-technique provides a systematic way to handle a person's retrospections, his reflections about himself and others, his introjections and projections, and much else of apparent 'subjective' nature" (Stephenson, 1953, p. 86).

At its most basic, the Q-sort is a task that requires the subject to sort cards (or pictures in some studies) into a series of piles or groupings. This study used 11 piles that followed the card total pattern of 2, 3, 4, 7, 9, 10, 9, 7, 4, 3, 2 (Kerlinger, 1986). At the two ends of the row of piles there are markers that state the polarities that the sorting is supposed to be based on (i.e., most like me, most unlike me). Each pile is weighted with markers for its values in terms of the polarities (+5, +4,. . .0. . .-4, -5) so that the middle group is the most neutral. As the cards are sorted, they are commonly not placed on top of each other but are, instead, placed above or below each other so that they are all visible during the sorting. Each pile has a marker that tells the subject how many cards may be placed in that pile. This is done so that the overall pattern resembles a somewhat flattened or platykurtic standard distribution (Brooks, 1970). This model is known as the "forced choice" model (Block, 1961; Brown, 1986; Kerlinger, 1972, 1986; McKeown & Thomas, 1988; Stephenson, 1953). Although the subjects can put the cards where they choose within the structure, they cannot determine the number of

piles or the number of cards in each pile nor can they leave cards out. When a subject is asked to sort cards, it is usually done with a particular idea in mind. That is, the subject will be given a condition of instruction (Dennis, 1986; McKeown & Thomas, 1988) such as, "Sort these cards in a way that best reflects how you see yourself now" or, "Sort these cards in a way that best reflects how you would like to be." While some studies have asked subjects to do numerous sorts under varying conditions of instruction (Wylie, 1974), others have only asked them to do one (Kitzinger & Rogers, 1985). Subjects in this study were only asked to do one full sort.

Q-sorts, in terms of their use and the interpretation of the data they provide, should be understood in light of their underlying methodological and philosophical structure. Proponents of Q repeatedly emphasize two aspects of this approach as particular strengths. The first is the emphasis on subjectivity (Brown, 1980) and the second is "its affinity to theory" (Kerlinger, 1986, p. 517).

Stephenson (1953), in a discussion of the difference between R or correlational methodology and Q methodology, saw the former as emphasizing the differences between individuals as significant while the latter focuses on what is significant to the individual. The emphasis is on the "inner frame of reference" (McKeown, 1984, p. 416) of the individual and what is of "psychological significance" to

him or her (McKeown & Thomas, 1988, p. 35). The hope is that with the Q sort, the individual can be helped to reveal patterns of thought, feeling, behavior, and belief in a way that is more reflective of his or her subjective reality than in approaches that require the subject to fit into predetermined constructs developed by the experimenter (Brown, 1980). This explains, at least in part, the central emphasis on factor analysis as a way of developing constructs from the subjects themselves rather than imposing them from the outside (Kitzinger & Rogers, 1985). This also helps explain the traditional emphasis on smaller numbers of subjects because, as McKeown and Thomas (1988) put it, "The major concern of Q methodology is not with how many people believe such-and-such, but with why and how they believe what they do" (p. 45).

In the twin emphases on subjectivity and theory, theory has, for Stephenson, been primus inter pares. Theory guides researchers in the selection of statements or stimuli populations, it helps them decide what propositions they wish to test, and it may guide them in factor rotation (Stephenson, 1953). With this approach, "the theory we are seeking to test is built into a Q sort" [italics in original] (Kerlinger, 1958, p. 15). Kerlinger (1986) argued that "if a theory, or aspect of a theory, can be expressed in categories and if items that express the categories can be produced, then Q can be a powerful approach to testing

theory" (p. 517). Brown (1986) noted that "there is hardly a corner of human endeavor to which it has not been applied" (p. 72) -- thus reflecting on the flexibility of the method.

Q methodology's traditional emphasis on few subjects also stems from the fact that the N of the study are the statements, not the people (Dennis, 1986). The researcher needs to collect a "'universe' of statements" (Stephenson, 1953, p. 19). These are then refined to become a representative sample of a given domain of interest. These statements are commonly derived in three ways: (1) statements may be taken directly or adapted from the literature on a given area; (2) statements are developed from already existing measures; and (3) statements are developed through interviews with the subjects of the study (Dennis, 1986). An example of this last is Kitzinger and Rogers' (1985) study of lesbian identity. In this study, they developed the Q-sort from statements derived from interviews with 41 gay women (as well as from lesbian/feminist literature). Using factor analysis, they were able to show that these cards were sorted into five distinct types of lesbian identities. They also argued that this was a "constructionist" approach inasmuch as they worked to allow these women to define their own subjective views of their sexuality and romantic inclinations rather than requiring them to fit into identities imposed by the researcher.

While statements may be randomly chosen from a universe of statements, they are sometimes structured, and this is often done with the use of judges (Stephenson, 1953). The question here is one of construct validity (Kerlinger, 1958). The common practice is to have expert judges select the statements which they feel best represent the theory. Using this consensual approach (Block, 1961), those statements with the highest level of agreement are those most likely to be used (Nunally, 1978). Statement selection is obviously of great importance in developing an effective Q-sort. Various writers have argued that attention be paid to the need for all the statements to come from a common frame of reference (Nunally, 1978), that they "should represent a large number of continua" in a given domain, have "the same average degree of desirability," and "have substantial variance" for different people (Cronbach, 1953, p. 380). In addition, they should be reliable (Dawis, 1987), and they should be understandable, representative, and workable (Waltz, Strickland, & Lentz, 1984).

Both aspects of Q methodology were used in the study. A theory-based Q-sort that followed an ANOVA model was used to address three of the hypotheses. This is a reflection of Kerlinger's (1958, 1972, 1986) work in this area. A factor analysis, which reflects the importance of subjectivity, was also done, and this was certainly influenced by the work of Brown (1980). In short, there was an expansive use of two

of the main virtues of Q methodology in this study.

Before addressing Kerlinger's (1958, 1972, 1986) model and the issue of subjectivity (Brown, 1980), the question of subject selection and issues pertinent to idiographic and nomothetic research will be touched upon. McKeown and Thomas (1988), in their writings on the question of subject selection, have pointed out that subjects may be selected on a "theoretical" basis ("because of their special relevance to the goals of the study") or on a "pragmatic" basis ("anyone will suffice") (p. 36). In addition, subjects can be approached in terms of intensivity or extensivity -- the former being a more in-depth analysis of a few individuals and the latter involving a greater number of subjects with a somewhat less comprehensive examination of each one. This study utilized a theoretical and extensive approach.

Q methodology sits on the boundary between the nomothetic and the idiographic. It is this which makes it such a compelling tool and which, perhaps, fuels some of the disagreements over its use, as some view it as more of an idiographic, subjective tool (Brown, 1980, 1986; Kitzinger & Rogers, 1985), while others push for a more normative approach (Brooks, 1970; Kerlinger, 1958, 1986; Nunally, 1978). Kerlinger (1958), touching both sides of the issue, observed that "Q methodology becomes, in effect a nomothetic methodology of the individual, a sort of liaison between the devotee of the case study and the devotee of the large-N

approach" (p. 19). He also went on to say that "Q operates on the principle of differences within individuals as well as among individuals" (p. 24). As a summation statement of the value of the Q-sort as a bridging instrument, he wrote, "I doubt that in any other measurement procedure do the objective and the subjective come so well together as they do in Q" (Kerlinger, 1972, p. 32).

Kerlinger's (1958, 1972, 1986) model of a structured sort is based on a one-way ANOVA research design -- a model, he noted, that Stephenson (1953) did not use (he preferred two- and three-factor models). Kerlinger's (1958, 1972, 1986) example was especially helpful because it provided a model that was very close to the one used in this study. In brief, he looked at the Allport-Vernon Study of Values test, which was an adaptation of Spranger's Types of Men. Spranger hypothesized that there were six types of men -- theoretical, economic, aesthetic, social, political, and religious. Kerlinger developed a 90-card Q-sort that consisted of 15 cards for each of the six types. Each card had one word on it that reflected that type -- i.e., for the religious type, a card might say "church" or "sermon." In the example he gave (Kerlinger, 1958, 1972, 1986), he reported the results of a Q-sort by a musician. Using an F test, he found that the subject's sorting of the cards for each of the six types was different. As one would hope, the musician scored highest on the aesthetic type. Further

analysis showed that the aesthetic, social, and theoretic types as a group were significantly favored over the economic, political, and religious types. This finding was supported by other information about the subject as well (Kerlinger, 1986).

In Kerlinger's discussion of this example and of the one-way structured Q-sort model, he made several points of relevance to Q-sorts in general and to the proposed identity study in particular. In a passage that reflects differing interests among Q-sort users, Kerlinger (1986) said that one could use this Vernon-Allport Q-sort with individuals to see how they scored on the various type items to get a profile or pattern of scores that would tell us something about the makeup of the person. He contrasted this applied use with the argument that Stephenson would not have used this approach. He felt that Stephenson would have used it on people whom one would predict would fit the type -- i.e., a minister or priest for the religious type, a banker for the economic. To the degree that these individuals favored these respective types and to the degree that the Q-sort was reflective of the theory, then the theory would be supported. This difference reflects a tension among those who use Q-sorts to test theory, those who use them to test people, and those who fall somewhere in between.

Some have felt that there were strict limits on the ways in which data could be used and what statistics could

be applied (Dawis, 1987; Brown, 1986). While acknowledging this argument, Kerlinger (1972) went on to state that while "we do add, multiply, and average Q data as though they were normative data. . .[it] does not change the nature of the measures. [However,] we use such methods because, although not strictly legitimate, they work rather well in practice" (p. 28).

Kerlinger makes some suggestions to help improve the statistical power of the approach: (1) He suggested telling subjects that they could always move a card or a group of cards from one pile to another until they were finished. He felt that this should be done to increase the independence of the procedure (Kerlinger, 1986). (2) He recommended using a .01 level of significance before accepting any findings as meaningful (Kerlinger, 1972, 1986). (3) He thought that there should be an adequate number of items and saw 60 as the acceptable minimum (Kerlinger, 1986). (4) The final way of checking the reliability of the results was through the use of factor analysis. If the Q-sort has been developed properly and the theory has some validity, "the person's factors should correspond to the major variables of the theory" (Kerlinger, 1986, p. 517). In terms of the ANOVA model we have been looking at, the results from the ANOVA analysis and the factor analysis should be similar (Kerlinger, 1986, 1972). In the example just mentioned, there would be an expectation of finding most of the

aesthetic (and perhaps a few of the theoretic) items at the positive end of the musician's factor array. If the same Q-sort was given to a group of musicians, there would again be an expectation of finding an "aesthetic factor." In this way, both the ANOVA design or the factor analysis can be used to test theory. It would seem logical that the more the results agree, the greater the support for the theory.

In addition to Kerlinger's model, Nunally's (1978) t-test model was also used. Nunally, who worked with Stephenson, argued that mean scores for substructures of the Q-sort could be compared between groups and that t-tests could be used to see if the groups differed significantly. (The mean score of the whole Q-sort is always 0 so that two complete Q-sorts cannot be compared in that way.) Adapting his thinking to the Kerlinger example, musicians and bankers could be compared to see if musicians endorsed aesthetic items at a significantly higher level and if bankers endorsed economic items at a significantly higher level. A similar model of between-group comparisons for specific items was also been proposed by Brooks (1970). If the t-tests are accurate, one would expect, at least for the most and least favored types, to see a similar difference between the groups emerging from an analysis of the factor arrays. In terms of the hypothesis testing, these two models were the core structures of the work.

Before discussing the role of factor analysis in Q

methodology, it might be useful to discuss the value of Q in identity research as well as some of the empirical work done with structured sorts. Q would appear to be an ideal methodology for research in multiple identity theory. If identity is, at least in part, the inner or psychological experience of role (McCall & Simmons, 1978), then both the potential for subjectivity and structure of the Q-sort would seem to be useful here. The emphasis on identity being a self-conception (Thoits, 1991) would fit well with Q methodology's "inner frame of reference" (McKeown, 1984, p. 416). Q methodology would not only provide researchers with the opportunity to test their theories about the content of identities, but also it would enable them to allow the contents to emerge from the subjects themselves. In addition, it enables researchers to look at the questions of hierarchy, structure, and the relationships among identities. Q-sort studies of identity have not been numerous. Some (Mallory, 1989) have looked at Erikson's (1959/1980) model rather than the multiple identity model being used. Kitzinger and Rogers' (1985) study, which was discussed earlier, is an example of developing varying models of an identity's content. A computer search has not found any examples of its use with multiple identity theory.

In a similar vein, the use of structured sorts (with or without analysis of variance) has been marginal. Kerlinger (1986) wrote, "Correlation approaches have more or less

dominated Q studies. One of Stephenson's important contributions, the testing of 'theory' and the principle of building 'theory' into Q sorts by means of structured samples of items, has been neglected" (p. 512). Recent attempts at using this model have included Metzger's (1979-1980) examination of the Kubler-Ross stage theory of death and dying. She found that her results did not support the theory that she had built into the Q-sort. Another example was Eisenthal's (1973) exploration of organizational theory. Directly designing his research on Kerlinger's (1958) model, Eisenthal found qualified support for his hypotheses and for the "roles" he had structured into his sort.

If the ANOVA model addresses the question of theory, the factor analytic model addresses subjectivity. As Brown (1980) has written ". . .the subject's frame of reference is given prominence through factor analysis, which may produce results quite other than what the investigator postulated originally" (p. 191). The factor analytic approach allows the subjects to present themselves without being forced into the categories of the researcher. If there is a similarity between the ANOVA and the factor analytic studies, then there is greater support for the theory being tested. As was found in this study, the factor analytic approach can provide a rich insight into the data that the ANOVA approach may be unable to provide while at the same bolstering the ANOVA findings.

The research outline

Introduction

As a way of testing the overall theory that the process of recovery involves a restructuring of the identity prominence hierarchy (McCall & Simmons, 1978) and the specific hypotheses discussed above, a Social Identity Q-sort (SIQ) (see Appendix C) was created specifically for this study with the Hospital and Agency men.

Population and sample

The Hospital program, at the time the data collection began, had 83 patients -- 76 of whom were men. Of the total Hospital population (n = 83), 37% were Latino men, 33% were African-American or Black men, and 22% were White men. Usually these men came to the clinic for various reasons, including: (1) they wanted help with their drinking (and, sometimes, drug) problems; (2) they had been referred to the program by Public Assistance and attendance was necessary if they were to continue to receive benefits; (3) they had been referred by the Hospital or another social service agency; (4) they had been referred by their parole or probation officers and they needed to participate if they were to avoid legal difficulties; or (5) they were homeless and wanted to change that situation. Regardless of motivation, each potential client was screened by one of the staff members to determine whether, indeed, they did have an alcohol problem. Those who were felt to be inappropriate for

treatment (i.e., they did not have a substance abuse/alcohol problem, or their psychiatric problems would not allow them to participate in treatment) were not accepted into the program. After being accepted, they first attended a five-week orientation program and, upon successfully completing this phase, they were then accepted into the formal treatment program. The program mixed a strong 12-Step base with medical (i.e., Antabuse), psychological (i.e., Rational-Emotive Therapy), and psychosocial (i.e., group therapy) approaches. Although it was ostensibly a program for alcoholism, many, if not most, of the clients had used drugs as well. In some cases, alcohol was the primary drug of abuse while in others it was not. Regardless, the program demanded complete sobriety and, for the most part, did not find the polysubstance abuse to be a problem that it could not address. Although there were no formal statistics, the staff estimated that roughly 50% of the clients would be able to maintain their sobriety while in treatment, and that roughly 50-60% attended A.A. meetings on the outside at least occasionally -- with a large overlap between these groups.

As noted, the program itself was divided into two phases -- an orientation phase and a program phase. Clients in the orientation phase attended two hours of psychoeducational groups, four days per week, for five weeks. After successfully attending all groups and

demonstrating sobriety through frequent and random breathalyzer tests, the client was formally welcomed into the program phase. During the treatment phase proper, the client attended two or three groups every day, five days a week, and had an individual therapist as well.

The Agency program was similar to the Hospital program in many respects. Its 1991 census showed that it had treated 82 clients -- 73 males and nine females. The ethnic make-up was 46.3% Hispanic, 37.8% African-American, 14.6% White, and 1.2% other. In terms of treatment philosophy, it, too, was a mixture of the 12-Step and psychosocial rehabilitation models. In the orientation phase, clients were expected to attend the program regularly and go to at least three A.A. meetings outside of the clinic per week. To move on to the next phase of treatment, they had to meet these requirements and maintain their sobriety for at least 30, but more commonly 60, days. The Agency had a series of other levels (Entry, Ongoing, Re-entry, and Aftercare) and subjects who were not doing well could be put back into the orientation phase -- something that did not happen at the Hospital unless someone left the program. Two Agency orientation members in this study had, in fact, been demoted back to the orientation phase. Other than putting people in an orientation group or a program group, the subdivisions were not taken into consideration in the study. The subjects who had been demoted to orientation group status

were considered to be orientation group members.

Because the focus was on the subjects' sense of identity and not on the effects of treatment, per se, the subjects from the Hospital and the Agency were put into one sample. Since they were quite similar on a number of SIQ scores and demographic variables (see Appendix B), there was a sense that the two groups of men were fairly homogeneous -- a sense that was supported by the data as well.

Sample demographics

The sample used for this study consisted of 63 men -- 48 from the Hospital and 15 from the Agency (see Table 1). The orientation group was represented by 22 subjects and the program group was represented by 41 subjects. The mean age of the sample was 45.73 (SD = 9.44 years). 41.3% were African-American, 27% were Latino, 20.6% were White, 3.2% were Afro-Caribbean, and the remaining 8% described themselves as various ethnic mixtures. 11.1% of the sample said that they were married, involved in a common-law relationship, or living with someone. 55.6% said that they had children, with one (on a scale of one to four or more) being the modal number of children and two being the median. Of those who had children, 25.7% said that they never saw their children and 45.7% said that they saw them once-a-month or more frequently. Subjects lived in a variety of settings.

Table 1

Sample and factor (1-3) demographics

Demographic Variables	Sample	Factor 1 Spirit-Recovery	Factor 2 Work	Factor 3 Recovery-Family
Program status				
Number of subjects	63	21	8	10
Hospital %	76.2	81.0	75.0	80.0
Agency %	23.8	19.0	25.0	20.0
Orientation %	34.9	19.0	37.5	30.0
Program %	65.1	81.0	62.5	70.0
Age	M = 45.73 SD = 9.44	M = 46.71 SD = 9.39	M = 45.75 SD = 8.70	M = 44.30 SD = 8.19
Ethnicity				
% African-American	41.3	38.1	12.5	40.0
% Afro-Caribbean	3.2	9.5	.0	.0
% Latino	27.0	28.6	37.5	40.0
% White	20.6	19.0	37.5	20.0
% Other	8.0	4.8	12.5	.0
Family				
% Single	88.9	90.5	75.0	90.0
% Married/ Common-law	11.1	9.5	25.0	10.0
% Have children	55.6	61.9	50.0	80.0
Modal number of children[a]	1.0	1.0	3.0	1, 2, 3, 4+
% no contact with children[a]	25.7	23.1	50.0	12.5

[a] Of those who have children.

Table 1

Sample and factor (1-3) demographics

Demographic Variables	Sample	Factor 1 Spirit-Recovery	Factor 2 Work	Factor 3 Recovery-Family
% see children 1x/month+[a,b]	45.7	53.8	25.0	50.0
Housing				
% In Hospital Sober dorm	36.5	33.3	25.0	60.0
% In transient hotels	15.9	19.0	.0	.0
% Living alone	11.1	19.0	25.0	.0
% Living in supervised housing	7.9	4.8	.0	10.0
% With spouse/ family of procreation	6.3	9.5	25.0	.0
% With family of origin	4.8	.0	.0	.0
% Living with friends	4.8	9.5	.0	10.0
% Homeless	3.2	.0	.0	.0
% In MICA shelter	3.2	4.8	.0	.0
% In regular Hospital shelter	1.6	.0	12.5	.0
% In non-Hospital shelter	1.6	.0	.0	10.0
% In senior citizen housing	1.6	.0	.0	.0
% Hospital inpatient	1.6	.0	12.5	10.0

[b] 1x/month means once-a-month or more frequently.

Table 1

Sample and factor (1-3) demographics

Demographic Variables	Sample	Factor 1 Spirit-Recovery	Factor 2 Work	Factor 3 Recovery-Family
Financial support				
% Receiving Public Assistance	47.6	38.1	25.0	60.0
% In Work/ School	28.6	38.1	50.0	20.0
% Receiving SSI	9.5	14.3	12.5	10.0
% No income	7.9	.0	12.5	10.0
% Social Security/ retirement/ disability/ recent unemployment	6.4	9.6	.0	.0
Religion				
% Protestant	46.0	42.9	25.0	40.0
% Catholic	36.5	42.9	50.0	50.0
% Personal beliefs	6.3	9.5	12.5	.0
% No religious affiliation	4.8	.0	.0	10.0
% Denomina-tional mixtures[c]	6.4	4.8	12.5	.0
% Never attend services	44.4	23.8	62.5	50.0
% Attend 1x/month+	28.6	42.9	25.0	20.0

[c] Examples of denominational mixtures in this study included Jewish-Catholic, Lutheran-Orthodox, and Hindu-Protestant.

Table 1

Sample and factor (1-3) demographics

Demographic Variables	Sample	Factor 1 Spirit-Recovery	Factor 2 Work	Factor 3 Recovery-Family
Education				
% 11th grade or less	42.9	38.1	50.0	30.0
% GED, High School Diploma, or vocational training	33.3	28.6	25.0	50.0
% One or more years of college	23.8	33.3	25.0	20.0
Alcohol and drug use				
% Alcohol users	61.9	61.9	62.5	60.0
% Drug users	3.2	4.8	.0	.0
% Both alcohol & drug users	34.9	33.3	37.5	40.0
% Never used drugs	31.7	23.8	25.0	50.0
% Used drugs in recent years[d]	58.8	66.7	62.5	40.0
% Not a recent drug user[e]	14.0	12.5	16.7	20.0
% Using cocaine/ crack[f]	67.6	78.6	60.0	75.0

[d] "Recent years" means within the last three years.

[e] This is in proportion to the group of subjects who said that they had ever used drugs.

[f] This refers only to recent drug users who used cocaine/crack alone or in combination with other drugs.

