Moments of Transformation: Narratives of Recovery and Identity Change

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Abstract

Researchers in many different fields are beginning to ask similar questions about the nature of change; from illness to wellness, from addiction to recovery, from criminal to citizen. Essential to all of these discussions is the concept of identity transformation. What all of these perspectives share are: (1) the limitations of formal systems to change individuals, (2) the importance of personal identity embedded in a cultural or personal narrative, (3) a reduced emphasis on deficits, (4) the role of the social context in defining the problem and the solution, and (5) the importance of role identity in illness and wellness. Through the collection and analysis of change narratives from persons who successfully negotiated the path from stigmatized to socially desired roles, this study investigates the personal meaning of change, the factors that act as catalysts and the nature of the roles assumed at the end of the process.

Findings suggest that people who have negative life experiences that often stigmatize them do not necessarily discuss recovery or healing from these experiences as central to their life narratives. In most cases, the problems of most importance to the respondents included issues such as poor self-esteem, isolation and unemployment; problems common to persons outside the formal correctional and treatment systems. Their end status also was often achievements common to people in society at large, including owning a home, being a parent, graduating from college and being employed in meaningful work.

Professionals must understand that the presenting problem may not be the issue of most importance to those seeking help. Further, persons seeking help have multiple roles and identities that can be mobilized to support the recovery process. Attending to individuals' life narratives may be as important a tool in the professional's armamentarium as any medication, therapy, or intervention.

Key words: recovery, stigma, narrative
Introduction

Through his observations of social behavior, Erving Goffman (1963) noted that the presence of certain characteristics could negatively affect the nature of interpersonal interactions and, in fact, limit a person's present and future experiences and opportunities. A physical characteristic, such as a facial deformity or the need to use crutches or a wheelchair, is considered a "stigma;" a visible blemish upon the individual (Goffman, 1963). Visible deformities and disabilities constitute only one of several kinds of stigmatizing factors. Also potentially stigmatizing are group association characteristics, such as race, ethnic origin, or religious affiliation; largely invisible characteristics, including a criminal act or a chronic illness; and association with a stigmatized individual or group.

There is an important distinction between the characteristic and its attendant stigma. Clearly, the lack of ability to stand or walk limits the manner in which a person executes his or her mobility. While placing bounds on physical ability, the real limit of physical ability is often greater than assumed by society in general, treatment providers and the individual him-or herself. Stereotypes of stigma, to which all in a social group are vulnerable including those to whom they are applied, circumscribe the type and nature of abilities associated with any handicap. This is the first effect of stigma. The second effect of stigma is generalizing the stigmatized characteristic to the individual as a whole. For example, a person who has hearing loss is presumed also to be weak or unintelligent. Stigma is a blemish upon the person as a whole. Stigma extends far beyond the direct consequences of the loss of ability, and connotes a devaluing of human worth. This particular aspect of stigma has far-reaching implications for all domains of a person’s life.

Stigma more effectively and profoundly limits an individual’s ability to achieve across life domains than the direct consequences of the stigmatized characteristic. Moreover, the manner in which stigma functions within social interactions is the same regardless of the type of negative characteristic (Goffman, 1963). Once acquired, the stigma commonly becomes the single most important factor in a person’s social interactions. The stigma is incorporated into the personal and social identity. While individuals may resist an undesirable label or role (i.e., stigma), the success of their resistance is largely dependent on how they negotiate their social interactions. Active negotiating of a socially acceptable role, reducing the prominence of the stigma, and engaging in personal identity transformation are necessary for restoration to full social life.

This study used narrative accounts of transformative experiences of persons who had experienced different types of life events (that is, had experiences that put them at risk of stigma) to ex-
plore similarities in themes, processes and outcomes of significant turning points.

Narrative identity

From a sociological perspective, identity is a cognitive understanding of self (Koski-Jäannes, 2002; Singer, 2004). Singer (2004) states that identity is how individuals understand themselves “as unique individuals and as social beings” (p.438). More importantly, understanding identity is to “understand how individuals craft narratives from experiences, tell these stories internally and to others, and ultimately to apply these stories to knowledge of self, other and the world in general” (Singer, 2004, p.438). Thus, individuals create meaning from life experiences to build a cogent life narrative that they tell themselves and others to explain who they are and justify their current life situation.