Table 1

Sample and factor (1-3) demographics

Demographic Variables	Sample	Factor 1 Spirit-Recovery	Factor 2 Work	Factor 3 Recovery-Family
Years of reported drinking	M = 25.50 SD = 10.60	M = 24.04 SD = 11.07	M = 25.88 SD = 8.51	M = 21.80 SD = 8.53
Years of reported drug use of recent users	M = 15.83 SD = 10.64 (n = 37)	M = 17.07 SD = 11.49 (n = 14)	M = 13.8 SD = 8.11 (n = 5)	M = 13.75 SD = 6.29 (n = 4)
Months of reported sobriety[g]	M = 9.70 SD = 11.72 (N = 62)	M = 14.39 SD = 15.04 (n = 20)	M = 6.12 SD = 8.54	M = 6.23 SD = 4.97
% Sober more than 6 months	50.8	66.7	25.0	50.0
Months of reported abstinence[h]	M = 12.05 SD = 11.28 (n = 37)	M = 15.70 SD = 10.92 (n = 14)	M = 10.15 SD = 10.13 (n = 5)	M = 18.75 SD = 13.89 (n = 4)
% Abstinent for more than six months[h]	64.9	78.6	60.0	100.0
Treatment factors				
% Wanting to address drinking/drug problems	65.1	71.4	100.0	40.0
% Public Assistance referral	7.9	9.5	.0	20.0
% Homeless-ness was motivator	3.2	.0	.0	.0
% Misc. Referrals	23.8	19.1	.0	40.0

[g] Excluding subject 52 who reported that he had 23 years of sobriety.

[h] For those who had used drugs in recent years.

Table 1

Sample and factor (1-3) demographics

Demographic Variables	Sample	Factor 1 Spirit-Recovery	Factor 2 Work	Factor 3 Recovery-Family
Months in treatment[i]	M = 11.56 SD = 12.08 (n = 52)	M = 13.81 SD = 12.90 (n = 19)	M = 12.18 SD = 16.89 (n = 8)	M = 5.53 SD = 4.85 (n = 8)
Sobquot[j]	.96 (n = 52)	1.09 (n = 19)	.50 (n = 8)	1.21 (n = 8)
% Not in current program before	85.7	85.7	87.5	80.0
% Never in any treatment before	27.0	38.1	12.5	20.0
% Detoxification/ rehabilitation programs only	23.8	14.3	37.5	30.0
% In one previous alcohol treatment program	15.9	19.0	.0	10.0
% In one previous drug treatment program	3.2	4.8	.0	.0
% In a MICA program	3.2	4.8	.0	10.0
% In more than one previous treatment program	22.2	14.3	50.0	20.0

[i] For those who had been in treatment at least .1 months -- excluding subject 52.

[j] Sobquot = Mean months of reported sobriety/mean months in treatment -- for those who had been in treatment 0.1 months or more (excluding subject 52).

Table 1

Sample and factor (1-3) demographics

Demographic Variables	Sample	Factor 1 Spirit-Recovery	Factor 2 Work	Factor 3 Recovery-Family
% On methadone -- past or present	4.8	4.8	.0	10.0
% currently taking Antabuse	4.8	4.8	12.5	10.0
% Not attending 12-Step meetings	9.5	.0	.0	.0
% Attending 12-Step meetings	90.5	100.0	100.0	100.0
% Attending both N.A. and A.A.[k]	21.1	14.3	12.5	20.0
Mean number of weekly meetings[k,l]	M = 5.23 SD = 1.85 (n = 56)	M = 4.76 SD = 1.97	M = 4.75 SD = 2.31	M = 6.00 SD = 1.25
% Who had attended meetings for more than six months[k]	64.3	71.4	62.5	50.0
% Who had attended meetings for less than 1 month[k]	8.9	9.5	.0	10.0
% Attending outside 12-Step meetings[k]	96.4	95.2	87.5	100.0
% Having a sponsor[k]	48.2	47.6	25.0	30.0

[k] Of those who attended 12-Step meetings.

[l] The maximum number coded was 7.

Table 1

Sample and factor (1-3) demographics

Demographic Variables	Sample	Factor 1 Spirit-Recovery	Factor 2 Work	Factor 3 Recovery-Family
Progress in recovery				
% Feeling "a great deal" better	68.9 (N = 61)	81.0	37.5	80.0
% Feeling "somewhat" better	29.5 (N = 61)	19.0	62.5	20.0
% Not feeling better	1.6 (N = 61)	.0	.0	.0
% Program helping "a great deal"[m]	87.0 (n = 46)	94.4 (n = 18)	66.7 (n = 6)	100.0 (n = 7)
% Program helping "somewhat"[m]	13.0 (n = 46)	5.6 (n = 18)	33.3 (n = 6)	.0 (n = 7)
% Program not helping[m]	.0 (n = 46)	.0 (n = 18)	.0 (n = 6)	.0 (n = 7)
% 12-Step meetings helping "a great deal"[n]	67.9 (n = 56)	76.2 (n = 21)	50.0 (n = 8)	80.0 (n = 10)
% 12-Step meetings helping "somewhat"[n]	30.4 (n = 56)	23.8 (n = 21)	50.0 (n = 8)	20.0 (n = 10)
% 12-Step meetings not helping[n]	.0 (n = 56)	.0 (n = 21)	.0 (n = 8)	.0 (n = 10)
% N.A. meetings helping[n]	1.8 (n = 56)	.0 (n = 21)	.0 (n = 8)	.0 (n = 10)

[m] Of those who had been attending the program for more than 0.6 months.

[n] Of those who attend 12-Step meetings.

Table 1

Sample and factor (1-3) demographics

Demographic Variables	Sample	Factor 1 Spirit-Recovery	Factor 2 Work	Factor 3 Recovery-Family
% Rated as maintaining their sobriety°	46.0/ 63.0	66.7/78.0	25/33.3	50.0/71.0
% Rated as "slipping" or worse°	25.4/ 35.0	19.1/22.0	37.5/50.0	20.0/29.0
% Therapist did not know°	1.6/ 2.0	.0/.0	12.5/16.7	.0/.0
% Insuf-ficient time in treatment for rating	27.0	14.3	25.0	30.0

° % including insufficient time for a rating/% based only on those who had been in treatment for more than 0.6 months.

The Hospital, in addition to having an alcohol program, had its own men's shelter. One part of this shelter was a special dorm for men who wished to break their addiction to drugs and alcohol (the "Hospital Sober Dorm"), another section was geared to men with psychiatric problems, and another part was a general men's shelter. Subjects in this study lived in all three sections. 36.5% lived in the Hospital Sober Dorm; 15.9% were living in transient hotels; 11.1% were living alone; 7.9% were living in some kind of supervised housing; 6.3% were living with their spouses and/or family of procreation; 4.8% were living with their family of origin; 4.8% were living with friends; 3.2% were homeless; 3.2% were living in a special MICA section of the Hospital shelter (a special program for patients with psychiatric problems who had difficulty with the shelter system); and 1.6% each were living in the Hospital shelter (not the Hospital Sober Dorm), a non-Hospital shelter, senior citizen housing, and on the in-patient MICA unit at the Hospital. There was, in addition, a link between the Hospital Sober Dorm and the Hospital program. In terms of financial support, 47.6% received public assistance, 28.6% were involved in a variety of work development, school, part- or full-time employment, and volunteer work situations while receiving benefits ("Work/School"). 9.5% of the sample were on SSI, 7.9% had no income; and the remaining 6.4% received social security/retirement benefits,

disability, or were just recently unemployed.

The reported religious affiliation of the sample was 46% Protestant, 36.5% Catholic, 6.3% personal beliefs, 4.8% no religious affiliation, and the remaining 6.4% cited various denominational mixtures (i.e., Hindu-Protestant). Baptist, Methodist, and Pentecostal were the Protestant denominations most frequently mentioned, and there appeared to be some relationship between religious affiliation and ethnicity. (For example, with the African-American subjects, 80% reported that they were Protestants, and with the Latino subjects, 64.7% reported that they were Catholics. The White subjects were more closely matched between Catholics [38.5%] and Protestants [23.1%].) 44.4% said that they never attended religious services and 28.6% said that they attended once-a-month or more frequently. The remainder attended services less frequently. In terms of education, 42.9% had completed 11th grade or less; 33.3% had a GED, a high school diploma, and/or had completed a formal vocational training program; and 23.8% had completed from one year of college to a Masters degree.

61.9% of the sample identified themselves as being primarily alcohol users; 34.9% identified as being users of both alcohol and drugs; and 3.2% said that they were primarily drug users. 31.7% said that they did not use drugs, and 58.8% said they had used drugs within the last three years ("recent years"). The rest had not used in

recent years. Of the recent users, 67.6% said that they used cocaine or "crack" alone or in combination with other drugs. This was the primary drug of the sample. (The specific drug of choice was unknown for 2.7% of the recent drug user sample.) The sample as a whole reported drinking an average of 25.5 years (SD = 10.6 years). While all subjects had a drinking history, not all had used drugs. Of those who had reported at least some recent drug use (n = 37), the mean length of reported involvement was 15.83 years (SD = 10.64 years). The mean length of reported sobriety (N = 62)[3] was 9.7 months (SD = 11.72 months) and 50.8% reported that they had been sober for more than six months. Of those who had used drugs in recent years (n = 37), the mean length of reported abstinence was 12.05 months (SD = 11.28 months), and 64.9% of the group reported that they had been abstinent for more than six months. In general, subjects tended to discontinue drug use before they stopped drinking.

In terms of motivation for treatment, 65.1% said that they came because they wanted to address their drinking and/or drug problems; 7.9% each said they came because of a public assistance or a Hospital referral; 3.2% said that their homelessness had brought them to treatment; and the remaining 15.9% cited various referral sources.

The sample as a whole had been in treatment for an average of 9.76 months (SD = 11.76 months) -- however, 10 subjects in the orientation group had no formal treatment

time when they completed the protocol. The remaining 53 had been in treatment for an average of 11.61 months (SD = 11.96 months). The mean length of reported sobriety for the group (n = 52)[3] was 11.15 months (SD = 12.23 months) showing that as a group, subjects stopped drinking around the time that they entered the program. Another way of looking at the ratio of time sober and time in treatment is through the use of the Sobquot. The Sobquot, which was inspired by Alksne's (1980) use of the Balance Index, is based on a ratio of mean months of reported sobriety/mean months in treatment -- for those who had been in treatment 0.1 months or more (excluding subject 52). The Sobquot for the sample was .96.

Concerning their present treatment, 85.7% said that they had never been a member of their current program before. In terms of other treatments, subjects were rated by the highest level of treatment. Program membership was seen as a higher level of treatment than having been through detoxification or rehabilitation programs. A subject who had been in both a rehabilitation and an alcohol program would be scored as having attended a program. 27% said they had never been in treatment before, 23.8% said they had been in detoxification and rehabilitation programs, 22.2% said they had been in more than one other treatment program, 15.9% said they had been in one alcohol treatment program, 3.2% said they had been in one drug treatment program. In addition, 4.8% said they had been on methadone in the past

or at the present time (as well as having had other treatments), and 4.8% of the total sample said that they presently took Antabuse.

In terms of 12-Step group attendance, 90.5% said that they attended meetings (they usually said A.A.), 21.1% of these added that they attended both A.A. and N.A. Of those who attended (*n* = 56), the mean number of reported meetings attended (with seven being the maximum number scored) was 5.23 per week (*SD* = 1.85). There was fairly solid involvement with 64.3% of this group (*n* = 56) having attended meetings for more than six months, and 8.9% having attended for less than one month. Most (96.4%) went to meetings outside of the Agency or the Hospital, and 48.2% had sponsors.

Measures of self-perception of progress in recovery were available for 61 subjects, and 68.9% said they were feeling "a great deal" better, 29.5% said they were "somewhat" better, and 1.6% said they were not feeling better. Of the 46 subjects who had been in the program for 0.6 months or more, 87.0% said the program was helping "a great deal," and 13.0% said the program was helping "somewhat," and none said the program was not helping. Of the 56 who attended meetings, 67.9% said the 12-Step meetings were helping "a great deal," 30.4% said they were helping "somewhat," and 1.8% volunteered that N.A. was helping. Again, no one reported that the meetings were not

helping. In general, it seems that the subjects found both 12-Step meetings and program attendance to be helpful. With the 44 subjects who were attending both the program and 12-Step meetings, 68.2% found them both equally helpful, 25% found the program to be more helpful than the meetings, and 6.8% found the meetings to be more helpful than the program.

Finally, therapist ratings of subject sobriety over the past five months or since the beginning of treatment (whichever was shorter) were examined. To be rated, the subject had to have been a program member or have been an orientation group member for more than 0.6 months; 17 subjects were characterized as having insufficient time in treatment to be rated. The unrated group had a mean length of reported sobriety of 1.92 months (SD = 2.34 months) with a range from no days to eight months of sobriety. The insufficient time rating can be seen as an indication of brief sobriety, if any at all. Overall, the unrated group made up 27% of the sample. Those who were seen as maintaining their sobriety made up 46% of the sample. Those who had only slipped once or twice (n = 12), those who were having trouble maintaining their sobriety (n = 3), and those who were drinking and/or using drugs (n = 1) were combined, and this combined group made up 25.4% of the sample. For 1.6%, the therapist did not know how the subject was doing. Recoding this to look at the rating proportions for those who could be rated, approximately 63% were maintaining their

sobriety, 35% were "slipping" or having more serious difficulties, and for 2% the therapist did not know how the subject was doing.

Instruments

The main instrument used was the Social Identity Q-sort (SIQ) (see Appendix C). The SIQ, which was developed for this project, consisted of five 12-card groups, each with one statement on it. This means that there were 12 cards for each of the identities under examination -- Addict, Recovery, Work, Family, and Religion -- for a total of 60 cards. The addiction and recovery identities were chosen because of their pertinence to the work of Waldorf, Biernacki, & Stall (Biernacki, 1986; Stall & Biernacki, 1986; Waldorf, 1983; Waldorf & Biernacki, 1981) as well as that of Stephens (1985). The decision to look at the work, family, and religion identities was influenced by Thoits' (1991) belief that empirical studies on identity should reflect "enduring, normative, reciprocal relationships . . . .that are ongoing. . .that are currently enacted . . .and that carry fairly clear rights and obligations in relation to others" (p. 103). Work, family, and religious identities would appear to be possible candidates for meeting these requirements as well as being central aspects of most people's lives. (The development of the SIQ is discussed in Appendix D.)

In addition to the SIQ, each subject was asked to sort

cards with the same 60 statements on them into two piles (the self-sort task). The Hospital subjects also received the Hospital consent form and an addendum which were verbally explained to them -- and the Agency group received a different consent form which was read to them (see Appendix E). There was also an addition of several questions to the Demographics Form during the course of the study (see Appendix F). Finally, each subject who had been in treatment for at least two weeks was rated by his therapist (see Appendix G).

The SIQ and the self-sort task were piloted on four "specimen" subjects -- two people who were in recovery (one man recovering from alcoholism and one woman recovering from marijuana abuse) and two ministers. These subjects also discussed their history and present preoccupations and concerns. The Q-sort and self-sort tasks were well-managed and appeared to be a fair reflection of their lives at the present time.

Procedure

Recruitment at the Hospital.

At the Hospital, the aim and methods of the study were first explained to the staff to elicit their support. The researcher addressed the clients at two community meetings where the original intention was to ask for those with three months or more sobriety. This plan was dropped because of the lack of an existing orientation group at the

commencement of the study. This absence also led to a decision to have the counselors rate the subjects' sobriety -- both decisions that improved the quality of the study. Flyers were posted at the Hospital (see Appendix H) to encourage the clients to participate and many clients were approached by the researcher who directly requested their participation.

Recruitment at the Agency.

The Agency was contacted at first with an interest in clients who were doing well. The research focus soon expanded to include any clients who were willing to participate and who could read. Here, the staff did the recruiting -- initially by making an announcement at their community meeting and then by approaching the patients directly. This was out of a sense of deference to their patients' feelings and their fears that the men would be embarrassed if they were approached directly by the researcher and they did not know how to read.

All the subjects were required to be able to read English and each received $5.00 for his participation. At the Hospital, 52 subjects participated and the data from 48 were used in the study; in turn, 17 Agency subjects participated and the data from 15 of them were used.

Tasks.

After completing the Consent Form and answering the questions for the Demographics Form (see Appendix F), all of

the subjects were given two tasks. The first task both pertained to Hypothesis 4 and served to familiarize the subjects with cards and with the process of sorting them. (See Appendix I for the verbal instructions for this task and the Q-sort task.) In this procedure, two marker cards were put on the table -- one labeled Like me and the other labeled Not like me. The subjects were then given 60 cards with the SIQ statements on them and were asked to create two piles of cards, with as many or as few cards as seemed appropriate for each pile. There was no time limit, and they were requested to put all the cards in one of the two piles. In contrast to the formal Q-sort, this was an unstructured self-representational task that allowed the subjects to freely indicate their identities.

Upon completion of the first task, they were then given the second task, which was to organize the 60 SIQ cards into a forced-choice, structured Q-sort. The Q-sort structure used 11 categories because this format enabled subjects to make "reliable discriminations" (Block, 1961, p. 80) without being subject to arduous conditions. The subjects were asked to organize the 60 cards in order from Most like me to Most unlike me in the following pattern -- 2, 3, 4, 7, 9, 10, 9, 7, 4, 3, 2. 60 cards were chosen because this number was felt to be an optimum number both for ease of manipulation and for statistical reliability (Kerlinger, 1986).

Design and data analysis

The design and data analysis of the project centered on the previously discussed one-way ANOVA structured Q-sort suggested by Kerlinger (1986), the t-test model suggested by Nunally (1978), and on factor analysis (Brown, 1980, 1986, 1992; Dennis, 1986; Kerlinger, 1958, 1972, 1986; McKeown, 1984; McKeown & Thomas, 1988; Nunally, 1978; Stephens, 1953). The four hypotheses were tested using a repeated measures one-way ANOVA model t-tests. Following this, factor analysis was done using QMethod (Atkinson, 1992) as a way of further testing the hypotheses.

Hypothesis 1.

This hypothesis posited that the addict identity would be higher in the Q-sort for the orientation group than for the program group. This was a reflection of the identity theory proposition that recovery involves a process of reshuffling identities so that, during the healing process, the addict identity will gradually diminish in salience and, in some cases, will eventually drop out of the repertoire altogether. A t-test of the mean addict identity scores in both groups was used to determine if there was a significant difference.

Hypothesis 2.

This hypothesis suggested that the recovery identity would be higher in the hierarchies of the program group than in those of the orientation group. As discussed above, it was

posited that the program group would have a central and significant identity specifically based on recovery. Again, a t-test of the mean recovery identity scores was used to analyze the differences between the groups.

Hypothesis 3.

This hypothesis suggested two ideas: (1) In the program group, the recovery identity would be the most prominent in the hierarchy; (2) The second prediction was that both the addiction and the recovery identities would be the two most prominent identities in the program group hierarchy. Both of these ideas were tested using the Helmert contrast method (Norušis, 1990b) which compared each mean identity total with the mean totals for the identities beneath it combined.

Hypothesis 4.

This hypothesis addressed both the question of identity damage caused by the addiction or alcoholism and identity development or rehabilitation as a phenomenon related to recovery. This meant that: (a) the mean number of non-addict cards endorsed as Like me would be greater for the program group than for the orientation group; and (b) the mean number of work, family, and religious identity cards endorsed as Like me would be greater for the program group than for the orientation group. Again, a t-test was used to see if these differences were significant.

Factor analysis.

In addition to the use of t-tests and ANOVA design, the Q-sorts of both groups were combined and examined through the use of factor analysis. As discussed above, factor analysis is an essential component in the use and understanding of Q (McKeown & Thomas, 1988). It helps to reveal both how people cluster together (McKeown & Thomas, 1988) and what their common attitudes (Brown, 1986), perspectives (McKeown & Thomas, 1988), or "modes. . .of subjective behavior" (Stephenson, 1953, p. 26) are. Factor analysis helps to reveal the underlying constructs existing in an individual (McKeown, 1984). In the ANOVA design described above, Kerlinger's (1958, 1972, 1986) emphasis on theory is in the fore. Factor analysis, on the other hand, gives acknowledgment to the importance of subjectivity in Q. That is, while the Q-sort may be created with a specific theory in mind, the individual sorts the cards as seems appropriate to him or her. While they are doing this, the researcher's theory does not impact on their behavior (McKeown, 1984). In this study, it provided an opportunity for the subjects to both reveal their identity organizations and structures and to show how they were both alike and unlike their fellows.

The mechanics of factor analysis in Q methodology are covered in four steps (McKeown & Thomas, 1988). In the first, a subject-by-subject correlation matrix is created.

This is a key instance where Q methodology differs from R methodology. In R methodology, tests would be intercorrelated -- not subjects (McKeown & Thomas, 1988; Stephenson, 1953). In the second step, after the correlation matrix is created, the data are factor analyzed (to determine the number of factors) and rotation takes place to help clarify the meaning of the factors. The third step involves factor scoring and the development of Q factor arrays and, lastly, the factors are interpreted.

The factors will be defined by groups of people who share similar attitudes or, in this case, identity structures. The interpretation of the factors can be arrived at through the use of two approaches (Kerlinger, 1958, 1972). The first approach is to look at the demographics (or another known "dimension") of those who are significantly loaded on a factor to see what, if anything, they share in common. The second approach is to develop a Q factor array. While each of the subjects under examination may be significantly loaded on a factor, they will vary in the degree to which this is true. A Q factor array is a complete Q-sort that reflects the "weighted responses of the individuals [who are loaded on a factor] to all the Q sort items" (Kerlinger, 1972, p. 25). That is, the sorting pattern of those who are more highly loaded on a factor will have greater impact on the overall definition of the factor. In this study, the weighted scores of the individuals loaded

on a factor for each of the 60 cards were added up in a Q-factor array that reflected their "factor nature" (Kerlinger, 1972, p. 25). That is, each factor was most represented by the more positive cards (+5, +4, +3) and least represented, negated, or opposed, by the more negative cards (-3, -4, -5,) on the Q continuum. Both of these extremes can be used to interpret the factor.

As mentioned before, factor analysis and ANOVA design can also work together. To the degree that the results from the ANOVA and the factor analysis are similar, then there is greater support for the theoretical constructs underlying the Q-sort (Kerlinger, 1972; Stephenson, 1953). Stephenson (1953), while arguing that variance analysis and factor analysis could be used in tandem, also pointed out that it is possible to learn something new from the factor analysis that might not be possible with the other method.

Computer programs.

The actual analysis of the data for the four hypotheses was done on the SPSS-PC program (Norušis, 1990a, 1990b, 1991). That is, SPSS-PC was used for the situations involving t-test and ANOVA designs. The factor analysis was done using QMethod (Atkinson, 1992) -- a mainframe computer program designed under the direction of Stephen Brown, PhD. This program was useful in a number of ways. The program used the Centroid method to determine the factors and automatically created seven factors. The researcher then

has the option of doing manual rotation or using varimax rotation. As sometimes happens, and as happened in this case, the varimax procedure provided a solution that was "theoretically acceptable" (Brown, 1980, p. 261). QMethod (Atkinson, 1992), in addition to providing the factor arrays, has another feature which proved to be quite helpful. It analyzed the factor arrays and noted those statements which were endorsed at a significantly higher, lower, or more central degree than by the other factors. This endorsement, especially at the high and low levels, was very helpful in determining the meaning of a factor and in seeing how factors differed one from another.

One minor shortcoming of QMethod, in this regard, is that it cannot distinguish if a factor is bipolar. In its comparison of the different factors, it looked at the +5 end as being the highest level of endorsement and the -5 end as the lowest end. In this study, Factor 5 was a bipolar factor. However, since it only had three people loaded on it (two at the positive end and one at the negative end), it was seen as a more heuristic factor with less clinical significance. The comparison of the positive statements of the different factors only took into consideration the perspective of the two subjects loaded on the positive end, not the one subject loaded on the negative end. The discussion that follows is written from that perspective.

Chapter three: Results

The four hypotheses

Hypothesis 1

In the identity hierarchies of those who are in the orientation group, the addict identity will be more prominent than among those who are in the program group. This hypothesis was sustained.

A precondition for this study was the use of an .01 level of significance for any statistic involving the Q-sort (Kerlinger, 1972, 1986). The mean Addict identity Q-sort total for the orientation group was significantly higher then for the program group, $t(61) = 3.71$, $p<.0005$[4] (see Table 2 and Figure 1).

Hypothesis 2

In the identity hierarchies of those who are in the program group, the recovery identity will have greater prominence than in those who are in the orientation group. This hypothesis was also sustained.

A comparison of the mean Recovery identity Q-sort totals (see Table 2 and Figure 1) for the program group and for the orientation group showed that the program group totals were significantly higher -- $t(61) = 2.83$, $p<.006$.

Table 2

Statistics for hypotheses 1, 2, and 4

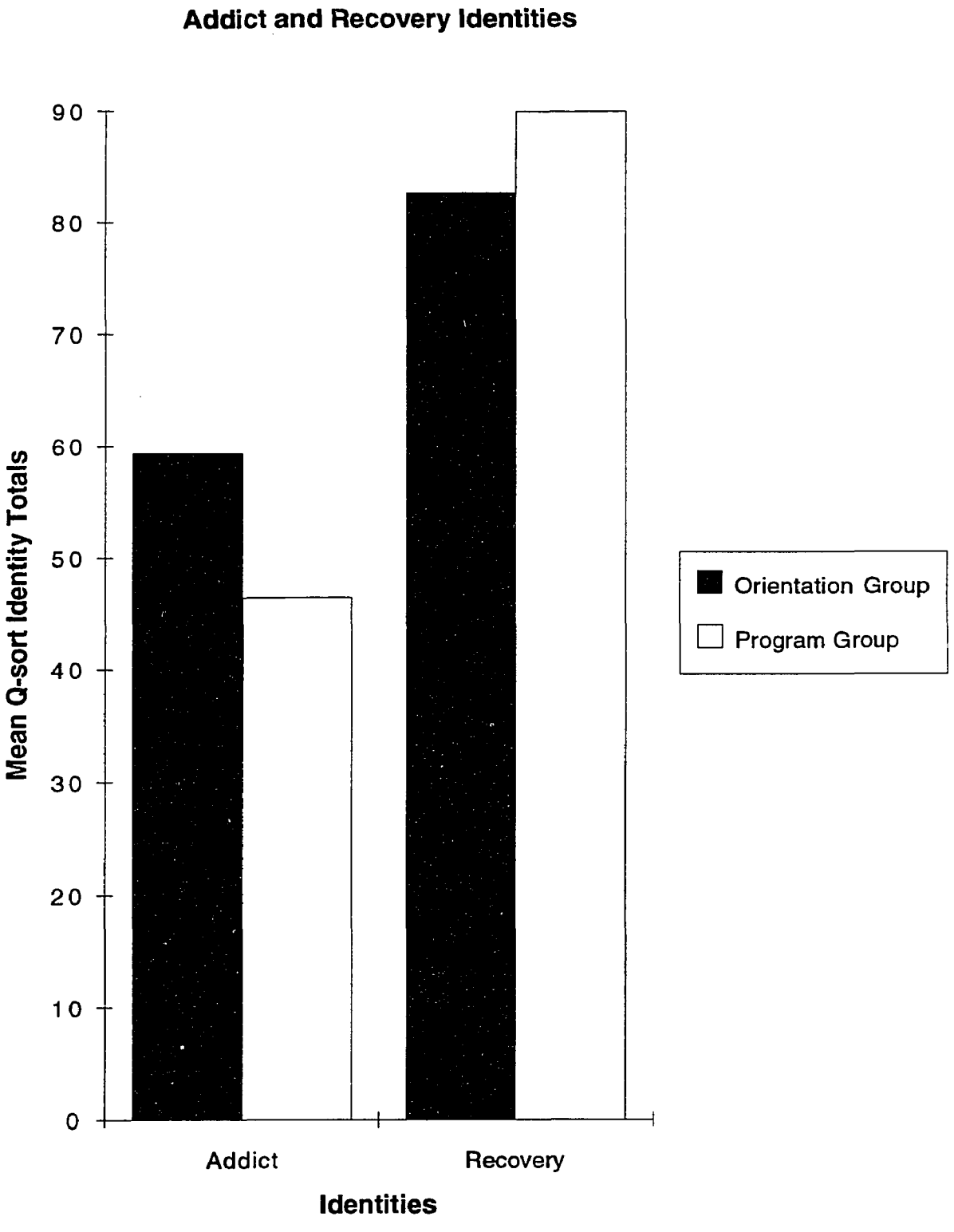
Variables	Program	Orientation	t-test
Hypothesis 1			
Addict Identity	M = 46.41 SD = 11.55	M = 59.41 SD = 16.02	t(61) = 3.71[a]***
Hypothesis 2			
Recovery Identity	M = 89.85 SD = 9.13	M = 82.59 SD = 10.69	t(61) = 2.83**
Hypothesis 4			
NONAD1[b]	M = 36.24 SD = 7.24	M = 33.68 SD = 7.17	t(61) = 1.34, n.s.
NONAD2[b]	M = 25.32 SD = 6.58	M = 23.86 SD = 6.01	t(61) = .86, n.s.
Self-Sort Cards			
Addict Identity	M = 2.37 SD = 2.96	M = 5.91 SD = 3.89	t(61) = 4.05[a]***
Recovery Identity	M = 10.93 SD = 1.40	M = 9.82 SD = 2.34	t(61) = 2.35[a]*

[a] Because of the inequality of the variances, the data was also analyzed using the Mann-Whitney U with similar results; "t-tests are presented here because they are more intrinsically appealing and people are more familiar with them" (M. Glassman, personal communication, May 27, 1993).

[b] NONAD1 equals the self-sort totals for the Recovery, Work, Family, and Religion identities. NONAD2 equals the self-sort totals for the Work, Family, and Religion identities.

*p<.05. **p<.01. ***p<.0005.

Figure 1


Addict and Recovery Identities
Mean Q-sort Identity Totals
90
80
70
60
50
40
30
20
10
0
Addict
Recovery
Identities
Orientation Group
Program Group

Hypothesis 3

Among those who are in the program group, both the Recovery and the Addict identities will be at the top of their hierarchies. This hypothesis was only partially supported (see Table 3).

In the program group sample (n = 41), the Recovery identity was at the top of the hierarchy while the Addict identity was at the bottom of the hierarchy. The program group hierarchy was organized in the following pattern: Recovery (M = 89.85; SD = 9.13), Work (M = 78.63; SD = 10.30), Religion (M = 76.66; SD = 14.44), Family (M = 68.44; SD = 13.87), and Addict (M = 46.42; SD = 11.55). There were significant differences among the five identities, $F(4,160) = 59.57$, $p.<.0005$. Using the Helmert contrast method (Norušis, 1990b), the Recovery identity was significantly higher than the average totals of the other four identities combined (contrasts = .894, -.224, -.224, -.224, -.224), $F(1,40) = 156.65$, $p.<.0005$.

As noted above, these results only lend support to half of the hypothesis, that the Recovery identity will be the most prominent identity. The Addict identity did not occupy a competing position on the identity hierarchy as it was on the bottom of the hierarchy.

Table 3

Statistics for hypothesis 3: Identity Structure and Anova

	Mean Q-sort Identity Totals					
Group	Recovery	Work	Religion	Family	Addict	ANOVA
Program *M* (*SD*)	89.85 (9.13)	78.63 (10.30)	76.66 (14.44)	68.44 (13.87)	46.42 (11.55)	*F*(4,160) = 59.57*
Helmert Con-trasts	.894	-.224	-.224	-.224	-.224	*F*(1,40) =156.65*
Orienta-tion *M* (*SD*)	82.59 (10.69)	72.91 (11.15)	75.59 (10.13)	69.50 (14.28)	59.41 (16.02)	*F*(4,84) = 7.98*
Helmert Con-trast	.894	-.224	-.224	-.224	-.224	*F*(1,21) = 21.60*

*$p < .0005$

While not specifically addressed in the hypothesis, the orientation group identity structure showed a similar pattern (see Table 3). The orientation group hierarchy was organized in the following pattern: Recovery (M = 82.59; SD = 10.69), Religion (M = 75.59; SD = 10.13), Work (M = 72.91; SD = 11.15), Family (M = 69.5; SD = 14.28), and Addict (M = 59.41; SD = 16.02). There were significant differences among the five identities, $F(4,84) = 7.98$, $p<.0005$. Using the Helmert contrast method, the Recovery identity was significantly higher than the average totals of the other four identities combined (contrasts = .894, -.224, -.224, -.224, -.224), $F(1,21) = 21.60$, $p<.0005$. Here again, the Addict identity was at the bottom of the hierarchy.

Hypothesis 4

Because the experience of addiction is often incompatible with the maintenance of nonaddict identities (Waldorf, 1983), those who are successfully recovering will have richer and fuller nonaddict identities than those who are just beginning treatment.

This hypothesis was tested using the self-sort cards and was looked at in two ways (see Table 2). In the first, the self-sort totals for the Recovery, Work, Religion, and Family for the two groups were compared and, in the second, the Recovery cards were not included. Because the Q-sort cards were not used here, a .05 level of significance was used. However, in both analyses, there were no significant

differences.

For the combined Recovery, Work, Family, and Religion self-sort totals (NONAD1) there was no significant difference between the program group and the orientation group totals, $t(61) = 1.34$, $p<.184$, n.s. (see Table 2).

For the combined Work, Religion, and Family self-sort totals (NONAD2), there was again no significant difference between the program group and the orientation group, $t(61) = .86$, $p<.393$, n.s. (see Table 2).

In a sense paralleling the findings using the Q-sort, there was a significant difference with the Addict self-sort cards between the orientation group and the program group. With $t(61) = 4.05$, $p<.0005$ (see Table 2)[4], the Addict identity self-sort totals were significantly higher for the orientation group than for the program group. A similar analysis was also done with the Recovery self-sort cards. There was also a significant difference with the Recovery self-sort cards between the program group and the orientation group. With $t(61) = 2.35$, $p<.022$ (see Table 2)[4], the Recovery identity self-sort totals were significantly higher for the program group than for the orientation group. These results would seem to imply that one of the major distinguishing characteristics between these groups is how much they identify with both the Addict and the Recovery identities as opposed to the strength of their other identities. A graphic expression of the

differences in the Addict and Recovery Q-sort totals is portrayed in Figure 1.

The factors

Using QMethod (Atkinson, 1992), six significant factors were found with Centroid method and Varimax rotation. As Brown (1980) has argued, eigenvalues are irrelevant in Q-methodology because they are dependent upon the vagaries of the P-sample used. By this he meant that the focus of Q is the discovery of types, not the prevalence of types.

Factor 1

Factor 1 was the largest and perhaps most defining factor of the study. This factor was called the Spirit-Recovery factor (see Appendix I). The term Spirit refers to the first five cards of the Religion identity (49 - 53) which are focused on a belief in, and the importance of, God. With the exception of Factor 5, this cluster was often separated from the remaining seven Religion cards which were more concerned with formal religious involvement. As one subject put it, "Religion and God are different things." An examination of the first nine cards of Factor 1 (+5 to +3), revealed that all five of these Spirit cards were present. The remaining four were all from the Recovery identity. Two of these emphasized the importance and centrality of sobriety and two reflected the usefulness of attendance at the treatment program and of therapy. Although not in the top nine, the statement "I go to Alcoholics Anonymous

meetings" was nearby (+2).

An examination of the rejected identity shows that there was a complete rejection of the addict experience and identity. The lowest nine cards (-3 to -5) were all Addict cards -- in fact, the lowest 12 cards were all Addict cards. The Factor 1 array had the lowest overall Q-array total for the Addict identity (Addict = 32). QMethod also revealed a significantly greater rejection of the Addict statements for seven cards -- cards 1, 2, 3, 5, 6, 8, 9 -- at the .01 level by Factor 1 than by the other five factors (See Appendix J).

In terms of demographics (see Table 1), Factor 1 (n = 21) was fairly representative of the sample as a whole. The Hospital:Agency ratio was 81:19 and the Program:Orientation ratio was 81:19. The mean age was 46.71 years (SD = 9.39). There was an African-American plurality (38.1%), followed by Latino (28.6%), and White (19.0%) subjects. The two Afro-Caribbean subjects (9.5%) in the study were also loaded on this factor. The group was predominantly single (90.5%); 61.9% had children, and the modal number of children was one. Of those who had children (n = 13), 23.1% had no contact with their children and 53.8% saw them once-a-month or more frequently. The most common living situations were the Hospital Sober Dorm (33.3%), living in an SRO/Transient hotel (19%), or living alone (19%). 38.1% were on Public Assistance and 38.1% were involved in work/school. As a group, they were a bit less likely to be on public

assistance (38.1/47.6%)[5] and a bit more likely to be involved in work/school (38.1/28.6%). They were equally divided between Catholics and Protestants (42.9% each) and they were somewhat more likely to attend religious services (never -- 23.8/44.4%; once-a-month or more frequently 42.9/28.6%). They were slightly more educated than the sample as a whole with 33.3/23.8% having had one year of college or more.

Looking at their addiction experiences, 61.9% described themselves as primarily alcohol users and 33.3% described themselves as both alcohol and drug users. For the whole group, 66.7% said they had used drugs in the recent past. Of those who had used drugs in recent years, 78.6% said cocaine/crack alone or in combination with other drugs had been their primary drug. The mean length of time reported drinking was 24.04 years (SD = 11.07). The mean length of time reported using drugs for those who used drugs (n = 14) was 17.07 years (SD = 11.49). The mean length of reported sobriety was 14.39 months (SD = 15.04). This was nearly five months longer than the mean length of reported sobriety of the sample as a whole (N = 62)[3] -- 9.7 months, SD = 11.72. In this group, 66.7% reported six months or more sobriety. In terms of abstinence from drug use for those who used drugs recently (n = 14), the mean length of reported time abstinent was 15.70 months (SD = 10.92). Of those who had used drugs recently, 78.6% of the Factor 1

group reported abstinence of more than six months.

The group was motivated for treatment as 71.4% emphasized their desire to address their alcohol and/or drug problems. Of those in the group who were actually attending the program (n = 19)[3], the mean treatment time was 13.81 months (SD = 12.90) which was greater than that for the sample as a whole[3] (n = 52) -- 11.56 months (SD = 12.08). The Sobquot (mean months of reported sobriety/mean months in treatment) for those who had been in treatment (n = 19)[3] was 15.12/13.81 = 1.09. This means that, on average, the subjects loaded on this factor reported that they began their sobriety when they began their treatment.

The measures of treatment history showed that 85.7% said that they had never been a member of their current program before. Compared with the sample as a whole, a slightly larger proportion said that they had never been in treatment before (38.1/27.0%). The most common treatment cited was one alcohol program (19.0%) followed by more than one other program (14.3%), and by detoxification and/or rehabilitation programs (14.3%). Of the whole group, 4.8% reported that they were presently on Antabuse. All of the subjects said that they attended 12-Step meetings and 14.3% said that they attended N.A. as well as A.A. The mean number of meetings attended was 4.76 (SD = 1.97) and 71.4% said that they had been attending for more than six months. Only 4.8% said that they did not attend meetings outside of

their program or the Hospital. About half of the group (47.6%) said that they had a sponsor.

Overall, the group was a bit more optimistic about and confident in their recovery. 81% said that they were feeling "a great deal" better (as compared with 68.9%; N = 61). Of those who were in a program (n = 18), 94.4% said that the program was helping them "a great deal" (87.0% for the sample as a whole; n = 46); and for those who were attending meetings (n = 21), 76.2% of the group said they were helping "a great deal" (67.9% for the whole sample; n = 56).

Finally, in terms of therapist ratings, this group seemed to be doing quite well -- 14.3% were seen as having insufficient time in treatment to be rated (27% for the sample as a whole), 66.7% were rated as maintaining their sobriety (46% for the sample as a whole), and 19.1% were seen as "slipping" or having more serious problems (25.4% for the sample as a whole). Recoding this to look at those subjects who had been in treatment long enough to be rated (n = 18), 78% were maintaining their sobriety and 22% were seen as "slipping" or having more serious problems.

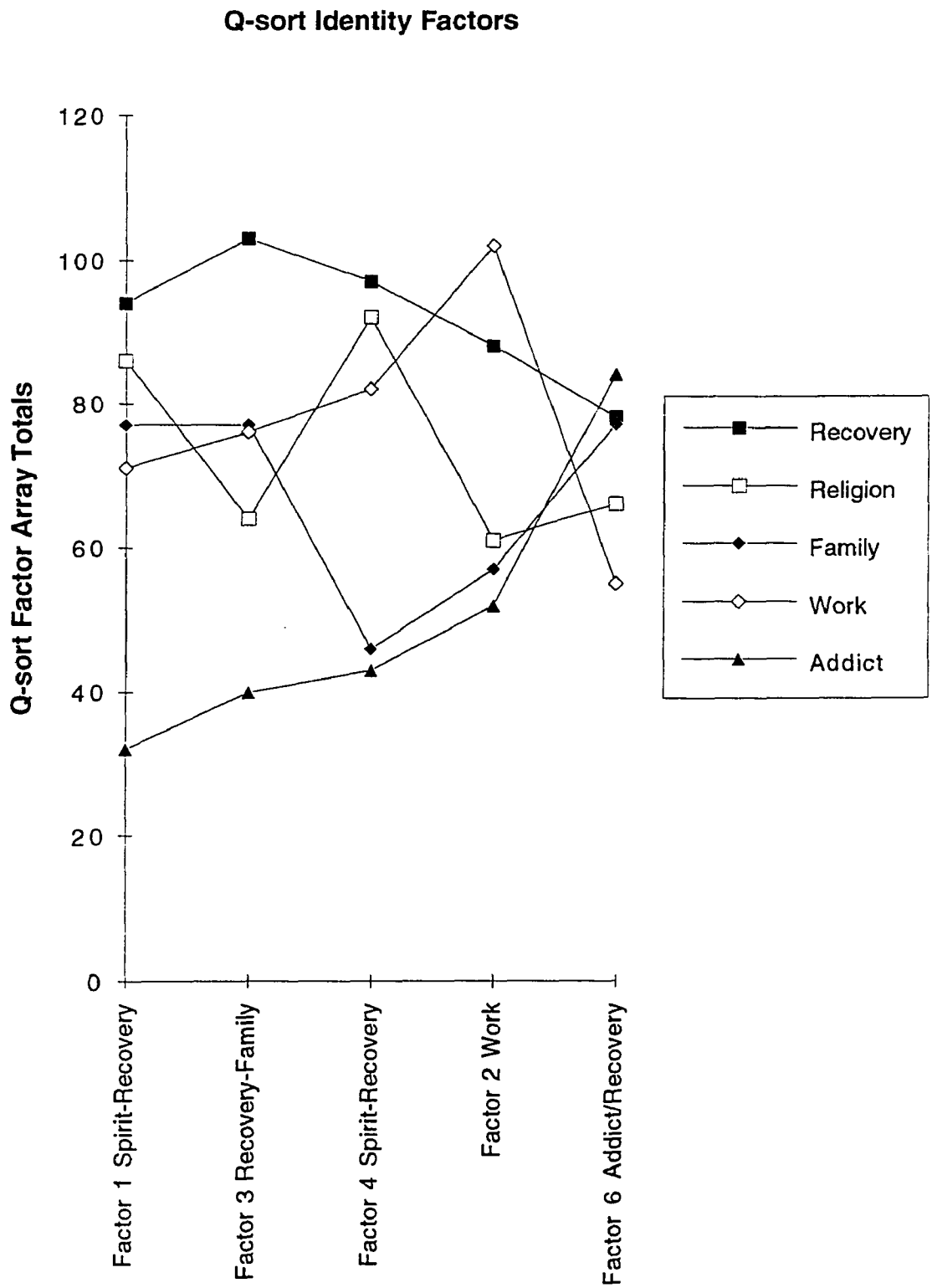
Factor 2

If Factor 1 represented a group and an identity structure that was a fairly successful one for recovering from addiction, Factor 2 represented one that was far more problematic. Factor 2 has been labeled a Work factor and

the top nine cards included six Work cards, two Recovery cards, and one Addict card. This array was significant in two ways; there was not only a lack of emphasis on recovery, but also an addict identity card -- "Sometimes when I'm drinking or getting high, I have trouble stopping" (+3) -- was high on the structure. Overall, the presence of even one addict card near the top of the hierarchy is pathognomonic. The nine rejected cards (-3, -4, -5) included four Addict cards, two Religion (but not Spirit) cards, and three Family cards. As can be seen, the addict identity was less firmly rejected than in Factor 1 (see Figure 2).