Individuals present aspects of their perceived identity through the roles they perform within social groups. Expectations for behavior within conventional and deviant (including illness) roles are widely known and shared (Goffman, 1963), but roles and identity are not static over time or social contexts. First, each individual assumes many roles and displays each according to the necessities of the moment. When roles conflict, persons may select which will be the dominant one among the repertoire of roles. Second, individuals enter and exit roles over the course of a lifetime. Many role entries and exits are developmental and normative, such as adulthood, employment, and parenthood, and some are not. This begs the question as to whether non-normative (i.e., deviant) role entries and exits are fundamentally different from normative ones.

Much study has been devoted to entry into deviant roles. Classical sociological theorists often investigated the macro processes of deviance definition (e.g., Foucault’s *Madness and Civilization* and Marx’s *Capital*). Labeling theorists (e.g., Becker and Scheff) and symbolic interactionists (e.g., Goffman and Lofland) studied intra- and interpersonal processes at the micro level. Entry into a deviant role is a particular type of role transition. Unlike many normative role transitions (e.g., school graduation), it is often sudden, forced and reflects unwelcome change in role/identity. In some cases, however, the role entry shares characteristics of normative role transitions; the change is gradual and desired. In such situations, seeking a “deviant” identity is driven by a desire for a positive self-identity within a group of like-minded peers (Anderson, 1994; 1998; Anderson & Mott, 1998), much like other role transitions.

Exiting roles has garnered much less attention. Ebaugh (1988) presents a general model of role exit that includes four stages: first doubts, seeking alternatives, the turning point, and creating an
ex-role. She explicitly states that this model applies to both normative and deviant role exit. In her model, identity and role performance are central. Individuals prepare to exit roles by first becoming dissatisfied with the current role, then by exploring alternative roles and practicing new role behaviors prior to assuming the new role. Distancing from the original group and developing attachments to a new group are also a part of the process, and, as a result, individuals change their social identities. Aspects of Ebaugh's (1988) role exit and identity transformation more generally have been applied to sex workers (Sanders, 2007), substance abusers (Matto, 2004; Walters, 2000), women with co-occurring mental health and substance use disorders (Stenius et al., 2005; Stenius & Veysey, 2005), survivors of sexual abuse (Harvey, et al., 2000) and people with “deviant” identities in general (Brown, 1991).

Ebaugh (1988) also states that the exiting process may be influenced by a number of factors, including among other things, voluntariness of the exit, centrality of the role to a person's identity, degree of control, and social desirability).

Illness, narrativity and recovery

Disease and physical difference are biological states. Illness, disability and deformity are social constructs. Being ill, it has been argued, is a social role (i.e., “sick role”) that grants privileges, but requires specific role behaviors in exchange (Parsons, 1951). The ill person (1) is excused from certain responsibilities, such as gainful employment, and (2) is not held accountable for the illness. In return, the individual is obligated (1) to acknowledge the illness and must want to recover and (2) must seek and follow the treatment advice of a qualified professional (Parsons, 1951). Even from the medical perspective, there is general agreement that medical practice is more than the control of disease processes and the amelioration of symptoms. Medicine is also concerned with how patients adjust to the medical problems in their lives. Kleinman (1988) states that medicine plays two roles; control of disease processes and the management of the illness experience. Coulehan (2005) similarly states that medicine plays both an instrumental and symbolic role. Medicine provides direct medical interventions to produce positive health outcomes, but more importantly, the diagnosis of illness and the ontological meaning illness carries for the patient are critical to the healing process. Bloom (2005) further states that persons who believe they will recover or who have narratives that find positive meaning in the illness experience are more likely to recover than those who don’t.

The idea that illness invokes a role with privileges and obligations is useful as a general heuristic. In fact, this model provides the dominant medical narrative of healing and recovery. In this
model, an individual has an illness. He or she must first seek help to properly diagnose the problem. At this point, the person becomes the patient, and is told that if he or she cooperates with the medical authority, he or she will get better. The actuality of healing often does not live up to its promise (Bloom, 2005). Some believe that this is largely due to the over-reliance of medical professionals on the allopathic effects of medicine and minimal understanding of the importance of the symbolic role of an illness/wellness narrative (Bloom, 2005; Coulehan, 2005; Kleinman, 1988).