When compared with the other five factors, Factor 2 stood out for its endorsement of work-based statements. Three statements -- "My work is important to me" (+4), "I feel responsible for the kind of job I do" (+3), and "I try to be creative at work" (+2) -- were more highly endorsed at the .01 level, and two statements -- "I know that if I work hard I will get ahead" (+4) and "I enjoy my work" (+4) -- were more highly endorsed at the .05 level. Two Spirit statements -- "I put my trust in God" (-2) and "I believe in God" (0) -- were more highly rejected at the .01 level and one religious statement -- "I speak with others about my religion" (-5) -- was more highly rejected at the .05 level.

Figure 2


Q-sort Identity Factors
Q-sort Factor Array Totals
120
100
80
60
40
20
0
Factor 1 Spirit-Recovery
Factor 3 Recovery-Family
Factor 4 Spirit-Recovery
Factor 2 Work
Factor 6 Addict/Recovery
Recovery
Religion
Family
Work
Addict

Factor 2 (n = 8) was fairly similar to the whole sample in terms of program demographics (see Table 1). The program:orientation ratio was 62.5:37.5 and the Hospital:Agency ratio was 75:25 (there were, however, no Agency program members on this factor). The mean age was 45.75 (SD = 8.70) and the group was more Latino (37.5%) and more White (37.5%) and less African-American (12.5%) than the sample as a whole. Surprisingly, given the strong rejection of family in this group, a slightly higher percentage were married or living with someone (25/11.1%). Half had children and the modal number of children was three -- which was higher than the modal sample number of one. However, they had less contact with their children with a higher proportion never seeing their children (50/25.7%) and a lower proportion seeing them once-a-month or more frequently (25/45.7%).

The Hospital Sober Dorm was home to 25%, and 25% were living alone. None was living in an SRO/transient hotel and 25% were living with a spouse. In a manner consistent with the thrust of the factor, a smaller proportion were on public assistance (25/47.6%) and a larger proportion were in a work/school situation (50/28.6%). In contrast to the overall sample, the group was more Catholic (50%) than Protestant (25%), and a larger proportion said that they never attended religious services (62.5/44.4%), while roughly the same proportion (25/28.6%) attended once-a-month

or more frequently. The group education levels were roughly the same -- 11th grade or less (50%), High School graduate, GED, and vocational training (25%), and one year of college or more (25%).

Alcohol users made up 62.5% of the group and 37.5% saw themselves as both alcohol and drug users. Some drug use in the recent past was reported by 62.5%, and 60% of those who had recently used drugs reported some use of cocaine/crack. The mean reported time drinking was 25.88 years (SD = 8.51). For those who reported using drugs in recent years (n = 5), the mean time of reported drug use was 13.8 years (SD = 8.11). The group had been sober for a shorter time period -- Factor 2 = 6.12 months (SD = 8.54); whole sample -- 9.7 months (SD = 11.72) -- and a smaller proportion (25/50.8%) reported being sober longer than six months. Of those who reported recent use of drugs (n = 5), the mean length of reported abstinence was less -- Factor 2 = 10.15 months (SD = 10.13); whole sample (n = 37) = 12.05 months (SD = 11.28) -- and 60% of this group reported that they had been drug-free for more than six months.

All the members of this group reported that the desire to address their drinking and/or drug problem was the major motivation for treatment. The time in treatment for the group (n = 8) was 12.18 months (SD = 16.89) and all eight members had some time in treatment. This was similar to the time in treatment for those sample members who had been in

treatment[3] (n = 52) -- mean treatment time = 11.56 months (SD = 12.08). The striking difference here is in the Sobquot (mean months of reported sobriety/mean months in treatment). For the sample as a whole who had been in treatment[3] (n = 52), the proportion was 11.15/12.08 = .96. This meant that, on average, sobriety coincided with the commencement of treatment. For Factor 2 (n = 8), however, the proportion was 6.2/12.18 = .50. This meant that these subjects were having trouble beginning or maintaining sobriety despite the fact that they had been in treatment, on average, for nearly a year. In short, this was a picture of a group that had developed a more problematic and less successful approach to recovery.

Most (87.5%) of the Factor 2 group subjects said that they had never been a member of their present program before. A lower proportion of the group reported no prior treatment (12.5/27%), and a higher proportion reported having attended more than one alcohol and/or drug program (50/22.2%) and as well as detoxification and/or rehabilitation programs (37.5/23.8%). One subject said that he was on antabuse. All subjects attended 12-Step meetings, and one attended A.A. and N.A. The mean number of meetings attended per week was 4.75 (SD = 2.31). Many (62.5%) said that they had attended 12-Step meetings for more than six months, and only one reported that he did not attend any meetings outside of the Hospital system. A higher

proportion did not have a sponsor (no sponsor 75/51.8%) and, overall, they were more pessimistic about their progress. When asked if they felt they were getting better, 62.5% said "somewhat" and 37.5% said "a great deal" (as opposed to 29.5% saying "somewhat" and 68.9% saying "a great deal" for the sample as a whole, $N = 61$). Their feelings toward the programs were somewhat more optimistic, if still less so than for the sample as a whole. For the six out of eight who had attended a program for more than 0.6 months, as compared to the sample ($n = 46$), a greater proportion said that the program helped "somewhat" (33.3/13.0%) and a smaller proportion said that it helped "a great deal" (66.7/87.0%). A similar pattern was found in their attitudes toward 12-Step attendance. For the group ($n = 8$), as compared with the sample members who attended 12-Step meetings ($n = 56$), a greater proportion found 12-Step meetings "somewhat" helpful (50/30.4%) and a smaller proportion found them "a great deal" helpful (50/67.9%). Finally, the therapist ratings of the group were less positive. While the same proportion had insufficient time to be rated (25/27%), a smaller proportion was rated as maintaining sobriety (25/46%), and a larger proportion was rated as "slipping" or having difficulty with sobriety (37.5/25.4%). One therapist said that he did not know how his client was doing. Recoding these ratings to look only at those who had been in treatment long enough to be rated

(n = 6), 33.3% were rated as maintaining their sobriety and 50% were felt to be "slipping."

Factor 3

Factor 3 represented an interesting and perhaps somewhat unanticipated way of successfully recovering. This factor was called the Recovery-Family factor (see Appendix J). This factor, which had six Recovery cards, two Family cards, and one Work card, was notable for two reasons. One was the overall prominence of the family identity, and the second was that the recovery focus is a social focus rather than a spiritual one. In that sense, it represented a viable counterpart to Factor 1.

The rejected identity cards included six Addict cards, two Family cards, and one Religion card. When compared with the other five factors, Factor 3 had a significantly higher endorsement of four Recovery statements and two Family statements. For Recovery identity statements, at the .01 level, these statements were "I go to Alcoholics Anonymous meetings" (+4), "Being clean and sober is the most important thing in my life" (+5), and "I find that therapy is helpful in dealing with my drug and/or alcohol problems" (+5). At the .05 level, "I spend time with other people who are getting over their alcoholism and/or drug addiction" (+2) was significant. Two family statements were also significantly endorsed at the .01 level. These were "My family is very important to me" (+4) and "A family dinner is

something I look forward to" (+2).

This factor (n = 10) had a program:orientation ratio of 70:30 and a Hospital:Agency ratio of 80:20. There were no Agency Orientation group subjects on this factor. The mean age was 44.3 years (SD = 8.19) and the ethnic mix had a slightly higher Latino component (African-American = 40%; Latino = 40%; and White = 20%). Most (90%) of the group was single, but a higher proportion had children (80/55.6%). There was an equal representation of subjects (n = 8) with from one to 4 or more children. A smaller proportion said that they never saw their children (12.5/25.7%), and roughly the same proportion said that they saw them once-a-month or more frequently (50/45.7%).

A strikingly high proportion of this sample lived in the Hospital Sober Dorm (60/36.5%). A higher proportion were on Public Assistance (60/47.6%), and a slightly smaller proportion were involved in work/school (20/28.6%). The group was slightly more Catholic (50%) than Protestant (40%), and 50% said they never attended religious services, while 20% said they went once-a-month or more frequently. The group was slightly more educated -- 30% had an 11th grade education; 50% had received a High School Diploma, GED, or vocational training; and 20% had completed one year of college or more.

Alcohol users made up 60% of the group and 40% said that they used both drugs and alcohol. Of the four subjects

who said that they had used drugs in the recent or distant past, three reported using cocaine/crack alone or with other drugs as their primary drug. The group, when compared with the sample, reported a slightly shorter involvement with alcohol -- the mean length of reported time drinking was 21.8 years (SD = 8.53) -- and roughly the same length of involvement with drugs -- (n = 4) the mean length of reported time using drugs = 13.75 years (SD = 6.29). The mean length of reported sobriety was 6.23 months (SD = 4.97) and 50% reported that they had been alcohol-free for six months or more. Among those who reported recent drug use (n = 4), the mean length of reported abstinence was longer -- 18.75 months (SD = 13.89) with 100% (n = 4) reporting abstinence of six months or more.

Interestingly, a slightly lower proportion reported a desire to address drinking and/or drug problems as a primary motivation (40/65.1%) and a higher proportion cited Public Assistance (20/7.9%) and the Hospital (20/7.9%) as their referral source. Mean time in treatment for those who had been in treatment (n = 8) was 5.53 months (SD = 4.85) which was nearly half of that for the sample as a whole. The Sobquot (mean months of reported sobriety/mean months in treatment), for those in the group who had been in treatment (n = 8), was 6.7/5.53 = 1.21, which reflected a sense that sobriety generally coincided with the beginning of treatment.

In terms of program membership, 20% said that they had been members of the current program before. In terms of previous treatment, 20% said that they had never been in treatment before; 20% said that they had been in more than one other alcohol and/or drug program; and 30% said that they had been in detoxification and/or rehabilitation programs. Antabuse was being taken by 10% of the group. All of the subjects attended 12-Step meetings and 20% attended both A.A. and N.A. The number of meetings attended were slightly higher ($\underline{M}$ = 6; $\underline{SD}$ = 1.25) and 50% said that they had been attending for more than six months. They all attended meetings outside of their programs and outside of the Hospital. They were less likely to use sponsors (no sponsors = 70/51.8%). They were an optimistic group with 80% saying that they were feeling "a great deal" better and 20% saying that they were feeling "somewhat" better. Of the seven who were program members, 100% said that the program was helping them "a great deal." They all attended 12-Step meetings with 80% saying that they helped "a great deal" and 20% saying that they helped "somewhat." Therapist ratings were in line with the ratings for the sample as a whole. 30% of the Factor 3 group had insufficient treatment time, 50% were seen as maintaining sobriety, and 20% were thought to have had "slips." Recoding these ratings to only include those who had been in treatment for more than 0.6 months ($\underline{n}$ = 7), 71% were maintaining their sobriety and 29% were

thought to have had "slips."

Factor 4

Factor 4 (n = 17) was fairly similar to Factor 1 and it was also a Spirit-Recovery factor. In fact, these two factors shared eight of their top nine cards in common. The top nine cards of Factor 4 were the five Spirit cards and four Recovery cards -- three of these addressing the importance and acceptance of the need to be sober and the fourth reflecting the value of therapy in the recovery process. The rejected identity consists of five Addict cards and four Family cards. The essential difference between Factor 1 and Factor 4, however, can be seen in the overall identity structure (see Figure 2). Factor 1 had a Recovery/Religion/Family/Work/Addict structure while Factor 4 had a Recovery/Religion/Work/Family/Addict structure. It was the extreme rejection of the family identity that distinguished Factor 4. In fact, the Factor 4 array Family identity total (46) was almost the same as the Addict identity total (43).

The distinguishing statements for Factor 4 included the highest level of endorsement, at the .05 level, of "I enjoy talking with the people at work" (+2) and a greater level of rejection, at the .05 level, for two family statements -- "I feel responsible for my family" (-2) and "My family is very important to me" (0).

In terms of demographics (see Table 4) the Hospital:Agency ratio for Factor 4 was 70.6:29.4 and the

Program:Orientation ratio was 64.7:35.3. The mean age was 48.88 years (SD = 10.18) and the ethnic representation was slightly more African-American (52.9%), followed by Whites (23.5%), and then Latinos, who were somewhat under-represented (11.8%).

Table 4

Sample and factor (4-6) demographics

Demographic Variables	Sample	Factor 4 Spirit-Recovery	Factor 5a Religion	Factor 5b Addict	Factor 6 Addict/Recovery
Program Status					
Number of subjects	63	17	2	1	4
Hospital %	76.2	70.6	50.0	--	100.0
Agency %	23.8	29.4	50.0	Yes	.0
Orientation %	34.9	35.3	50.0	Yes	100.0
Program %	65.1	64.7	50.0	--	.0
Age	M = 45.73 SD = 9.44	M = 48.88 SD = 10.18	M = 33.50 SD = 7.78	43	M = 37.50 SD = 6.35
Ethnicity					
% African-American	41.3	52.9	100.0	--	50.0
% Afro-Caribbean	3.2	.0	.0	--	.0
% Latino	27.0	11.8	.0	--	50.0
% White	20.6	23.5	.0	--	.0
% Other	8.0	11.8	.0	Yes	.0
Family					
% Single	88.9	88.2	100.0	Yes	100.0
% Married/ Common-law	11.1	11.8	.0	--	.0
% Have children	55.6	35.3	50.0	Yes	50.0
Modal number of children[a]	1.0	1, 2, 4+	1.0	1.0	1, 4+
% no contact with children[a]	25.7	50.0	.0	--	.0

[a] Of those who have children.

Table 4

Sample and factor (4-6) demographics

Demographic Variables	Sample	Factor 4 Spirit-Recovery	Factor 5a Religion	Factor 5b Addict	Factor 6 Addict/Recovery
% see children 1x/month+[a,b]	45.7	16.7	.0	Yes	100.0
Housing					
% In Hospital Sober dorm	36.5	41.2	50.0	--	.0
% In transient hotel	15.9	23.5	50.0	--	.0
% Living alone	11.1	.0	.0	--	25.0
% Living in supervised housing	7.9	17.6	.0	--	.0
% With spouse/family of procreation	6.3	.0	.0	--	.0
% With family of origin	4.8	.0	.0	100.0	50.0
% Living with friends	4.8	.0	.0	--	.0
% Homeless	3.2	5.9	.0	--	25.0
% In MICA shelter	3.2	5.9	.0	--	.0
% In regular Hospital shelter	1.6	.0	.0	--	.0
% In non-Hospital shelter	1.6	.0	.0	--	.0
% In senior citizen housing	1.6	5.9	.0	--	.0
% Hospital inpatient	1.6	.0	.0	--	.0

[b] 1x/month+ means once-a-month or more frequently.

Table 4

Sample and factor (4-6) demographics

Demographic Variables	Sample	Factor 4 Spirit-Recovery	Factor 5a Religion	Factor 5b Addict	Factor 6 Addict/ Recovery
Financial support					
% Receiving Public Assistance	47.6	58.8	50.0	--	75.0
% In Work/ School	28.6	17.6	50.0	--	.0
% Receiving SSI	9.5	.0	.0	--	25.0
% No income	7.9	11.8	.0	Yes	.0
% Social Security/ retirement/ disability/ recent unemployment	6.4	11.8	.0	--	.0
Religion					
% Protestant	46.0	58.8	100.0	--	50.0
% Catholic	36.5	17.6	.0	Yes	25.0
% Personal beliefs	6.3	5.9	.0	--	.0
% No religious affiliation	4.8	5.9	.0	--	25.0
% Denominational mixtures[c]	6.4	11.8	.0	--	.0
% Never attend services	44.4	47.1	50.0	--	75.0
% Attend 1x/month+	28.6	23.5	50.0	--	.0

[c] Examples of denominational mixtures in this study included Jewish-Catholic, Lutheran-Orthodox, and Hindu-Protestant.

Table 4

Sample and factor (4-6) demographics

Demographic Variables	Sample	Factor 4 Spirit-Recovery	Factor 5a Religion	Factor 5b Addict	Factor 6 Addict/Recovery
Education					
% 11th grade or less	42.9	47.1	.0	Yes	75.0
% GED, High School Diploma, or vocational training	33.3	35.3	100.0	--	.0
% One or more years of college	23.8	17.6	.0	--	25.0
Alcohol and drug use					
% Alcohol users	61.9	76.5	.0	--	50.0
% Drug users	3.2	.0	50.0	--	.0
% Both alcohol & drug users	34.9	23.5	50.0	Yes	50.0
% Never used drugs	31.7	41.2	.0	--	25.0
% Used drugs in recent years[d]	58.8	47.0	100.0	Yes	75.0
% Not a recent drug user[e]	14.0	20.0	.0	--	.0
% Using cocaine/crack[f]	67.6	50.0	100.0	--	66.7

[d] "Recent years" means within the last three years.

[e] This is in proportion to the group of subjects who said that they had ever used drugs.

[f] This includes those who used cocaine/crack alone or in combination with other drugs and who had used it in recent years.

Table 4

Sample and factor (4-6) demographics

Demographic Variables	Sample	Factor 4 Spirit-Recovery	Factor 5a Religion	Factor 5b Addict	Factor 6 Addict/Recovery
Years of reported drinking	M = 25.50 SD = 10.60	M = 30.91 SD = 12.16	M = 17.50 SD = 3.54	29.0	M = 21.75 SD = 5.68
Years of reported drug use	M = 15.83 SD = 10.64 (n = 37)	M = 14.83 SD = 15.58 (n = 8)	M = 13.50 SD = 3.54	27.0	M = 16.67 SD = 5.77 (n = 3)
Months of reported sobriety[g]	M = 9.70 SD = 11.72 (N = 62)	M = 11.24 SD = 11.58	M = 4.13 SD = 5.48	1.0	M = .53 SD = .41
% Sober more than six months	50.8	58.8	50.0	--	.0
Months of reported abstinence[h]	M = 12.05 SD = 11.28 (n = 37)	M = 10.23 SD = 12.38 (n = 8)	M = 4.13 SD = 5.48	1.0	M = 3.03 SD = 4.30 (n = 3)
% Abstinent for more than six months[h]	64.9	50.0	50.0	--	33.3
Treatment factors					
% Wanting to address drinking/drug problems	65.1	52.9	100.0	--	75.0
% Public Assistance referral	7.9	5.9	.0	--	.0
% Homeless-ness was motivator	3.2	11.8	.0	--	.0
% Misc. Referrals	23.8	29.5	.0	Yes	25.0

[g] Excluding subject 52 who reported that he had 23 years of sobriety.

[h] For those who had used drugs in recent years.

Table 4

Sample and factor (4-6) demographics

Demographic Variables	Sample	Factor 4 Spirit-Recovery	Factor 5a Religion	Factor 5b Addict	Factor 6 Addict/Recovery
Months in treatment[i]	M = 11.56 SD = 12.08 (n = 52)	M = 13.39 SD = 11.11 (n = 14)	M = 4.30 SD = 5.23 (n = 2)	1.1	.0
Sobquot[j]	.96 (n = 52)	.96 (n = 14)	--	--	--
% Not in current program before	85.7	82.4	100.0	--	100.0
% Never in any treatment before	27.0	23.5	50.0	--	.0
% Detoxification/ rehabilitation programs only	23.8	23.5	50.0	--	25.0
% In one previous alcohol treatment program	15.9	23.5	.0	--	25.0
% In one previous drug treatment program	3.2	5.9	.0	--	.0
% In a MICA program	3.2	.0	.0	--	.0
% In more than one previous treatment program	22.2	23.5	.0	--	25.0

[i] For those who had been in treatment at least .1 months -- excluding subject 52.

[j] Sobquot = Mean months of reported sobriety/mean months in treatment -- for those who had been in treatment .1 months or more (excluding subject 52).

Table 4

Sample and factor (4-6) demographics

Demographic Variables	Sample	Factor 4 Spirit-Recovery	Factor 5a Religion	Factor 5b Addict	Factor 6 Addict/ Recovery
% On methadone -- past or present	4.8	.0	.0	--	25.0
% Taking Antabuse	4.8	.0	.0	--	.0
% Not attending 12-Step meetings	9.5	11.8	.0	Yes	75.0
% Attending 12-Step meetings	91.5	88.2	100.0	No	25.0
% Attending both N.A. and A.A.[k]	21.0	20.0	100.0	--	100.0
Mean number of weekly meetings[k,l]	M = 5.23 SD = 1.85 (n = 56)	M = 5.79 SD = 1.58 (n = 14)	M = 3.50 SD = .71 (n = 2)	--	7.0
% Who had attended meetings for more than six months[k]	64.3	71.4	50.0	--	.0
% Who had attended meetings for less than one months[k]	8.9	.0	50.0	--	100.0
% Attending outside 12-Step meetings[k]	96.4	100.0	100.0	--	100.0
% Having a sponsor[k]	48.2	78.6	.0	--	100.0

[k] Of those who attended 12-Step meetings.

[l] The maximum number coded was 7.

Table 4

Sample and factor (4-6) demographics

Demographic Variables	Sample	Factor 4 Spirit-Recovery	Factor 5a Religion	Factor 5b Addict	Factor 6 Addict/Recovery
Progress in recovery					
% Feeling "a great deal" better	68.9 (N = 61)	64.7	100.0	--	50.0 (n = 2)
% Feeling "somewhat" better	29.5 (N = 61)	35.3	.0	Yes	.0 (n = 2)
% Not feeling better	1.6 (N = 61)	.0	.0	--	50.0 (n = 2)
% Program helping "a great deal"[m]	87.0 (n = 46)	76.9 (n = 13)	100.0 (n = 1)	Yes	--
% Program helping "somewhat"[m]	13.0 (n = 46)	23.1 (n = 13)	.0 (n = 1)	--	--
% Program not helping[m]	.0 (n = 46)	.0 (n = 13)	.0 (n = 1)	--	--
% 12-Step meetings helping "a great deal"[n]	67.9 (n = 56)	64.3 (n = 14)	50.0 (n = 2)	--	.0
% 12-Step meetings helping "somewhat"[n]	30.4 (n = 56)	35.7 (n = 14)	.0 (n = 2)	--	100.0 (n = 1)
% 12-Step meetings not helping[n]	.0 (n = 56)	.0 (n = 14)	.0 (n = 2)	--	.0
% N.A. meetings helping[n]	1.8 (n = 56)	.0 (n = 14)	50.0 (n = 2)	--	.0

[m] Of those who had been attending the program for more than .6 months.

[n] Of those who attend 12-Step meetings.

Table 4

Sample and factor (4-6) demographics

Demographic Variables	Sample	Factor 4 Spirit-Recovery	Factor 5a Religion	Factor 5b Addict	Factor 6 Addict/Recovery
% Rated as maintaining their sobriety°	46.0/ 63.0	41.2/ 54.0	50.0/ 100.0	--	--
% Rated as "slipping" or worsen,°	25.4/ 35.0	35.3/ 46.0	.0/ .0	Yes	--
% Therapist did not know°	1.6/ 2.0	.0/ .0	.0/ .0	--	--
% Insuf-ficient time in treatment for rating	27.0	23.5	50.0	--	100.0

° % including insufficient time for a rating/% based only on those who had been in treatment for more than 0.6 months.

Those who were single made up 88.2% of the group, and fewer had children than the sample as a whole (none = 64.7/44.4%). Among those who had children (n = 6), two each had one, two, and four or more children. This group had strikingly less contact with their children, with twice the proportion as the sample saying that they never saw their children (50/25.7%), and only a quarter (16.7/45.7%) saying that they saw them once-a-month or more frequently. 41.2% lived in the Hospital Sober Dorm and 23.5% lived in SRO/Transient hotels. A higher proportion lived in supervised housing (17.6/7.9%). 58.8% were on public assistance, 17.6% were involved in work/school, and 11.8% had no income. The group was more highly represented by Protestants (58.8) than by Catholics (17.6). 47.1% said that they never attended religious services and 23.5% said that they went once-a-month or more frequently. In terms of education, 47.1% had completed the 11th grade or less, 35.3% had a High School diploma, a GED, or had received vocational training, and 17.6% had one year of college or more.

A slightly higher proportion of the group saw themselves primarily as alcohol users (76.5%) while the rest (23.5%) saw themselves as users of both alcohol and drugs. 41.2% said that they did not use drugs and, of those who had used drugs in the recent past (n = 8), 50% reported using cocaine/crack alone or in combination with marijuana. This group had a somewhat longer drinking history -- the mean

reported time drinking was 30.91 years (SD = 12.16). Of those who reported using drugs in recent years (n = 8), the mean time using drugs was 14.83 years (SD = 15.58). The mean length of reported sobriety was 11.24 months (SD = 11.58) and 58.8% reported sobriety of more than six months. Of those who reported recent drug use (n = 8), the mean length of reported abstinence was 10.23 months (SD = 12.38). Of those reporting recent drug use (n = 8), 50% reported six months or more abstinence. In terms of motivation for treatment, 52.9% said that a desire to address drinking and/or drug problems was the key factor, and the second most frequent reason was homelessness (11.8%). In fact, the only subjects in the whole sample who cited homelessness as their main motivation were loaded on this factor. Of those who were in treatment (n = 14), the mean time in treatment was 13.39 months (SD = 11.1). The Sobquot (mean months of reported sobriety/mean months in treatment) for those in treatment (n = 14) was 12.92/13.39 = .96. This means that for the group as a whole, sobriety coincided with program entry.

In terms of their current treatment, 17.6% said that they had been in their program before; and in terms of total treatment, 23.5% said that they had never been in treatment, 23.5% said that they had been in detoxification and/or rehabilitation programs, 23.5% said that they had been in one previous alcohol program, and 23.5% said that they had

been in more than one alcohol and/or drug program,. None reported being on Antabuse. 12-Step meetings were attended by 88.2%. Of those who went to meetings (n = 14), 20% attended both A.A. and N.A. The mean number of weekly meetings was 5.79 (SD = 1.58), and 71.4% said that they had been attending for more than six months. All the attenders said that they went to meetings outside of their program and outside of the Hospital. A surprisingly high 78.6% had sponsors (48.2% for the sample as a whole; n = 56). When asked about their progress in treatment, 64.7% responded that they were "a great deal" better, and 35.3% said that they were "somewhat" better. Of the 13 who were in the program, 76.9% agreed that the program was helping them "a great deal" -- this was slightly less than the sample as a whole where it was 87.0%; n = 46. 23.1% said that the program was helping them "somewhat." Of those who were attending 12-Step meetings (n = 14), 64.3% felt that they were helping "a great deal" and 35.7% felt that they were helping "somewhat." Finally, therapist's ratings showed that 23.5% had insufficient time in treatment, 41.2% were maintaining sobriety, 35.3% were "slipping" or having trouble. This last was slightly higher than the sample proportion of 25.4%. Recoding this to only include those who could be rated, 54% were maintaining their sobriety and 46% were "slipping" or having trouble.

Factor 5

Demographically, Factor 5 was difficult to interpret. It was interesting, nonetheless, because it was the only bipolar factor in the study and in that sense it reflected how two identities could be incompatible with each other. Factor 5 was the Religion/Addict factor, and the top nine cards included five Religion cards (with three referring to formal religious involvement) as well as two Work cards, one Recovery card, and one Family card. The rejected identity included three Addict, two Recovery, two Family, one Work, and one Spirit. A polarity existed between an addict identity with a slightly positive feel to it and a formal religious identity. Subjects 10 and 63 were positively loaded on the Religion end of the factor, and subject 62 was positively loaded on the Addict end of the factor.

From the vantage point of the religious end of the pole, the distinguishing statements included four Religion items that were more significantly endorsed at the .01 level. These were -- "My religious beliefs guide me in the things that I do" (+5), "My religious activities are important to me" (+3), "I take part in religious services" (+3), and "I speak with others about my religion" (+2). There was also a significant rejection, at the .01 level, of one of the Addict statements -- "I have a lot in common with my friends who drink and/or use drugs" (-5). However, there were also a few surprises in the distinguishing statements

of the factor. Such Addict statements as "A lot of my time and energy is spent getting drunk or high" (+1) and "I know its not good for me but I just can't stop drinking or getting high" (0), were more highly endorsed, at the .05 level, than by the other five factors. In turn, such Recovery statements as "I accept the fact that I cannot drink and/or use drugs" (-4) was also significantly more rejected, at the .01 level, by this factor. In addition, the Spirit statement "I feel that God has helped me" (-3) was significantly more rejected by this factor than by the other five -- despite the fact that this was the Religion factor.

Because of the bipolarity of the factor, subjects 10 and 63 were looked at together and then subject 62 was examined (see Table 4). The small numbers of subjects meant that only a few patterns were discerned and they do not really present a coherent picture. For those who were positively loaded on the factor, there was one Hospital program member and one Agency orientation member. They were younger -- mean age = 33.5 (SD = 7.78) -- than the sample as a whole -- mean age = 45.73 (SD = 9.44). They were both African-American, single, and Protestant. While one attended religious services twice-a-month, the other never went. They both had High School diplomas and one identified himself primarily as a drug user while the other used both drugs and alcohol. Both said that their primary drug was

cocaine/crack. Their mean length of reported time drinking was 17.5 years (SD = 3.54), which was less than the sample mean -- 25.5 years (SD = 10.6). Their mean length of reported time using drugs was also less: Factor 5 -- M = 13.5 years (SD = 3.54); sample = 15.83 years (SD = 10.64). Their reported length of both sobriety and abstinence was 4.13 months (SD = 3.54), but one subject reported a week of sobriety while the other reported eight months. They both said that a desire to address their drinking and/or drug problems was what brought them to treatment. They had been in treatment for a mean of 4.3 months but again there was a split with one having been in treatment for 0.6 months and the other for 8 months. Neither had been a member of their program before. In terms of previous experiences, one had no treatment history and one had been in detoxification and/or rehabilitation programs. Neither were taking Antabuse, and both attended N.A. and A.A. They went to fewer meetings per week -- M = 3.5 meetings (SD = .71). One reported 12-Step attendance for more than six months while the other had been attending for less than one month. Neither had sponsors. They both felt that they were "a great deal" better; only one had sufficient time in treatment to be rated and he felt that his program helped him "a great deal." One said that 12-Step meetings helped "a great deal" and one specifically said that N.A. helped. Finally, one was rated as maintaining his sobriety and the

other had insufficient time in treatment.

Subject 62, in turn, was loaded on the Addict-oriented end of the factor, which reflected an intense involvement with alcohol and drugs. This Addict factor, however, was slightly different from that found in Factor 6 in that there still seemed to be some pleasure and some social connectedness in the drug and alcohol use. The Addict pole included such statements as "I have a lot in common with my friends who drink or use drugs," "If I stopped drinking or using drugs, I would lose a lot of friends," and "I have a lot of fun drinking and/or using drugs." The subject loaded on this factor was a 43-year-old member of the Agency-Orientation group who described himself as both Puerto Rican and African-American. He was single and had one child whom he saw every day. He was living with his family of origin, and he had no income. He was Catholic but never attended religious services. He had completed the 11th grade and said that he was a user of both alcohol and drugs. In terms of a primary drug, he was a polysubstance abuser. He had been using alcohol for 29 years, which was slightly longer than the mean drinking time for the sample. He had been using drugs for 27 years which was considerably longer than the mean for those in the sample who reported recent drug use (n = 37) = 15.83 years (SD = 10.64). He reported that he had been both sober and abstinent for one month. His motivation for treatment was a referral from his parole

officer, and he had been in treatment for 1.1 months. He had never been in any treatment before, and he did not attend any 12-Step meetings. He said that he was feeling "somewhat" better and he felt that the program was helping him "a great deal." His therapist thought that he had been "slipping" since his entry into the program.

Factor 6

Factor 6 was the Addict/Spirit-Recovery factor, and it was a good reflection of individuals who are beginning an attempt to break out of their addiction and recover. The top nine cards consisted of two Addict cards, four Spirit cards, and three Recovery cards. As was found in the Factor 2 array, the presence of even one Addict card in the top nine cards was highly pathognomonic, and the presence of two was even more so. The overall identity structure was also quite revealing (see Figure 2) -- Addict/Recovery/Family/Religion/Work. The rejected identity cards included five Religion cards, one Addict, one Recovery, one Family, and one Work. All five of the rejected Religion cards referred to formal religious involvement.

The intensity of the addict involvement can also be seen in the distinguishing statements for this factor. At the .01 level, four Addict statements -- "Drinking and/or using drugs is exciting" (+2), "I think about drinking and/or getting high often" (+5), "Sometimes when I can't drink or use drugs, my body starts to feel bad" (+2), and "I

have a lot of fun drinking and/or using drugs" (+2) -- were more highly endorsed than by the other five factors. The Addict statement "I have a lot in common with my friends who drink or use drugs" (0) was more highly endorsed, at the .05 level, than by the other five factors. The Family statement "I know what the people in my family are doing" (+2) was also more highly endorsed, at the .05 level, than by the other five factors.

Several Recovery, Work, and Religion statements were also more specifically rejected by the group. The two rejected Recovery items were "I go to Alcoholics Anonymous meetings" (-4), at the .01 level, and "Helping other alcoholics/addicts helps keep me sober" (-1), at the .05 level. The rejected Work statements were "Having a job helps me feel good about myself" (-2), "I enjoy talking with the people at work" (-5), and "My work is important to me" (-2), at the .01 level, and "I feel responsible for the kind of job I do" (-2), at the .05 level. A couple of Religion items, both formal religious statements, were also rejected. These were "My religious beliefs guide me in the things that I do" (-3), at the .01 level, and "Religion has changed me for the better" (-4), at the .05 level.

In terms of demographics (see Table 4), all four subjects were in the Hospital group -- two had completed the protocol before they had an intake meeting, one completed it after his intake meeting, and one had just

become an orientation group member. This was a younger group -- M = 37.5 (SD = 6.35). It was 50% African-American and 50% Latino. All of these men were single and half of them had children. Those who had children saw them once-a-week or more frequently. For financial support, 75% were receiving Public Assistance, 25% were receiving SSI, and none was working. In terms of religious affiliation, 50% were Protestants and 25% were Catholics; 75% never attended services, and none attended once-a-month or more frequently. They were somewhat less educated than the sample, with 50% having an 8th grade education or less, 25% having a 10th grade education, and 25% having one year of college.

In terms of their addictions, 50% saw themselves primarily as alcohol users, and 50% saw themselves as users of both drugs and alcohol. 75% did use drugs and 66.7% of these used cocaine/crack. The drug used by the remaining third was unknown. The group had been drinking for a slightly shorter period of time -- (mean time drinking = 21.75 years; SD = 5.68) -- than the sample as a whole. They had, however, been using drugs for roughly the same amount of time (n = 3; mean time using drugs = 16.67 years; SD = 5.77). The mean time sober was .53 months (SD = .41) and none of the subjects reported being sober for more than a month. The mean reported time drug-free (n = 3) was 3.03 months (SD = 4.3) and 33.3% reported abstinence of more than six months.

In terms of motivation for treatment, 75% reported a desire to address their drinking and/or alcohol problems and 25% said they had been referred by another section of the Hospital. The group as a whole had no time in treatment and none of them had been in their current program before. They had all had previous treatment -- 25% had been in detoxification and/or rehabilitation programs, 25% had been through a detoxification program in the past and were currently on methadone, 25% had been in one alcohol treatment program, and 25% had been in more than one alcohol and/or drug treatment program. None was on Antabuse. Their involvement with 12-Step meetings was low as 75% did not attend A.A., while 25% attended both A.A. and N.A., had been attending seven meetings-a-week for less than one month, and had a sponsor. Half of the group were asked if they felt they were getting better -- 50% said "no" and 50% said "a great deal." The 25% who were attending 12-Step meetings felt that they were "somewhat" helpful. And, finally, none of them could be rated by his therapist.

The coefficient of intraclass correlation

Kerlinger (1958) recommended the use of the coefficient of intraclass correlation as a way of testing the internal consistency of a Q-sort. This analysis was done with the factor arrays for Factors 1, 3, 4, 2, and 6 (see Table 5) -- both for all five identities and then without the Religion identity. This second analysis was done because of the

observed split between the Spirit cards and the more formally religious cards. By internal consistency, Kerlinger (1958) meant the degree to which cards relating to the same idea cluster together. In this case, it would be the degree to which the Addict, Recovery, Work, Family, and Religion cards were sorted into groups that matched their identity designations. Kerlinger said that a coefficient over .50 meant that a person was internally consistent, and a score below .30 meant that a person was internally inconsistent. Looking at the Table 5 scores for all five identities, the three successful factors (1, 3, 4) all showed internal consistency. Factor 2 almost reached the criteria for good internal consistency and Factor 6 demonstrates almost no internal consistency. When the Religion identity was pulled out of the equation, the level of internal consistency improves. Factors 1 and 4 showed a very high internal consistency, Factor 3 remained fairly close to where it was, Factor 2 reached a significant level of internal consistency, while Factor 6 remained internally inconsistent.

Table 5

Coefficients of intraclass correlation

Identities	Factor 1	Factor 3	Factor 4	Factor 2	Factor 6
All Five	.58*	.53*	.67*	.48	.08
Without Religion Identity	.72*	.57*	.78*	.54*	.17

* Significant internal consistency.

Chapter four: Discussion

The human dimension

The fundamental question of this study was, "Is there a relationship between identity structure and the process of recovery from addiction?" At least in terms of the identity structures as measured by the Q-sort and the self-sort, the answer appears to be yes. However, before examining the hypotheses and the factors in an effort to explicate this, it might give a richer feel to the study to briefly comment on the emotional intensity of the research situation.

Many of these men had had very hard lives and they had experienced or were presently experiencing, in addition to alcohol and drug problems, physical illness, psychiatric problems, the effects of being crime victims, HIV positive status, physical and emotional abuse as children, homelessness, parental alcoholism, imprisonment, racial prejudice, death of children, reform schools, and transvestitism. Sorting the cards was a powerful affective experience for many. A number of men struggled to be as honest as possible, and many were painstaking in their organizing of the cards. Some saw it as a form of self-examination and one man said that it "helped me do my daily inventory." At least two subjects explained the significance of every card they had sorted and why they had put them where they had.

It was not uncommon for some of the subjects to want to

break the forced-choice pattern because they did not want to put things that were important to them toward the not like me end of the distribution. This behavior was a reflection of the seriousness with which they treated the task. Another man, after looking at his sort, said, "I see myself . . .when I look at these cards I want to cry. . .Here's God, here's my family, here's drugs, and here's some loneliness. . . ." Another subject said, "I liked this test. . .it made me find myself. . .this is me." Overall, the sorting was a powerful and, at times, helpful experience that allowed them to reflect on their lives and their values.

The Hypotheses

Hypothesis 1

The first hypothesis, along with the second, is relatively straightforward. As was found, the addict identity for the orientation group was significantly higher than for those who were full program members. The reason for this is probably that these program members had made progress in treatment and felt less identified with the Addict identity. In addition, both of these programs were very strict about sobriety, and continued drinking and substance use would not go without confrontation.

Hypothesis 2

Hypothesis 2 was also significantly supported with the subjects in the program group having a higher level of

identification with the Recovery identity than the orientation group. The Recovery identity was, in fact, fairly crucial to recovery, and, second to the Addict identity, it was a good predictor of success or failure in treatment as defined by both self-reports and counselor ratings. The actual way that it was used is complex, but the data gives some support to the idea that these men, because of their general life situation, chose (and needed to choose) a specifically recovery-based identity as a way to recover, because other identities were either not available to them or were not viable. This seems to have been supported by the factors as well. Factors 1, 3, and 4 all represented fairly successful subjects (as defined by both subject and therapist ratings) and these factors were all dominated by Recovery items. Factors 2 and 6, whose overall identity structure were not as Recovery dominated, were less successful.

Hypothesis 3

Hypothesis 3 grew out of Hypothesis 2. Looking at the subjects as either members of a program or an orientation group, one sees that, in both cases, the Recovery identity is at the top of the hierarchy and the Addict identity is at the bottom: Program structure -- Recovery/Work/Religion/ Family/Addict; Orientation structure -- Recovery/Religion/ Work/Family/Addict. What is interesting here is the sense of distance -- both statistically and subjectively --

between the Recovery and Addict identities. For the program group, the difference between the mean totals for the Recovery and Addict identities is 43.44, while for the orientation group the difference is 23.18 (for a visual representation, see Figure 1). In a way, these numbers serve as a kind of metaphor for the nearness or presence of the addictive experience for these men.

The idea of competing identities posited that the program subjects would have both recovery and addict identities at the top of their hierarchy. This idea, which was not significant in the overall picture of the sample, did manifest itself in the Factor 6 group where the top five cards included the following items -- "I think about drinking and/or getting high often" (+5), "Being clean and sober is the most important thing in my life" (+4), "I realize that I must be completely sober to recover" (+4), "Sometimes when I'm drinking or getting high, I have trouble stopping" (+4), "Drinking and/or using drugs is exciting" (+2), and "I have a lot of fun drinking and/or using drugs" (+2). This is the kind of juxtaposition of conflicting senses of self that was implied. The overall identity structure for the Factor 6 array was Addict/Recovery/ Family/Religion/Work.

Hypothesis 4

The fourth hypothesis was unsupported. While it attempted to measure the impact of addiction and recovery on the other

identities, there was no significant difference between the orientation and the program groups. A further analysis, which attempted to see if time in treatment were a factor, compared the self-sort cards of the orientation group with those program members who had been in treatment for 18 months or more. There were still no significant differences. Only the Addict and Recovery Self-sort cards were significantly different by program status.

Broadly speaking, the overall conclusion that one can reach from the four hypotheses is that the Recovery and Addict identities were playing crucial roles in the recovery process for these men. The factors illuminate how this is taking place.

The factors

Factors 1, 3, and 4 were associated with successful recovery, Factor 2 was associated with less successful recovery, and Factor 6 was associated with addiction. Factor 5 was a bipolar Religion-Addict factor that is perhaps of more heuristic than clinical interest because it was represented by only three subjects.

Factor 1 -- Spirit-Recovery

Factor 1 (see Appendix J) was the most popular factor (21 subjects), and it was very close to the archetypal 12-Step approach to recovery. The need for and importance of sobriety, the importance of program attendance, and the value of therapy were all emphasized. 12-Step meeting

attendance was important as well, if not quite as central as program attendance and therapy. Compared with the other five factors, what distinguishes Factor 1 is the strong rejection of the Addict identity. In a sense, Factor 1 is a representation of a familiar phenomenon in the world of alcohol and substance abuse treatment. One subject perhaps epitomized this factor when he pointed to three cards that he had highly endorsed -- "Being clean and sober is the most important thing in my life," "I realize that I must be completely sober to recover," and "God is very important to me" -- and said, "This is the foundation; without this, none of the rest of the cards are possible."

As was noted earlier, the demographic data support a view that this is a successful way to recover from an addictive problem. This was a productive, optimistic group that was involved in positive activities. They reported that they had been sober and abstinent for several months longer than the sample as a whole and, in a possibly more objective measure of their recovery, those in treatment were seen by their therapists as doing very well. Thus, for them (as well as for Factors 3, 4, 2, and 6) a fairly consistent picture emerges from the way they performed the Q-sort, the way they answered the demographic questions, and the way they were seen by their therapists.

Factor 3 -- Recovery-Family

Factor 3 (n = 10) (see Appendix J) is one of the surprises

of the study in that it offered a viable alternative to Factor 1. This factor represented a more social rather than a spiritual recovery. Here there was an emphasis on the importance of and the acceptance of the need for sobriety. In addition, there was an acknowledgment of the centrality of therapy, treatment, and A.A. In addition, the importance of social support from other recovering people, the importance and availability of family, and the value of hard work were also stressed. Factor 3 was very similar to Factor 1 in terms of its endorsement of recovery items, but quite different in its emphasis on family and other people as being important forces during the recovery process. The rejected identity was, again, marked by a preponderance of Addict items. In addition, two Family cards and one Religion card were rejected. A question that arises is how can the Family identity be both highly endorsed and rejected simultaneously. A possible explanation could be that the Family identity works more as an internal representation than as people with whom the subject has actual contact. The array reveals a sense of the depth of the connection and the family potential for support. However, the family dinner statement (48) has a slight implication that this was an uncommon event.

On the other hand, an examination of the least endorsed Family statements reveals a clear rejection of the idea that this group has a great deal of actual contact with their

families. Perhaps for this group there is a memory of a benign or nurturing family, a sense of wanting to meet family standards, and/or a hope that sobriety and recovery would lead to a reincorporation into the family system.

Some of the men on this factor spoke about the importance of their children and a sense that they hoped to be able to reconnect with them after they had made more progress in recovery. Some had actual contact with their children while others only spoke with them on the phone. For the four who discussed it, there seemed to be a fair amount of estrangement from their wives or ex-wives.

In terms of the distinguishing statements for this factor, there was a greater emphasis on A.A. attendance, on being with other recovering people, the importance of sobriety, and the utility of therapy. The importance of family and the family dinner were also more highly endorsed.