The typical medical healing narrative follows a pattern regardless of the diagnosis: symptom presentation, diagnosis, initial treatment, follow-up and maintenance with the result being improved health or at least reduced suffering. This model may be applied to behavioral health conditions as well. That criminogenic characteristics may be treated in the same manner is plausible. In fact, the growth of the use of cognitive-behavioral therapies with correctional populations (see, for example, Clawson, et al., 2004) suggests that criminal behavior is an appropriate target for treatment.

A medical model recovery narrative is only one of many recovery narratives. The mental health, addiction and criminological literatures each have a body of research dedicated to such narratives. More importantly, researchers in addiction, health, mental health and criminology are beginning to ask similar questions about the nature of change; from illness to wellness, from addiction to recovery; from criminal to citizen. What all of these perspectives share is: (1) the limitations of formal systems to change individuals, (2) the importance of personal identity embedded in a cultural or personal narrative, (3) a reduced emphasis on deficits, (4) the role of the social context in defining the problem and the solution, and (5) the importance of role identity in illness and wellness.

Moving recovery from a medical into a social model requires the development of new collective narratives. The centrality of narratives in the recovery process is nowhere so clear as in the Alcoholics Anonymous (AA) community. AA meetings provide individuals opportunities to tell personal stories, and results in a collective narrative of recovery. In fact, the Big Book and the 12-steps is a recipe for recovery. Identity projects within the AA community focus on acknowledging the addiction first, “I am an addict.” Altruism and giving back are the recovery goals. The final identity project, therefore, is the transformation from alcoholic/addict to servant of the greater good.

Within the mental health field, recovery is also prominent. Recently, Noordsy and colleagues
(2002) identified three constructs within recovery: “(a) hope; (b) taking personal responsibility for illness management and wellness; and (c) ‘getting on with life’ beyond illness” (p. 318). Narrative restructuring is critical in recovery from childhood abuse and its adult consequences (Harvey, et al., 2000; Veysey et al., 2004). Like AA, recovery is about creating a fulfilling and meaningful life beyond the illness. The same may be said of narrative studies of transitions to a crime-free life (Maruna, 2001; Vaughn, 2007).

While each person’s recovery narrative is unique in its particulars, similar themes emerge in each recovery community. These narratives, then, are communal resources providing similarly situated persons: (a) a roadmap, (b) a community of fellow travelers, and (c) an opportunity to use the “bad thing that happened” as a strength and resource for the benefit of others. Taken together this means that the theoretical construct of recovery could be conceived as a special case of role transition.

Methodology

Narratives are an especially powerful vehicle for understanding complex processes of change and movement from one societal status to another (Maruna, 2001; Singer, 2004; Vaughn, 2007). This study collected short narratives solicited through two vaguely worded questions. This was done with the understanding that narratives are a selective retelling of meaningful events that are linked together to reflect, explain or justify a current self-perception. In every story, choices are made about relevance and impact. The verbal and the written one also differ. Verbal communication includes opportunities for both greater detail as well as the inclusion of less relevant or tangential elements and commonly, but not always, nuances of intonation and body language. Written narratives tend to be shorter and more consciously constructed.

The study asked the following two open-ended questions: (1) “Please describe an experience that changed your life in a positive way,” and (2) “How did this influence your later life?” The questions were purposefully vague and asked in a general way so as not to focus the respondents’ attention on any one or more stigmatized role(s). The survey concluded with a checklist of all four identities that might apply and minimal demographic information (i.e., sex, race/ethnicity and age).

Sampling frame

Individuals from the four stigmatized groups (i.e., mentally ill, addict/alcoholic, victim/surviv-
behavior, criminal) were identified through existing expert lists. These are lists of meeting participants in Substance Abuse and Mental Health Services Administration (SAMHSA) (i.e., federally-sponsored) meetings. SAMHSA’s commitment to substantial involvement of persons with lived experience guarantees that a significant proportion of attendees at some point in their lives have struggled with one or more of these problems. Because they also have achieved great stature in the field, they are likely to have successfully overcome or successfully managed their identified problem. These lists reflect participants in: (1) the Center for Mental Health Services (CMHS) Recovery Summit, (2) the Center for Substance Abuse Treatment (CSAT) Recovery Summit, and (3) the Dare to Vision Conference focused on persons with histories of physical and/or sexual abuse.