The demographics (see Table 1) again support the picture presented by the cards. The factor had the highest proportion of Latinos loaded on it of the three recovery factors. At least some observers have felt that Latino culture in general places a strong emphasis on family involvement -- for example, see Garcia-Preto (1982) on Puerto-Rican families. As a group, a higher proportion had children than in Factors 1, 4, 2, and 6, and fewer of them said that they never saw their children than in Factors 1, 4, or 2. Interestingly, nearly double the sample proportion

lived in the Hospital Sober Dorm -- which involved them in a more intense communal life. In terms of the sense of distance from actual contact with their families, not one of these subjects was living with either his family of procreation or family of origin. They all attended meetings, and they went a bit more frequently than the sample as a whole (although fewer had sponsors). They were optimistic and those in treatment were doing well. They were less likely to be involved in work/school but this may have been because they had less time in treatment and the work/school involvement was generally connected to both time in treatment and progress in treatment.

Factor 4 -- Spirit-Recovery

Factor 4 (n = 17) (see Appendix J) is perhaps more notable for what it rejects than for what it endorses. While it has a strong resemblance to Factor 1 on the positive end, it differs from Factor 1 in that the Work and Family identities are reversed. There is more to it than that, however. Factor 4 rejects the Family identity quite strongly, and the mean array family identity total is barely above that for the Addict identity.

As a reflection of this, the rejected identity cards consist of Addict and Family statements. Not surprisingly, the distinguishing statements for this factor include the rejection of two Family statements (37, 38).

A question arises concerning the relationship between

work and family. In contrast to Factor 3, this factor had strikingly fewer Latino men loaded on it. Fewer of these men had children, and of those who did, half of them said they never saw them. And of those who did see them, far fewer saw them monthly or more frequently. They were also actually slightly less involved in work/school than the sample. Most attended meetings frequently and a higher proportion had sponsors. Of those in treatment, just over half were maintaining their sobriety. All in all, this was a slightly less successful version of Factor 1.

The Recovery Quartet

Factors 1, 3, and 4 represent viable identity structures for successful recovery. While the spiritual focus of 1 and 4 and the family/social focus of 3 represent the differences in the factors, a comparison of the factors was done to show the commonalities. When the relative importance of the 12 Recovery statements is compared for the three factors, four statements appear in the top six Recovery statements for each of the three factors. These are:

13. I accept the fact that I cannot drink or use drugs.

21. Being clean and sober is the most important thing in my life.

23. I go to my treatment program every day.

24. I find that therapy is helpful in dealing with my alcohol and/or drug problems.

In addition, each of these statements was given a +2 rating

or higher in the factor arrays.

These four statements -- the Recovery Quartet -- can be seen as possibly forming a core recovery construct. What does this mean in terms of identity theory? Statement 13, in a sense, offers an identity by rejecting its opposite -- the Addict identity. Addiction is being rejected as a no-longer-viable vehicle for the self. In addition, it points to the phenomena of "acceptance," which is considered to be a crucial component of recovery -- especially in 12-Step-oriented programs. Statement 21 emphasizes the centrality of sobriety. This is both a cognitive and a behavioral experience in that it involves both values and (non)action. Statement 23 reflects both identity-based action and reflects a commitment to the identity. Statement 24 acknowledges a sense that one's actions and interconnections have successfully served to both maintain one's identity as a recovering person and in keeping away the rejected Addict identity.

What is also striking here is what is not endorsed. Of the Recovery cards that were not in the top six for any of the factors (14, 16, 17, 19, 20), four of them are concerned with relationships to other recovering people and one is about recovery ideology. From the perspective of identity theory, one might expect that all four components would be represented -- self-definition, identity-based action, ideology, and group identification. However, the pattern

that developed here placed a greater emphasis on the individual experience of self-definition and action rather than the group-oriented experience of social connectedness and ideology. While Factor 3 was more social and shared the statement "I go to Alcohol Anonymous meetings" with Factor 1, and the statement "I get love and support from others in recovery" with Factor 4 in its top six cards, it was still less endorsing of the social recovery items. Perhaps the social needs of the subjects were met through their sense of connectedness to their families. Although, as noted above, this family may be more one that was in the subject's head rather than one that was flesh and blood. The social "needs" of these men on these factors may have been met through a relationship with the family, with God, or with the therapist. In addition, the identification with the program may be similar to that of Factor 3's identification with the family. That is, these men may have felt more comfortable with a strong but more distant connection to the program, and that is why they are less keen about intense interpersonal relationships with their peers as they order their recovery priorities.

Factor 2 -- Work

Factor 2 (n = 8) (see Appendix J) and Factor 6 were the factors representing those who were having difficulties with their addiction. The identity structure for the Factor 2 array is Work/Recovery/Religion/Family/Addict (see Figure 2)

and with an Addict identity array total of 52, this factor has the second highest Addict identity total of the five factor arrays under discussion. Compared with the three successful factors, the Recovery cards seem to share the same acknowledgment of the need for sobriety, but they do not share the central importance of sobriety and, even more so, they do not reflect a central connection to the therapeutic process. The higher endorsement of the Addict cards may well reflect a kind of tension about recovery, a sense that self-control is not yet fully rooted. The work emphasis is grounded in some reality as those loaded on the factor were more likely to be in a work/school situation and less likely to be collecting Public Assistance.

This factor, then, represents those who were in the program but who were having trouble with their sobriety. With the Sobquot (mean months of reported sobriety/mean months in treatment) equal to .50, their sobriety was roughly half of their time in treatment. They had also been in more previous treatments than the sample, and they had gone to 12-Step meetings as frequently and for as long a period of time as the sample. Their problem was not just that they were slow starters who caught up later (which might explain the roughly six month difference between time sober and time in treatment). Those who were rated by their therapists as "slipping" had actually been in treatment an average of almost nine months longer that those who were

rated as maintaining their sobriety. These subjects did not see themselves as doing well, and they did not find their program or the 12-Step meetings to be as helpful. There was congruence between the subjects' and the therapists' view in that they both felt that these subjects were having trouble maintaining sobriety.

Factor 5 -- Religion/Addict

Factor 5 was the only bipolar factor. Inasmuch as there were only three subjects loaded on this factor, it cannot be very extensively interpreted. At one end of the factor was an acknowledged connection to organized religion. At the other end, there was an endorsement of the Addict identity. What made this different from Factor 6 was that the Addict identification was much more positive. That is, if one were to reverse the polarity of the loadings on the factor array statements so as to capture this perspective, one would see the high endorsement of such statements as "If I stopped drinking or using drugs, I would lose a lot of friends" (+4) and "I have a lot of fun drinking and/or using drugs" (+3) which implies that there is still some pleasure to be gotten out of the addictive experience and some involvement in addict/alcoholic social networks. The subject loaded on this pole was the only subject to say that he had entered treatment because his parole officer sent him. Overall, this factor pointed to a possible incompatibility between an organized religious identification and an Addict identity.

It should be noted that this same incompatibility does not exist between the Addict identity and the Spirit cards (see Factor 6) -- only between the addict self and the formal religious self.

Factor 6 -- Addict/Spirit-Recovery

Factor 6 was the Addict/Spirit-Recovery factor and this was the only factor that was entirely composed of orientation group members. This factor was interesting in a number of ways. In a sense, it is a representation of what the orientation group and perhaps even the program group were originally expected to look like. That is, overall, it is an Addict-dominated identity with a factor array of Addict/Recovery/Family/Religion/Work (see Figure 2). In addition to having an Addict-dominated structure, in the top nine cards there was an intermingling of Addict and Recovery items -- a possible reflection of the Heiss (1981) phenomenon discussed above. In terms of the Addict statements endorsed, the top two were "I think about drinking and/or getting high often" (+5) and "Sometimes when I'm drinking or getting high, I have trouble stopping" (+4). This second statement was also endorsed by the Factor 2 group which gave it a +3 rating. The shared concern about loss of control makes sense clinically in terms of how people often feel. In addition, the second highest card in Factor 2 was "I think about drinking and/or getting high often" (0) which may also point to the subjective experience

of preoccupation with drugs and alcohol -- another common clinical experience. In fact, one subject in the study spoke of his life-long obsession with alcohol.

Additionally, these two statements were also the most highly endorsed Q-sort Addict statements for the whole sample. That this group was close to the alcoholic/addict experience was also supported by the fact that two of the four subjects had just come from a detoxification program, and one was coming from the Hospital where he had just completed a detoxification program and had also been treated for depression.

Factor 6 is also noteworthy for its strong rejection of three formal religious cards. This, in a sense, gives some support to the Factor 5 dynamic and the sense of incompatibility between an addict identity and a formal religious identity.

It is also interesting to look at how the Recovery Quartet was being used by these two Addict-influenced factors. With Factor 2, there was an emphasis on sobriety (13, 21) but not on connection to treatment (23, 24). That these two treatment cards are not in the top six Recovery cards for the Factor 2 array gives a sense that these subjects have either only done half the work necessary, or that they need to readjust their priorities. Factor 6 subjects, on the other hand, have their priorities in order in the sense that the Recovery Quartet is in their top six

Recovery cards, but they are not ranked +2 or higher. In addition, there are two Addict statements in the top nine cards endorsed. This may be a reflection of a group of men who either had some sense of what to do but still had issues interfering with their fully implementing the necessary actions, were not yet committed enough to the necessary changes, or were just beginning the process.

The coefficient of intraclass correlation

As noted earlier, the consistency of the factor array identity structures was high for the successful factors (1, 3, and 4), moderate for factor 2, and low for factor 6 (see Table 5). There is a hint in this that those who were doing well had a clearer sense of who they were and what their priorities were. This is also illustrated in Figure 2 where the successful factors (1, 3, 4) tend to be more spread out when compared with the less successful ones (2, 6). In addition, the high internal consistency of the identity arrays gives some support to the validity and representativeness of the Q-sort cards themselves.

Orientation group dynamics

Crossing lines

One of the "problems" of the data is the fact that the orientation group is not that different from the program group; that is, the orientation group does not, with one exception, have its own factor voice. Overall, orientation group members make up one third of the sample (34.9%) and

they make up 19% of the Factor 1 group, 30% of the Factor 3 group, and 35% of the Factor 4 group (the three factors that are doing well), and 37.5% of Factor 2, and 100% of Factor 6. Theoretically, Factor 6 would be the defining Orientation factor but there are only four Orientation group members loaded on it.

What this means is that there may well be different kinds of subjects entering treatment. If there are four Orientation members on Factor 6 and two on bipolar Factor 5, then there are 16 orientation members who are sharing successful factors with program members. Possible explanations for this can be found in the work of Schlesinger (1992) and Prochaska, DiClemente, and Norcross (1992).

Schlesinger and the cycles of change

Schlesinger (1992), in an article on increasing the efficiency of therapy, posited that when people are faced with difficulties, they try a whole series of actions (both internal and external) to resolve their problems. While many never come to therapy, some do. Expanding slightly on his work, they may be divided into three groups. The first consists of people who only come in for one session. This group comes in, essentially, to review the work that they have already done by themselves. The therapy encounter serves as a kind of a "confirmation" (p. 9) of this self-work. The patients thank the therapist and leave. The

second version of this would be that they conclude that they have resolved a problem but are also motivated enough by the therapy to begin work on another issue or series of issues. The third group consists of those who come in to report that their attempts at resolving their difficulties have been unsuccessful or less successful than they wanted them to be. Schlesinger speaks of how a process of self-treatment is coming to an end when a patient begins his or her "'official' psychotherapy" (p. 10). Another way of looking at this is to see that patients are actually in the middle of therapy when they first arrive for formal treatment. Schlesinger emphasizes the importance of understanding what the patients have been doing, where they have succeeded, and where they have failed, when they first arrive for therapy.

What this means in terms of the study is that the orientation group consisted of subjects who had had different experiences working with their addictive problems. Factor 6, which was the Addict factor in terms of the overall identity structure, was still highly influenced by the Recovery cards -- as reflected by their presence in the top 12 cards of the factor. Even here there is a sense that some, or even a great deal of, internal work had gone on before they arrived at the Hospital. In short, the beginning of recovery precedes the beginning of treatment.

Prochaska et al. and the stages of change

Another way of looking at this phenomena is exemplified by the work of Prochaska et al. (1992). Prochaska et al. have taken a transtheoretical approach to change processes. By this they mean that there are basic change stages and processes that must occur regardless of therapist or program ideology. The lack of completion of these stages will lead to unsuccessful behavior change. They have developed a model that includes both states of change and processes of change; however, only the stages of change will be examined here.

There are five stages of change -- precontemplation, contemplation, preparation, action, and maintenance.

> (1) Precontemplation is the stage at which there is no intention to change behavior in the foreseeable future. Many individuals in this stage are unaware or underaware of their problems. . . .When pre-contemplators present for psychotherapy, they often do so because of pressure from others (p. 1103).
>
> (2) Contemplation is the stage in which people are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action. People can remain stuck in the contemplation stage for long periods (p. 1103).
>
> (3) [Preparation] -- Individuals in this stage are intending to take action in the next month and have

> unsuccessfully taken action in the past year. (p. 1104).
>
> (4) Action is the stage in which individuals modify their behavior, experiences, or environment in order to overcome their problems. . . .Individuals are classified in the action stage if they have successfully altered the addictive behavior for a period of from one day to six months (p. 1104).
>
> (5) Maintenance is the stage in which people work to prevent relapse and consolidate the gains attained during action. . . .[through] Stabilizing behavior change and avoiding relapse. . . . (p. 1104).

One way of using this approach would be to say that the subjects are in different stages -- even as they enter the program -- and that fact is a component in determining the kind of identity solutions that they choose. Another way would be to see the recovery process as a series of changes and decisions, each of which require the subject to go through these stages.

A sense of where this might apply can be seen when looking at the Recovery Quartet and how it is manifested in the factors. Broadly speaking, the quartet has two components -- centrality of sobriety and connectedness to the program. A look at the top 12 cards of Factor 2, Factor 6, and the Addict end of bipolar Factor 5 (see Appendix I) reveals an endorsement of sobriety but not one of program

connectedness. In turn, a look at Factors 1, 3, and 4 reveals an endorsement of both components in the favored Recovery cards. One way of understanding this would be to say that the subjects of Factors 1, 3, and 4 are in the Action or Maintenance stages while those on Factors 2, 6, and Addict bipolar 5 are in the Contemplation or Preparation stage. In terms of how this would make sense if they are already in a program (i.e., Factor 2), it may be that some subjects have to go through these five stages just to make the decision to enter the program. They may have to go through this cycle again to really connect to, open up with, and use the program successfully. Others (possibly some Factor 6 members) may just have to go through the whole cycle once on their road to recovery. A third possibility is that some of the Factor 2 group have relapsed and they have moved back down the cycle to an earlier stage (Prochaska et al., 1992). Clinically, this would make sense in terms of patients who are attending the program every day but whom, one feels, are just not "getting it."

Identity and recovery: Empirical implications

As a final area of exploration, it might prove helpful to look at these results in terms of some of the identity principles discussed in the beginning of the dissertation. A basic premise of the dissertation was that recovery was a process involving identity creation and/or restructuring. While the process of structure change cannot be definitively

discussed, there certainly did seem to be a relationship between structure and recovery, and the relative strengths and importance of the Addict and the Recovery identities appeared to be quite crucial to the well-being of these subjects.

A key component in the literature review was the emphasis on the social nature of identity. This would include both a sense of membership (Deaux, 1991; Stryker & Serpe, 1982) as well as formal and informal social interactions with others. The picture that comes from the data is one that generally places a much greater emphasis on the sense of membership than on social interaction. In the Recovery Quartet, there was a key emphasis on program attendance. In Factor 3 there was an emphasis on family connectedness. In both cases, this did not mean that actual contact or interaction with other recovering or family members was crucial. Similarly for the Factor 2 group, the social aspects of work are less emphasized than the internal aspects of the working experience. Only on the addict end of Bipolar Factor 5 do we see an emphasis on the social side of identity, with the endorsement of a statement linking drug and alcohol use with friendship. Alternately, it is the sense of self-definition or self-conception that seems to be more emphasized here. Another example of this is that while 12-Step attendance was ubiquitous, it was not part of the Recovery Quartet. In a related vein, the importance of

ideology -- as reflected in "I read Alcoholics Anonymous literature" -- was also not in the top seven cards shared in part or in whole by the successful factors. Again, it is the internal aspect of identity that seems central rather than the social or group-based experience.

Backman and Secord (1968) discussed the possibility of latitude in role portrayal. By this they mean the degree to which people are free to meet or fulfill the requirements of a given role or identity in their own personal way. In terms of Factors 1, 3, and 4, it seems that there is some freedom in the way in which people realize or manifest their recovery identity; that is, the Spirit-Recovery approach and the Recovery-Family approach show that the recovery path may be fairly wide.

Perhaps the final area where identity theory was supported was that concerning action. The subjects who were successful got up and went to the places they needed to be -- namely, the program and the meetings. One of the Recovery Quartet statements dealt with the issue of action -- i.e., going to the program every day. It is this act and the importance of this act that helps define the successfully recovering subject. It is notable that for the Factor 2 group, this act was not as important. They defined themselves by the act of going to work -- which, in half the cases, they were doing. The Factor 6 Addict group was also defined by their actions in the sense that this was a group

with only two weeks of reported sobriety. Interestingly, the top nine cards were primarily about internal states and a denial of action. Perhaps they were in the middle of an identity transition and were no longer sure what actions were appropriate for identity maintenance.

Research strengths and limitations

The value of the findings

The main strength of this research is in the factors. They appear to provide some support to the idea that identity structure is related to progress in recovery and treatment. They are also fairly clear and distinct. The fact that both expected and unexpected successful factors were found helps to strengthen one's confidence in the validity of the findings.

The hypotheses were, in a sense, based on a more linear conception of recovery -- that is, patients would enter treatment with powerful addict identities and "shed" these along the way. This was clearly not the case. Of the five major factors of the study (Factors 1, 3, 4, 2, 6), four of these included members of both the orientation and the program groups. The findings support the idea that a much broader view of the patient's treatment history and a better understanding of the patient's identity resources would be a valuable thing to know in designing individual treatment plans. The fact that these identity factors crossed program status (as well as Hospital/Agency lines) leads one to the

tentative conclusion that these are types and that it might be useful for treatment programs to understand the types of men who are entering their programs and to try to develop a course of treatment that is in tune with their identity structures. In this case, the Work group may be benefiting less from treatment than the Spirit-Recovery group or the Recovery-Family group.

The concurrence of ANOVA and factor analytic findings

Kerlinger (1972, 1986), as mentioned above, argued that if both ANOVA and factor analytic findings were similar, there would be greater support for the basic hypotheses of the study. This was the case here. If the overriding concern of the study was the relative importance of the Recovery and Addict identities as components in the healing process, then both approaches demonstrated that a higher endorsement of the Recovery identity was associated with greater time in treatment, greater progress in recovery, or, in some cases, a combination of the two. In turn, a higher endorsement of the Addict identity was associated with shorter time in treatment, less progress in recovery, or in some cases, a combination of the two. Overall, these were the two most significant identity components in terms of the struggle against addiction.

Limitations of the study

The primary limitation of the study was that it was not longitudinal and so it is impossible to say if people change

their identity structures dramatically, moderately, or not at all during the course of treatment. A question here would be, "Does the Recovery-Family group, which averaged about seven months in treatment, turn into a Spirit-Recovery group, which averaged about a year in treatment?" Another exciting idea would be to trace the identity changes of the Factor 6 group. As they currently stand, they have both an Addict and a Spirit-Recovery component. Would this group become a Spirit-Recovery group with the Addict identity dropping away over time, or would this group split into other factors?

Suggestions for further research

In the account of the limitations of the study lies the suggestions for future research. First, it would be important to know if these identity factors appear in other programs as well. This would give some support to a typological approach to patients. Second, as Brown (1980) has discussed, Q methodology can reveal the types that it finds in the sample used. This means that these types are real types but it makes no claim to be able to reveal how common these types are nor does it argue that it has revealed all the types that exist. Continued Q-sort research with other populations may reveal many other successful or unsuccessful identity patterns. Third, a longitudinal study of identity structures would help us to understand if and how identity changes during the treatment

process and how these affect whether an individual does well or poorly in treatment.

Conclusion

This study sought to show that there is a connection between an individual's identity structure and his successful recovery from addiction. For the particular sample run in the study, the development and prominence of a recovery-centered identity was found to be crucial if they were to be successful. This idea found support from both the ANOVA and factor analysis designs and the convergence of the therapists' ratings and the subjects' self-ratings.

It was a hope of the study that the clinical usefulness of identity theory would receive some support. This would appear to be the case. The finding that there are (at least) two successful ways to heal -- Spirit-Recovery and Recovery-Family -- uphold those who argue for greater flexibility in treatment design. Similarly, the finding that there are "types" of people entering into treatment with varying treatment histories and levels of motivation challenges us to meet the patient where he or she is and to be wary of a simplistic, linear view of addiction and recovery.

Endnotes

1. An abridged version of this chapter was published as Kellogg, S. (1993). Identity and recovery. Psychotherapy, 30, 235-244.

2. The Prayer of St. Francis is as follows"

"Lord, make me a channel of thy peace--that where there is hatred, I may bring love--that where there is wrong, I may bring the spirit of forgiveness--that where there is discord, I may bring harmony--that where there is error, I may bring truth--that where there is doubt, I may bring faith--that where there is despair, I may bring hope--that where there are shadows, I may bring light--that where there is sadness, I may bring joy. Lord, grant that I may seek rather to comfort than to be comforted--to understand, rather than to be understood--to love, than to be loved. For it is by self-forgetting that one finds. It is by forgiving that one is forgiven. It is by dying that one awakens to Eternal Life. Amen." (Alcoholics Anonymous, 1953, pp. 101-102)

The Serenity Prayer states:

"God grant us the serenity to accept the things we cannot change, the courage to change the things we can, and the wisdom to know the difference." (Alcoholics Anonymous, 1967, p. 20)

3. One subject reported 23 years of sobriety and his score was not included in the sobriety measures or here.

4. Because of the inequality of the variances, the data were also analyzed using the Mann-Whitney U with similar results. "t-tests are presented because they are more intrinsically appealing and people are more familiar with them" (M. Glassman, personal communication, May 27, 1993).

5. The numbers in parentheses are the percentages from the subjects in the factor group compared with the percentages for the sample as a whole.

Appendix A

Procedural imperfections and the validity of the data

There were several procedural imperfections which led to the collecting of more data at the Agency. Happily, these problems did not appear to have had any effect on the data, and the additional 15 Agency subjects, in fact, made for a stronger study. The procedural difficulties were as follows:

1. Due to a research oversight, the 12 Addict identity cards in the self-sort task had a small "2" in the upper right-hand corner. This was noticed after the first or second subject and the decision was made by the researcher to continue to use these "2" cards with the thought that all the subjects were thus being exposed to the same treatment. It was later realized that this could potentially bias the results. At that point, these cards were changed for cards without the marking. In total, 44 subjects (33 Hospital program, eight Hospital orientation, 3 Agency program, 0 Agency orientation) used these cards.

2. A second problem came in speaking with the subjects after the protocol was completed. A number of subjects pointed to the Addict cards they had put in the "Most unlike me" end of the distribution and said that that was how they used to be. The researcher said that he thought the process of recovery was the process of exchanging these cards (pointing to the Most unlike me end) with these cards

(pointing to the Most like me end). While it seemed at the time that he was merely paraphrasing what the subjects had said, it was brought to his attention that there was a possibility that he had revealed the premises of the study. This occurred with roughly eight to ten Hospital subjects. The concern was that these subject would then go and tell future subjects.

3. The third and more minor imperfection was that there was a slight increase in the number of questions in the demographic section of the protocol as the researcher realized that there was some additional information that needed to be obtained.

The validity of the data can be supported both empirically and clinically. One way the data were tested was by comparing the mean score for each of the self-sort cards, the mean identity totals for the self-sort cards, the mean score for each of the Q-sort cards, and the mean Q-sort totals for each of the five identities for the Hospital and the Agency orientation groups and the Hospital and Agency program groups. In total, 118 comparisons were made for the two orientation groups and 113 comparisons were made for the two program groups. (They did not each equal 130 because there were 12 cases in the orientation group and 17 cases in the program group where all the subjects in one or both of the groups endorsed a particular self-sort card, which meant that there was no variance. In these cases, it was not

possible to do a t-test.) Where comparisons could be made with the self-sort cards, there were only two significant differences between the two orientation groups. The Hospital group more highly favored Addict statement 1 and the Agency group more highly favored Addict statement 7. Similarly, when comparisons could be computed, there were no significant differences between the two program groups in terms of the endorsement of the self-sort cards or the self-sort totals.

In terms of the orientation groups placement of the Q-sort cards, there were only five significant differences. The Hospital group more highly favored Recovery statements 21 and 22 and Work statement 30, and the Agency group more highly favored Addict statements 7 and 9 and Work statement 26. The mean Work identity total was also higher for the Hospital than for the Agency group but this seemed to be a reflection of an actual difference between the two programs as the Hospital group had more members working and a more active vocational program (the Factor 2 demographics are also a reflection of this). All in all, this meant that out of 231 comparisons, there were only 10 significant differences.

Table 6

Statistics for hypotheses 1, 2, and 4 using Agency data only

Variables	Program	Orientation	t-test
Hypothesis 1			
Addict identity	M = 47.50 SD = 8.98	M = 58.00 SD = 8.52	t(13) = 2.31[a]*
Hypothesis 2			
Recovery Identity	M = 92.38 SD = 6.48	M = 81.71 SD = 6.65	t(13) = 3.14**
Hypothesis 4			
NONAD1[b]	M = 34.50 SD = 7.46	M = 33.71 SD = 8.32	t(13) = .19, n.s.
NONAD2[b]	M = 23.75 SD = 6.67	M = 23.43 SD = 7.12	t(13) = .09, n.s.

[a] Since (Kerlinger's 1972, 1986) .01 requirement was used, this is a trend rather than a significant finding.

[b] NONAD1 equals the self-sort totals for the Recovery, Work, Family, and Religion identities. NONAD2 equals the self-sort totals for the Work, Family, and Religion identities.

*p<.05. **p<.01.

The validity of the data was also checked by testing the four hypotheses while only using the Agency group data. This group consisted of eight program members and seven orientation members. As can be seen in Table 6, the results were quite similar to those for the study as a whole.

The first hypothesis compared the Addict identity totals for the orientation group (M = 58; SD = 8.52) and the program group (M = 47.50; SD = 8.98), $t(13) = 2.31$, $p.<.038$. Because Kerlinger's (1972, 1986) .01 requirement was used, this is a trend rather than a significant finding. Hypothesis 2 called for an examination of the Recovery identity totals for the program group (M = 92.38; SD = 6.48) and the orientation group (M = 81.71; SD = 6.65), $t(13) = 3.14$, $p.<.008$. The difference here is significant. Hypothesis 3 (see Table 7) utilized at the overall identity structure for the program group. In this case, the program group structure was Recovery/Religion/Work/Family/Addict. The mean total Recovery identity was significantly higher than the average totals of the other identities combined using the Helmert contrast, $F(1,7) = 79.11$, $p.<.0005$, and there was a significant difference among the five identities -- $F(4,28) = 13.43$, $p.<.0005$. Hypothesis 4 looked at the totals for the nonaddict identities using the self-sort cards. For the Recovery-Work-Family-Religion self-sort totals, there was no significant difference between the program group (M = 34.50; SD = 7.46) and the orientation

group (M = 33.71; SD = 8.32), t(13) = .19, p.<.850, n.s. Similarly, for a comparison of the two groups without the Recovery self-sort cards, there was no significant difference between the program group (M = 23.75; SD = 6.67) and the orientation group (M = 23.43; SD = 7.12), t(13) = .09, p.<.929, n.s. In general the findings here were almost identical to those for the four hypotheses using all 63 subjects.

Another argument in support of the data is the interrelationship between the factors, the demographics, the self-reports, and the therapists' ratings. For example, in the factors centered on work, more subjects are involved with work/school; in the factor centered on the family, a higher proportion have children; in the factor centered on the Addict identity, 75% had recently finished some kind of detoxification experience; and with the Spirit-Recovery factors, one sees high 12-Step meeting attendance. Where therapists think that subjects are doing well there is longer reported sobriety and/or higher Sobquot scores and a more optimistic view about their recovery (i.e., Factors 1, 3, and 4). Where therapists feel that the subjects are "slipping" or having difficulties with sobriety, subjects report less sobriety, lower Sobquot scores, and less optimism about their recovery (i.e., Factor 2).

In terms of Factors 1, 3, and 4, the subjects from both the Hospital and the Agency were loaded on the factors in

proportions roughly equal to their proportion in the overall sample. That is, if there had been a bias in the Hospital sample, one would have expected to find a distinct Agency factor, but this did not occur. The fact that there were no Agency program members loaded on Factor 2 is a reflection, as mentioned above, of the lesser emphasis placed on vocational training at the Agency. Factor 6 is a distinctly Hospital group but it only has four subjects. The Addict end of bipolar 5 is an Agency member who symbolizes the addict experience for that treatment program.

Also, as seen in Factors 2 and 6, where there is a high endorsement of even one Addict statement, the people loaded on that factor are having more difficulty maintaining their sobriety. In this way, there appears to be some predictive validity to the endorsement of the Addict identity cards.

On a more clinical level, the subjects seemed honest. They were often painstaking in their attempt to get the cards sorted correctly and they were willing to speak spontaneously about their difficulties and mistakes. Inasmuch as so many subjects were attending 12-Step meetings, a general culture of honesty seemed to pervade the sample.

Table 7

Statistics for hypothesis 3 using Agency data only: Identity structure and ANOVA

	Mean Q-sort Identity Totals					
Group	Recovery	Work	Religion	Family	Addict	ANOVA
Program M (SD)	92.38 (6.48)	71.88 (12.62)	77.38 (12.49)	70.88 (13.60)	47.50 (8.98)	F(4,28)= 13.43***
Helmert Con-trasts	.894	-.224	-.224	-.224	-.224	F(1,7) = 79.11***
Orienta-tion M (SD)	81.71 (6.65)	76.57 (11.30)	76.29 (10.28)	67.43 (19.19)	58.00 (8.52)	F(4,24)= 3.42[a]**
Helmert Con-trast	.894	-.224	-.224	-.224	-.224	F(1,6) = 14.93**

[a] Since Kerlinger's (1972, 1986) .01 requirement was used, this a trend rather than a significant finding.

*p<.05. **p<.01. ***p<.0005.

Appendix B

Hospital-Agency demographic comparison

When some central demographic variables were examined, it was found that the two groups were very much alike. The Hospital orientation group (n = 15) and the Agency orientation group (n = 7) were compared, and the Hospital program group (n = 33) and the Agency program group (n = 8) were compared, on the following variables. Few significant differences were found.

1. Age -- For the orientation groups, there was no significant difference between the Hospital (M = 42.27 years; SD = 7.15) and the Agency (M = 42.86 years; SD = 9.92). For the program groups, there was no significant difference between the Hospital (M = 47.03 years; SD = 10.13) and the Agency (M = 49.38 years; SD = 8.75).

2. Sobriety -- For the orientation groups, there was no significant difference in reported time sober between the Hospital (M = 2.13 months; SD = 2.43) and the Agency (M = 1.59 months; SD = 1.79). Similarly, for the program groups, despite the difference in means, there was no significant difference between the Hospital (M = 12.74 months; SD = 9.79) and the Agency (M = 19.72 months; SD = 21.93).

3. Abstinence -- In general the Hospital sample had a higher level of involvement with drugs than the Agency sample. When recent abstinence from drug use of the orientation groups was compared, there was no significant

difference between the Hospital (n = 4; M = 4.25 months; SD = 2.63) and the Agency (n = 5; M = 4.20 months; SD = 3.54). The program groups could not be compared because only one Agency program member reported both recent drug use and abstinence while 23 Hospital members did.

4. 12-Step Attendance -- For the orientation groups, there was no significant difference between the Hospital (n = 14; M = 4.86 meetings; SD = 3.21) and the Agency (M = 4.14; SD = 2.48) in terms of weekly meeting attendance. Similarly, for the program groups, there was no significant difference between the Hospital (M = 5.03; SD = 1.94) and the Agency (M = 3.75; SD = 2.12).

5. Years Drinking -- When the reported time spent drinking was compared, again there were no significant differences between the Hospital orientation group (M = 24.47 years; SD = 8.04) and the Agency orientation group (M = 23.07 years; SD = 12.91) or between the Hospital program group (M = 25.51 years; SD = 11.99) and the Agency program group (M = 29.5 years; SD = 6.28).

6. Years of Drug Use -- In terms of years of reported drug use, for those who actually used drugs, there was no significant difference between the Hospital orientation group (n = 9; M = 13.33 years; SD = 6.06) and the Agency orientation group (n = 5; M = 15.8 years; SD = 8.93). The two program groups could not be compared because while 25 Hospital members reported drug use (M = 16.34 years; SD =

11.92), only one Agency program member reported drug use (use = 8 years). However, it is clear from this that there was much greater reported involvement with drugs in the Hospital program group than in the Agency program group.

7. Time in Treatment -- Here again there was a split. For those who had been in treatment, the time in treatment for the Agency orientation group (n = 7; M = 5.1 months; SD = 5.98) was significantly greater than that for the Hospital orientation group (n = 5; M = .16 months; SD =.09) -- $t(20) = 3.37$, $p.<.003$[4]. This can be explained by the difference in orientation group membership at the Agency. Some members of this group had either never gotten out of orientation because they refused to do the things necessary to be upgraded to a higher status, or they had been put back into the orientation group after having achieved a higher program status. The Hospital group tended to be people who had just entered the program. There was no significant difference between the Hospital program group (M = 14.48 months; SD = 12.47) and the Agency program group (M = 12.58 months; SD = 12.06) in terms of time in treatment.

Appendix C

Social Identity Q-Sort

Addict Identity

1. Drinking and/or using drugs is exciting.

2. I think about drinking and/or getting high often.

3. I use alcohol or drugs to help solve my problems.

4. I have a lot in common with my friends who drink or use drugs.

5. Sometimes when I'm drinking or getting high, I have trouble stopping.

6. A lot of my time and energy is spent getting drunk or high.

7. If I stopped drinking or using drugs, I would lose a lot of friends.

8. I know it's not good for me but I just can't stop drinking or getting high.

9. I find I'm drinking more and getting high more than I used to.

10. Sometimes when I can't drink or use drugs, my body starts to feel bad.

11. Sometimes I have to drink or use drugs to get straight.

12. I have a lot of fun drinking and/or using drugs.

Recovery Identity

13. I accept the fact that I cannot drink or use drugs.

14. Helping other alcoholics/addicts helps keep me sober.

15. I go to Alcoholics Anonymous meetings.

16. I have the phone numbers of other people in recovery.

17. I read Alcoholics Anonymous literature.

18. I get love and support from others in recovery from

alcoholism and/or drug addiction.

19. I feel a bond with people who are recovering from alcoholism and/or drug addiction.

20. I spend time with other people who are getting over their alcoholism and/or drug addiction.

21. Being clean and sober is the most important thing in my life.

22. I realize that I must be completely sober to recover.

23. I go to my treatment program every day.

24. I find that therapy is helpful in dealing with my alcohol and/or drug problem.

Work Identity

25. Having a job helps me feel good about myself.

26. My job is part of who I am.

27. I enjoy talking with the people at work.

28. I feel like I'm part of the company.

29. It's nice to see that my work is appreciated.

30. I know that if I work hard, I will get ahead.

31. My work is important to me.

32. I feel responsible for the kind of job I do.

33. I enjoy my work.

34. I try to be creative at work.

35. Sometimes working hard makes you feel good.

36. I am a good worker.

Family Identity

37. I feel responsible for my family.

38. My family is very important to me.

39. I am very close to my parents.
40. When I really need help, my family is there for me.
41. I know what the people in my family are doing.
42. I am in touch with my family.
43. My family knows what I am doing.
44. My family has been important in making me who I am.
45. I see my family often.
46. When I need some help, my partner is there for me.
47. I spend the holidays with my family.
48. A family dinner is something I look forward to.

Religious Identity

49. I feel that God has helped me.
50. God is very important to me.
51. I put my trust in God.
52. I believe in God.
53. I believe that God will forgive me.
54. My religious beliefs guide me in the things that I do.
55. Religion has changed me for the better.
56. My religious activities are important to me.
57. I take part in religious services.
58. I know many people through my religious activities.
59. I am a member of a religious group.
60. I speak with others about my religion.

Appendix D -- Development of the SIQ

The goal in the development of the Social Identity Q-sort (SIQ) was to have each identity represented by 12 statements. To this end, a pool of 261 statements was originally created from a wide body of literature on addiction, recovery, family therapy, work, and religious beliefs and practices. This pool was analyzed to find redundancies and was then reduced to a group of 100 statements -- 20 for each identity. All of the members of the Identity Research Seminar, a research seminar led by Kay Deaux, PhD, at the CUNY Graduate Center, were asked to match the statements to a description of the identity (after Dawis, 1987). Of those items that were correctly matched, the seminar members were asked to rank each card as to whether it was a good, fair, or poor representation of the identity category. From this procedure, the original 60-card SIQ was developed. All the cards in this group received a six out of seven or seven out of seven recognition rate and all (but one) were thought to be good or fair representations of the identity. (One addiction card -- "I have a lot of fun drinking and/or using drugs" -- received five "good" ratings and one "poor" rating.)

The cards for the addiction, recovery, and religious identities were then given to Harold Lifshutz, PhD, and Andrew Weintraub, PhD, both psychologists working in the substance-abuse field. They were asked to match the cards

to the proper identity. The cards for addiction and recovery that were correctly sorted were then rated for quality. The results confirmed the choices made by the Identity Research Seminar. Because of the spiritual nature of the 12-Step groups, this second group of experts were given the religious identity cards as well to see if they could successfully discriminate between the Religion and Recovery identities. They were able to do this.

Upon further examination, it was felt that the addict identity cards had a less "social" quality than the other identity cards. This was an important issue because it had bearing on the hypotheses being tested. After consultation with Kay Deaux, PhD, the two addict cards with the least number of "good" quality ratings were replaced with two cards that were felt to be more social ("I have a lot in common with my friends who drink and/or use drugs" "If I stopped drinking or using drugs, I would lose a lot of friends"). These cards were specifically created for the purpose of bringing the addict identity statements more in line with the other identity statements.

Appendix E -- Agency Consent Form

THE CITY COLLEGE
OF
THE CITY UNIVERSITY OF NEW YORK
NEW YORK, NY 10031

THE PSYCHOLOGICAL CENTER
DEPARTMENT OF PSYCHOLOGY

212 690 6602, 3, 4

Consent Form

Thank you for your willingness to participate in this study of men in treatment programs. You will be asked to do or agree to the following:

1. You will be asked to sign this consent form.

2. You will be asked some questions about your current and past life experiences so that I may complete a demographics questionnaire.

3. The clinic records will be checked to determine how long you have been a member of the Bowery Residents Committee.

4. Your counselor will be asked to rate your sobriety at present and in the recent past.

5. You will be given two card-sorting tasks to complete.

6. Upon successful completion of the protocol, you will be given Five Dollars. This is my way of thanking you for your participation in the study.

7. There are no known risks in this study.

8. Everything you say will be kept strictly confidential and it will have no impact on your treatment at the

This research is being conducted under the auspices of the Program in Clinical Psychology at the CUNY Graduate Center and it has been approved by the

Date _____ Subject _____

Witness _____

Appendix F -- Revised Demographics Form

Demographics

Date_____ Subject ID _____

Program status:

(a) Which program are you a member of?

1. Hospital orientation group
2. Hospital program group
3. Hospital pre-intake
4. Hospital post-intake
5. Agency orientation group
6. Agency program group

Date of birth_____ Age_____

Race/Ethnicity
0. Italian/Native American/African American
1. White
2. Hispanic/Latino
3. African-American
4. Afro-Caribbean
5. Puerto Rican/African-American
6. Native American/African-American
7. Guyanese
8. Hispanic/White

Date of orientation group acceptance_____

Date of full program membership_____

Total time in treatment (Months)_____

Marital/family status:

(a) What is your current marital status?

1. single
2. married
3. common-law/living with partner
4. separated
5. divorced
6. widowed
7. other_____

(b) Do you have children?

1. no
2. yes

(c) How many?

0. none
1. one
2. two
3. three
4. four or more

(How old are your children?_____)

(d) How frequently do you see them?

0. never
1. less than once a year
2. once every six months
3. once every three months
4. "holidays"
5. once a month
6. once every two weeks
7. once a week
8. every day

Housing status:

(a) Where do you live?

1. homeless
2. SRO/transient hotel-welfare hotel
3. non-Hospital shelter
4. Hospital shelter (regular)
5. Hospital Sober dorm
6. living with friends
7. living with family of origin
8. living alone
9. living with spouse-family of procreation
10. other
11. supervised residence
12. Hospital MICA shelter
13. Hospital in-patient
14. senior citizen housing

Financial/Employment status:

(a) What do you do for money?

1. no income-panhandling-"hustling"
2. Public Assistance
3. SSI
4. pre-Vocational program
5. work development/Public Assistance

6. part-time job
7. full-time job
8. social security - retired
9. recent unemployment
10. disability
11. school/SSI
12. work development/Part-time job
13. post-work development/volunteer/Public Assistance
14. post-work development/volunteer/SSI
15. student/Public Assistance
16. post-work development/Public Assistance
17. part-time job/Public Assistance
18. part-time job/SSI
19. part-time job/unemployment
20. work development/SSI
21. stipendee/Public Assistance
22. Disability/SSI

(What kind of work do you do?_____)

(b) Why did you come to this program?

0. referred by friend
1. public assistance referral
2. parole officer referral
3. probation referral
4. desire to address drinking-drug problem
5. other
6. shelter referral
7. Hospital referral
8. MD referral
9. [Rural men's shelter] referral
10. detox referral
11. MICA program referral
12. homelessness
13. church referral
14. combined self/public assistance

(c) Were you previously a member of this program?

0. was never a member
1. once before
2. twice before
3. three or more times before

(d) Have you been in other drug or alcohol treatment programs?

0. no
1. one alcohol treatment program
2. one drug treatment program
3. more than one other program
4. detoxification and/or rehabilitation programs only
5. [Rural religious alcohol treatment center]
6. MICA program
7. methadone (Past)
8. methadone & TC
9. methadone (Current)

Addiction/Recovery status:

(a) Do you see yourself primarily as:

1. an alcohol user
2. a drug user

What is your primary drug(s)?_____

(b) How long have you been alcohol-free?

1. less than one week
2. one to two weeks
3. two weeks to one month
4. one to two months
5. two to three months
6. three to four months
7. four to six months
8. more than six months

(c) How long have you been drug-free?

0. Not a drug user
1. less than one week
2. one to two weeks
3. two weeks to one month
4. one to two months
5. two to three months
6. three to four months
7. four to six months
8. more than six months

(d) Are you taking Antabuse?

1. no
2. yes
3. on occasion

(e) Do you attend Alcoholics Anonymous and/or other 12-Step meetings?
1 no
2 yes
3 N.A. & A.A.

(f) [If yes] How often?

0. [Does not attend]
1. less than once a month
2. once a month
3. twice a month
4. three times per month
5. once a week
6. several times per week
7. every day

(Number of meetings per week_____)

(g) How long have you been attending Alcoholics Anonymous and/or other 12-Step meetings?

0. every now and then
1. one month
2. one to three months
3. three to six months
4. more than six months

(h) Do you attend meetings outside of the [Hospital/Agency]?

1. no
2. yes
3. [Hospital in-patient unit only]

(i) Do you have a sponsor?
0. does not attend
1. no
2. yes

(j) Do you feel that you are getting better?

0. not a program member
1. no
2. somewhat
3. a great deal

(k) Do you feel the [Hospital/Agency] is helping you?

0. insufficient time
1. no
2. somewhat
3. a great deal

(l) Do you feel that A.A., N.A., etc. meetings are helping you?

0 does not attend A.A.
1. no
2. somewhat
3. a great deal
4. N.A. - helps a great deal
5. N.A. helps

Religious status:

(a) What is your religious affiliation?

0. none
1. Catholic
2. Protestant
3. Jewish
4. Catholic/Jewish
5. Protestant/Hindu
6. personal beliefs
7. other
8. Protestant/Greek Orthodox
9. Catholic/Lutheran

(b) How often do you attend religious services?