Recruitment

A request for participation was sent to 406 individuals via e-mail (CMHS=63, CSAT=112, Dare to Vision=221). The e-mail invitation briefly described the project and some research protections. It also included a link to the web-based survey. The introduction embedded in the survey fully explained human subjects protections, and response to the web-based survey constituted consent.

Coding

Responses to the questions were analyzed for both content and structure. Initially, the narratives were themed independently by three readers. An initial set of codes was developed and codes were then assigned to all the narratives. Coding discrepancies between readers were discussed and resolved. This process was repeated resulting in a final set of themes and codes.

Respondents’ personal narratives of transformation described both why and how they changed their lives in a positive way, and what they learned from the experience. More specifically, they described how people framed their identities, whether their primary identities were implicitly or explicitly tied to the experiences (i.e., addiction, psychiatric treatment, survivor/victim of physical or sexual abuse, incarceration) selected in closed ended portions of the survey, and how their understanding of their problems shaped their approaches to change.

The common structure of the narratives emerged through an iterative process of review and coding. The common aspects of the narratives included: (1) initial identity, (2) understanding of the problem, (3) nature of the moment of transformation characterized by three constructs (i.e.,
Table 1. Characteristics of Respondents (n=37)

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographics</strong></td>
<td></td>
</tr>
<tr>
<td>% Female</td>
<td>77.1</td>
</tr>
<tr>
<td>Age Group</td>
<td></td>
</tr>
<tr>
<td>% 20s</td>
<td>5.7</td>
</tr>
<tr>
<td>% 30s</td>
<td>8.6</td>
</tr>
<tr>
<td>% 40s</td>
<td>37.1</td>
</tr>
<tr>
<td>% 50s</td>
<td>37.1</td>
</tr>
<tr>
<td>% 60s</td>
<td>11.4</td>
</tr>
<tr>
<td><strong>Racial/Ethnic Identity</strong></td>
<td></td>
</tr>
<tr>
<td>% African-American/Other Black</td>
<td>14.3</td>
</tr>
<tr>
<td>% Asian</td>
<td>5.7</td>
</tr>
<tr>
<td>% Caucasian</td>
<td>5.7</td>
</tr>
<tr>
<td>% Hispanic</td>
<td>60</td>
</tr>
<tr>
<td>% Native American/Pacific Islander</td>
<td>0</td>
</tr>
<tr>
<td>% Mixed</td>
<td>8.6</td>
</tr>
<tr>
<td>% Other</td>
<td>5.8</td>
</tr>
<tr>
<td><strong>Experiences</strong></td>
<td></td>
</tr>
<tr>
<td>% Addiction</td>
<td>65.7</td>
</tr>
<tr>
<td>% Psychiatric Treatment</td>
<td>62.9</td>
</tr>
<tr>
<td>% Physical and/or Sexual Abuse</td>
<td>62.9</td>
</tr>
<tr>
<td>% Incarceration</td>
<td>22.9</td>
</tr>
<tr>
<td><strong>Number of Life Experiences</strong></td>
<td></td>
</tr>
<tr>
<td>% One Only</td>
<td>31.4</td>
</tr>
<tr>
<td>% Two</td>
<td>34.3</td>
</tr>
<tr>
<td>% Three</td>
<td>22.9</td>
</tr>
<tr>
<td>% All Four</td>
<td>11.4</td>
</tr>
</tbody>
</table>

event or process, internal or external motivating factor, cognitive shift), and (4) end status. Developing a common narrative structure allowed us to identify important dynamics in the change process, and the language respondents' used conveyed both the unique elements of each story as well as the meaning individuals imbue to these elements.