0. never
1. once a year
2. on the holidays
3. every two or three months
4. once a month
5. twice a month
6. every week or more
7. funerals

Educational status:

(a) What was the highest level of education that you completed?
1. Less than 8th grade
2. 8th grade
3. 9th grade
4. 10th grade
5. 11th grade

6. GED diploma
7. vocational training certificate
8. High School Diploma
9. one year-college
10. two years-college
11. three years-college
12. college graduate
13. post-graduate studies

How long have you been drinking? _____

How long have you been using drugs? _____

Appendix G

Therapist Rating Form

Therapist: _____

Each subject in the study has agreed, in writing, to allow me to ask you to rate his level of sobriety and abstinence over the last few months. If you would rate the following patient and return this form to my box as soon as possible, I would be most grateful.

Please rate the following patient's progress in terms of abstinence and sobriety from alcohol and drugs over the past five months or since his admission to the program -- whichever is briefer.

Patient's name: _____

(Please circle the one that applies.)

1. Patient has been consistently abstaining from alcohol and drugs.

2. Patient has been abstaining from alcohol and drugs but has had one or two slips.

3. While there have been periods of sobriety, the patient has been having difficulty maintaining his abstinence from alcohol and/or drugs.

4. The patient is drinking and/or using drugs.

5. I do not know the patient's sobriety status.

If you have any questions, please feel free to contact me. Thank you again for your assistance.

Appendix H -- Hospital Flyer

Volunteers Needed!

Research project overview: I am currently looking for volunteers for a study of men who are in treatment for problems with alcohol and other substances at [the Hospital].

This study focuses on how people see themselves, what they think is important, and the kinds of interactions they have with others during their recovery. I would like to meet with you regardless of whether you are just beginning treatment or have been in the program for a while and we also want to meet with people who are still having problems with drugs and/or alcohol as well with those who are maintaining their sobriety.

If you volunteer, what will you have to do?: Each volunteer will first be asked some questions from a brief questionnaire and then he will be requested to sort a group of cards with statements on them into piles that best reflect the way he sees his life at the present time. This sorting process will be done twice -- in two different ways. The whole process should take 30 to 40 minutes to complete. At the end of the study, I will ask the therapists to briefly rate the progress of each volunteer.

Compensation: As a way of thanking you, each volunteer who completes the study will be paid $5.00 for his time and effort.

Who is eligible?: To participate in the study, you must meet the following requirements:

1. You must be male.

2. You must be able to read English.

3. Any man who is in the orientation phase of treatment or who is a full program member is welcome to participate.

4. You can participate whether you are maintaining your sobriety or not.

How can I get involved?: If you have any questions or you would like to participate in the project, please speak with your therapist or contact Scott Kellogg, Psychology Fellow. He is the main researcher and he will be in the front office or in room 113 in the [Hospital] every day for the next 2-3 weeks. He can also be reached at ext. 7435, ext. 3809, or ext. 7267.

If you think that you would like to be a part of this study, please contact us at your earliest convenience.

This project has been approved by the [Hospital].

Appendix I -- Instructions

Because of the nature of the subjects involved in this study, the instructions were explained to them rather than read verbatim. The researcher's instructions generally followed these forms:

Self-Sort Instructions

"I have a set of cards here with some statements on them. I'd like you to read each card and think about whether it applies to your life at the present time. If you think that it's like you or true for you at the present time, I'd like you to put it in this pile (Like me), if you feel that it's not like you or not true for you at the present time, I'd like you to put it in this pile (Not like me). You can have as many or as few cards as you like in either pile but all the cards have to go in one of the two piles."

Q-Sort Instructions

"I have another set of cards here with the same things written on them as the ones you just looked at. I'm going to want you to make a pile where each of these white cards are. Now if you look at this end it says Most like me and at this end it says Most unlike me. And if you look at each of these white cards, there's a plus three, and a plus four, and a plus five. At this end I'm going to want you to put the cards that are most like you or most true for you at the present time, and at the other end where it says minus three, minus four, minus five, I'll want you to put the

cards that are most unlike you or untrue for you at the present time -- not necessarily bad things, just things that aren't true for you at the present time. So as we go out this way, the cards get more like you or more true for you at the present time, and as we go out that way the cards get more unlike you or more untrue for you at the present time. And here in the middle are the neutral cards, cards that fall in-between, or cards that you don't feel strongly about one way or another.

If you look at the bottom of the card, there's a three or a four or a nine or a ten. That tells you how many cards go in each pile. And as you put the cards down, I want you to put them down above each other so that you can see them all (researcher demonstrates), and I want you to feel free to move them around as much as you want. What I'm trying to get is a picture of your life at the present time through the cards."

After each subject finished the sort he was asked to re-check the cards to see if he wanted to change any cards or do any fine-tuning. If a subject did not follow the pattern, he was immediately told. Subjects were encouraged to feel free to move the cards around after they had put them down, and most of them did.

Appendix J -- Q-sort arrays

Normalized Factor Scores -- For Factor 1

No.	Statement	Q-score	Z-Scores
22	I realize that I must be com	+5	1.787
50	God is very important to me.	+5	1.754
21	Being clean and sober is the	+4	1.472
51	I put my trust in God.	+4	1.369
49	I feel that God has helped m	+4	1.287
52	I believe in God.	+3	1.205
53	I believe that God will forg	+3	1.111
23	I go to my treatment program	+3	1.024
24	I find that therapy is helpf	+3	0.940
38	My family is very important	+2	0.930
15	I go to Alcoholics Anonymous	+2	0.898
13	I accept the fact that I can	+2	0.868
42	I am in touch with my family	+2	0.850
31	My work is important to me.	+2	0.754
14	Helping other alcoholics/add	+2	0.610
47	I spend the holidays with my	+2	0.480
45	I see my family often.	+1	0.468
20	I spend time with other peop	+1	0.467
40	When I really need help, my	+1	0.459
17	I read Alcoholics Anonymous	+1	0.421
54	My religious beliefs guide m	+1	0.380
32	I feel responsible for the k	+1	0.379
36	I am a good worker.	+1	0.372
33	I enjoy my work.	+1	0.293
39	I am very close to my parent	+1	0.253
46	When I need some help, my pa	0	0.235
26	My job is part of who I am.	0	0.217
19	I feel a bond with people wh	0	0.214
37	I feel responsible for my fa	0	0.203
25	Having a job helps me feel g	0	0.196
56	My religious activities are	0	0.136
18	I get love and support from	0	0.121
29	It's nice to see that my wor	0	0.097
55	Religion has changed me for	0	0.071
35	Sometimes working hard makes	0	0.066
30	I know that if I work hard,	-1	0.003
44	My family has been important	-1	-0.003
16	I have the phone numbers of	-1	-0.016
27	I enjoy talking with the peo	-1	-0.025
43	My family knows what I am do	-1	-0.041
59	I am a member of a religious	-1	-0.087
41	I know what the people in my	-1	-0.096
57	I take part in religious ser	-1	-0.128
48	A family dinner is something	-1	-0.149
34	I try to be creative at work	-2	-0.251
28	I feel like I'm part of the	-2	-0.344
58	I know many people through m	-2	-0.453

Normalized Factor Scores -- For Factor 1

No.	Statement	Q-score	Z-Scores
60	I speak with others about my	-2	-0.508
7	If I stopped drinking or usi	-2	-0.954
4	I have a lot in common with	-2	-1.164
10	Sometimes when I can't drink	-2	-1.462
11	Sometimes I have to drink or	-3	-1.574
5	Sometimes when I'm drinking	-3	-1.666
12	I have a lot of fun drinking	-3	-1.722
1	Drinking and/or using drugs	-3	-1.810
3	I use alcohol or drugs to he	-4	-1.868
2	I think about drinking and/o	-4	-1.917
8	I know it's not good for me	-4	-1.998
6	A lot of my time and energy	-5	-2.011
9	I find I'm drinking more and	-5	-2.148

Normalized Factor Scores -- For Factor 2

No.	Statement	Q-scores	Z-Scores
25	Having a job helps me feel g	+5	1.962
22	I realize that I must be com	+5	1.764
31	My work is important to me.	+4	1.703
30	I know that if I work hard,	+4	1.667
33	I enjoy my work.	+4	1.615
5	Sometimes when I'm drinking	+3	1.553
32	I feel responsible for the k	+3	1.409
13	I accept the fact that I can	+3	1.234
35	Sometimes working hard makes	+3	1.131
34	I try to be creative at work	+2	1.060
49	I feel that God has helped m	+2	0.967
21	Being clean and sober is the	+2	0.877
26	My job is part of who I am.	+2	0.812
36	I am a good worker.	+2	0.803
38	My family is very important	+2	0.756
53	I believe that God will forg	+2	0.749
19	I feel a bond with people wh	+1	0.727
29	It's nice to see that my wor	+1	0.676
15	I go to Alcoholics Anonymous	+1	0.582
18	I get love and support from	+1	0.580
44	My family has been important	+1	0.567
24	I find that therapy is helpf	+1	0.529
23	I go to my treatment program	+1	0.459
43	My family knows what I am do	+1	0.454
14	Helping other alcoholics/add	+1	0.381
20	I spend time with other peop	0	0.329
57	I take part in religious ser	0	0.171
28	I feel like I'm part of the	0	0.156
52	I believe in God.	0	0.146
27	I enjoy talking with the peo	0	0.095
16	I have the phone numbers of	0	-0.071
17	I read Alcoholics Anonymous	0	-0.139
50	God is very important to me.	0	-0.260
37	I feel responsible for my fa	0	-0.332
2	I think about drinking and/o	0	-0.339
11	Sometimes I have to drink or	-1	-0.377
46	When I need some help, my pa	-1	-0.406
54	My religious beliefs guide m	-1	-0.473
56	My religious activities are	-1	-0.483
3	I use alcohol or drugs to he	-1	-0.729
55	Religion has changed me for	-1	-0.734
47	I spend the holidays with my	-1	-0.754
40	When I really need help, my	-1	-0.772
6	A lot of my time and energy	-1	-0.773
51	I put my trust in God.	-2	-0.779
48	A family dinner is something	-2	-0.863
45	I see my family often.	-2	-0.972
8	I know it's not good for me	-2	-0.995
1	Drinking and/or using drugs	-2	-1.010

Normalized Factor Scores -- For Factor 2

No.	Statement	Q-scores	Z-Scores
7	If I stopped drinking or usi	-2	-1.082
59	I am a member of a religious	-2	-1.088
10	Sometimes when I can't drink	-3	-1.110
58	I know many people through m	-3	-1.191
9	I find I'm drinking more and	-3	-1.233
41	I know what the people in my	-3	-1.241
39	I am very close to my parent	-4	-1.322
4	I have a lot in common with	-4	-1.473
12	I have a lot of fun drinking	-4	-1.522
42	I am in touch with my family	-5	-1.640
60	I speak with others about my	-5	-1.753

Normalized Factor Scores -- For Factor 3

No.	Statement	Q-score	Z-Scores
21	Being clean and sober is the	+5	2.708
24	I find that therapy is helpf	+5	2.132
15	I go to Alcoholics Anonymous	+4	1.828
38	My family is very important	+4	1.734
13	I accept the fact that I can	+4	1.502
23	I go to my treatment program	+3	1.391
30	I know that if I work hard,	+3	1.084
18	I get love and support from	+3	1.062
40	When I really need help, my	+3	1.027
20	I spend time with other peop	+2	0.905
52	I believe in God.	+2	0.862
48	A family dinner is something	+2	0.833
22	I realize that I must be com	+2	0.744
35	Sometimes working hard makes	+2	0.704
19	I feel a bond with people wh	+2	0.668
37	I feel responsible for my fa	+2	0.584
36	I am a good worker.	+1	0.543
14	Helping other alcoholics/add	+1	0.532
43	My family knows what I am do	+1	0.520
51	I put my trust in God.	+1	0.438
29	It's nice to see that my wor	+1	0.367
42	I am in touch with my family	+1	0.366
49	I feel that God has helped m	+1	0.340
32	I feel responsible for the k	+1	0.282
39	I am very close to my parent	+1	0.123
17	I read Alcoholics Anonymous	0	0.121
25	Having a job helps me feel g	0	0.108
31	My work is important to me.	0	0.103
33	I enjoy my work.	0	0.080
2	I think about drinking and/o	0	0.063
16	I have the phone numbers of	0	0.025
50	God is very important to me.	0	-0.033
46	When I need some help, my pa	0	-0.091
55	Religion has changed me for	0	-0.096
34	I try to be creative at work	0	-0.133
26	My job is part of who I am.	-1	-0.146
44	My family has been important	-1	-0.150
54	My religious beliefs guide m	-1	-0.174
60	I speak with others about my	-1	-0.232
41	I know what the people in my	-1	-0.325
4	I have a lot in common with	-1	-0.594
27	I enjoy talking with the peo	-1	-0.624
6	A lot of my time and energy	-1	-0.718
56	My religious activities are	-1	-0.745
28	I feel like I'm part of the	-2	-0.772
53	I believe that God will forg	-2	-0.811
5	Sometimes when I'm drinking	-2	-0.948
58	I know many people through m	-2	-1.028
59	I am a member of a religious	-2	-1.066

Normalized Factor Scores -- For Factor 3

No.	Statement	Q-score	Z-Scores
10	Sometimes when I can't drink	-2	-1.141
7	If I stopped drinking or usi	-2	-1.182
57	I take part in religious ser	-3	-1.209
1	Drinking and/or using drugs	-3	-1.236
47	I spend the holidays with my	-3	-1.237
3	I use alcohol or drugs to he	-3	-1.305
45	I see my family often.	-4	-1.358
8	I know it's not good for me	-4	-1.498
9	I find I'm drinking more and	-4	-1.531
12	I have a lot of fun drinking	-5	-1.613
11	Sometimes I have to drink or	-5	-1.783

Normalized Factor Scores -- For Factor 4

No.	Statement	Q-score	Z-Scores
51	I put my trust in God.	+5	2.152
50	God is very important to me.	+5	2.018
52	I believe in God.	+4	1.856
21	Being clean and sober is the	+4	1.674
49	I feel that God has helped m	+4	1.633
22	I realize that I must be com	+3	1.621
13	I accept the fact that I can	+3	1.558
53	I believe that God will forg	+3	1.398
24	I find that therapy is helpf	+3	1.246
18	I get love and support from	+2	1.128
23	I go to my treatment program	+2	1.041
14	Helping other alcoholics/add	+2	0.844
19	I feel a bond with people wh	+2	0.716
25	Having a job helps me feel g	+2	0.689
17	I read Alcoholics Anonymous	+2	0.671
27	I enjoy talking with the peo	+2	0.600
15	I go to Alcoholics Anonymous	+1	0.504
30	I know that if I work hard,	+1	0.475
20	I spend time with other peop	+1	0.474
36	I am a good worker.	+1	0.468
28	I feel like I'm part of the	+1	0.377
32	I feel responsible for the k	+1	0.359
55	Religion has changed me for	+1	0.358
35	Sometimes working hard makes	+1	0.337
31	My work is important to me.	+1	0.332
54	My religious beliefs guide m	0	0.327
34	I try to be creative at work	0	0.223
26	My job is part of who I am.	0	0.145
29	It's nice to see that my wor	0	0.040
16	I have the phone numbers of	0	-0.022
33	I enjoy my work.	0	-0.040
60	I speak with others about my	0	-0.057
58	I know many people through m	0	-0.274
56	My religious activities are	0	-0.314
38	My family is very important	0	-0.399
7	If I stopped drinking or usi	-1	-0.403
5	Sometimes when I'm drinking	-1	-0.408
4	I have a lot in common with	-1	-0.525
59	I am a member of a religious	-1	-0.563
48	A family dinner is something	-1	-0.668
46	When I need some help, my pa	-1	-0.688
10	Sometimes when I can't drink	-1	-0.727
57	I take part in religious ser	-1	-0.787
47	I spend the holidays with my	-1	-0.799
2	I think about drinking and/o	-2	-0.815
45	I see my family often.	-2	-0.888
43	My family knows what I am do	-2	-0.925
1	Drinking and/or using drugs	-2	-0.956
3	I use alcohol or drugs to he	-2	-1.013

Normalized Factor Scores -- For Factor 4

No.	Statement	Q-score	Z-Scores
37	I feel responsible for my fa	-2	-1.047
41	I know what the people in my	-2	-1.169
40	When I really need help, my	-3	-1.173
6	A lot of my time and energy	-3	-1.174
8	I know it's not good for me	-3	-1.224
39	I am very close to my parent	-3	-1.238
9	I find I'm drinking more and	-4	-1.239
44	My family has been important	-4	-1.300
12	I have a lot of fun drinking	-4	-1.424
11	Sometimes I have to drink or	-5	-1.475
42	I am in touch with my family	-5	-1.530

Normalized Factor Scores -- For Factor 5

No.	Statement	Q-score	Z-Scores
54	My religious beliefs guide m	+5	1.897
25	Having a job helps me feel g	+5	1.850
52	I believe in God.	+4	1.653
44	My family has been important	+4	1.348
53	I believe that God will forg	+4	1.348
21	Being clean and sober is the	+3	1.312
57	I take part in religious ser	+3	1.229
35	Sometimes working hard makes	+3	1.125
56	My religious activities are	+3	1.066
60	I speak with others about my	+2	1.066
24	I find that therapy is helpf	+2	1.018
30	I know that if I work hard,	+2	0.995
33	I enjoy my work.	+2	0.971
15	I go to Alcoholics Anonymous.	+2	0.888
3	I use alcohol or drugs to he	+2	0.855
50	God is very important to me.	+2	0.820
14	Helping other alcoholics/add	+1	0.692
51	I put my trust in God.	+1	0.680
31	My work is important to me.	+1	0.632
55	Religion has changed me for	+1	0.573
38	My family is very important	+1	0.552
6	A lot of my time and energy	+1	0.478
26	My job is part of who I am.	+1	0.351
23	I go to my treatment program	+1	0.341
59	I am a member of a religious	+1	0.270
58	I know many people through m	0	0.196
22	I realize that I must be com	0	0.175
11	Sometimes I have to drink or	0	0.024
48	A family dinner is something	0	0.002
41	I know what the people in my	0	-0.033
19	I feel a bond with people wh	0	-0.057
18	I get love and support from	0	-0.057
10	Sometimes when I can't drink	0	-0.166
32	I feel responsible for the k	0	-0.187
8	I know it's not good for me	0	-0.201
17	I read Alcoholics Anonymous	-1	-0.211
2	I think about drinking and/o	-1	-0.223
34	I try to be creative at work	-1	-0.235
37	I feel responsible for my fa	-1	-0.339
39	I am very close to my parent	-1	-0.362
45	I see my family often.	-1	-0.374
16	I have the phone numbers of	-1	-0.516
27	I enjoy talking with the peo	-1	-0.656
43	My family knows what I am do	-1	-0.713
36	I am a good worker.	-2	-0.727
46	When I need some help, my pa	-2	-0.739
1	Drinking and/or using drugs	-2	-0.739
5	Sometimes when I'm drinking	-2	-0.831
40	When I really need help, my	-2	-0.900

Normalized Factor Scores -- For Factor 5

No.	Statement	Q-score	Z-Scores
9	I find I'm drinking more and	-2	-0.902
29	It's nice to see that my wor	-2	-1.101
49	I feel that God has helped m	-3	-1.113
20	I spend time with other peop	-3	-1.194
28	I feel like I'm part of the	-3	-1.324
12	I have a lot of fun drinking	-3	-1.419
42	I am in touch with my family	-4	-1.511
7	If I stopped drinking or usi	-4	-1.523
13	I accept the fact that I can	-4	-1.592
47	I spend the holidays with my	-5	-1.698
4	I have a lot in common with	-5	-2.764

Normalized Factor Scores -- For Factor 6

No.	Statement	Q-Score	Z-Scores
51	I put my trust in God.	+5	2.019
2	I think about drinking and/o	+5	1.994
21	Being clean and sober is the	+4	1.847
22	I realize that I must be com	+4	1.838
5	Sometimes when I'm drinking	+4	1.660
49	I feel that God has helped m	+3	1.558
52	I believe in God.	+3	1.505
53	I believe that God will forg	+3	1.167
13	I accept the fact that I can	+3	1.165
1	Drinking and/or using drugs	+2	1.132
50	God is very important to me.	+2	1.011
10	Sometimes when I can't drink	+2	0.926
42	I am in touch with my family	+2	0.827
41	I know what the people in my	+2	0.779
40	When I really need help, my	+2	0.770
12	I have a lot of fun drinking	+2	0.628
30	I know that if I work hard,	+1	0.613
45	I see my family often.	+1	0.535
11	Sometimes I have to drink or	+1	0.528
39	I am very close to my parent	+1	0.505
24	I find that therapy is helpf	+1	0.389
47	I spend the holidays with my	+1	0.279
38	My family is very important	+1	0.263
3	I use alcohol or drugs to he	+1	0.254
18	I get love and support from	+1	0.109
4	I have a lot in common with	0	0.079
37	I feel responsible for my fa	0	0.054
29	It's nice to see that my wor	0	0.036
43	My family knows what I am do	0	0.009
23	I go to my treatment program	0	-0.018
19	I feel a bond with people wh	0	-0.024
7	If I stopped drinking or usi	0	-0.030
48	A family dinner is something	0	-0.060
9	I find I'm drinking more and	0	-0.250
17	I read Alcoholics Anonymous	0	-0.287
35	Sometimes working hard makes	-1	-0.302
14	Helping other alcoholics/add	-1	-0.302
6	A lot of my time and energy	-1	-0.344
36	I am a good worker.	-1	-0.441
26	My job is part of who I am.	-1	-0.540
20	I spend time with other peop	-1	-0.562
16	I have the phone numbers of	-1	-0.589
34	I try to be creative at work	-1	-0.631
33	I enjoy my work.	-1	-0.680
46	When I need some help, my pa	-2	-0.807
31	My work is important to me.	-2	-0.981
32	I feel responsible for the k	-2	-1.011
28	I feel like I'm part of the	-2	-1.015
25	Having a job helps me feel g	-2	-1.080

Normalized Factor Scores -- For Factor 6

No.	Statement	Q-Score	Z-Scores
59	I am a member of a religious	-2	-1.095
56	My religious activities are	-2	-1.107
60	I speak with others about my	-3	-1.119
57	I take part in religious ser	-3	-1.231
44	My family has been important	-3	-1.243
54	My religious beliefs guide m	-3	-1.274
8	I know it's not good for me	-4	-1.280
15	I go to Alcoholics Anonymous	-4	-1.331
55	Religion has changed me for	-4	-1.370
58	I know many people through m	-5	-1.699
27	I enjoy talking with the peo	-5	-1.775

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