Results

The following sections present the demographic characteristics of the sample and the self-identified group membership distributions.
Characteristics of respondents

Thirty-seven individuals responded to the survey. Table 1 presents the sample characteristics. Most of the respondents (77%) were female. Age was grouped into decades. Six percent of respondents were in their 20s, 9 percent in their 30s, 37 percent in their 40s, 37 percent in their 50s and 11 percent in their 60s. Sixty percent identified as Caucasian, 14 percent as African-American, 6 percent Hispanic, 6 percent Asian and 9 percent as being of mixed race/ethnicity. An additional 6 percent stated “other.”

Of the respondents, 66 percent acknowledged having an addiction, 63 percent had noted psychiatric treatment, 63 percent had acknowledged having been physically and/or sexually abused, and 23 percent checked the incarceration box among their experiences. Thirty-one percent identified with only one category, while 11 percent acknowledged having experiences across all four categories.

The transformation process

Initial identity

Within the narrative structure, most individuals began their stories with some description of who they perceived themselves to be. While the survey’s check boxes requested respondents to identify previous life experiences, this initial identity reflected how respondents saw themselves without a requirement to orient their response to one or more of the stigmatized identities. Unlike many studies that focus on recovery from specific problems, one of the purposes of including a narrative in this study was to identify the aspects of respondents’ lives that were most salient to them without regard to their problem area(s).

In some cases the initial identity was stated explicitly, “I was a hard-core injection heroin and cocaine addict for 27 years” (Participant 13) or “I have lived with mental differences-labeled with many diagnoses—for 35 years” (Participant 16). Other times the initial identity was inferred from the context of the story about the experience that changed the respondent’s life in a positive way. A respondent describing a trip to Nepal said “I survived all our adventures without getting sick—despite the fearful exhortations of loved ones” (Participant 27). “Sick” is an ambiguous term and could refer to a physical illness, an addiction or a mental illness. The respondent later stated, “…proving to the nation that ‘lunatics can do great things,’” thus inferring her initial identity and the nature of her illness.
While everyone in the study had one, and a large majority had two or more life experiences, the narratives reflect a more diverse understanding of self-perceived identity. Importantly, the initial identity that respondents claimed varied more widely than the four stigmatized identities; including normal citizen roles such as wife/divorcesee (Participant 4) and employee ("working as an ABC News producer" Participant 10), other stigmatized identities, such as being unemployed (Participant 7) and being gay (Participant 2), and other unspecified identities, such as Participant 17 who begins her narrative with, "When I was in junior high school, I was struggling with being accepted and finding the 'right' group to be a part of."

Table 2 presents a display of the intersection between life experiences and initial identity. Since many of the individuals checked more than one of the life experiences boxes, the percent of people who identify with specific identities reflects a duplicated count. Of those who have an experience of addiction, 55 percent claimed addict or alcoholic as their initial identity; of those who had received psychiatric treatment, only 15 percent had an initial identity of mental health consumer; 25 percent of those with a history of physical and/or sexual abuse had an initial identity of survivor/victim and none of the formerly incarcerated had a primary initial identity as of offender. In all categories of life experiences, the role of addict/alcoholic was equal or greater than any other initial identity. Further, in all categories of life experiences, a substantial proportion of the sample was comprised of initial identities other than those directly linked to life experiences.

Despite multiple experiences, most respondents (in all but two cases) focused their initial identity, and therefore problem and solution, on a single identity (See Table 3 for distributions of response categories for each of the coded parts of the narrative). The most prevalent identity was
### Table 3. Moments of Transformation (n=37)

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Identity</strong></td>
<td></td>
</tr>
<tr>
<td>% mental health services consumer</td>
<td>9.1</td>
</tr>
<tr>
<td>% offender</td>
<td>0</td>
</tr>
<tr>
<td>% survivor/victim</td>
<td>15.2</td>
</tr>
<tr>
<td>% addict/alcoholic</td>
<td>36.4</td>
</tr>
<tr>
<td>% citizen</td>
<td>6.1</td>
</tr>
<tr>
<td>% other stigmatized category</td>
<td>15.2</td>
</tr>
<tr>
<td>% unspecified</td>
<td>18.2</td>
</tr>
<tr>
<td><strong>Nature of the Problem</strong></td>
<td></td>
</tr>
<tr>
<td>% mental health related</td>
<td>12.1</td>
</tr>
<tr>
<td>% criminal</td>
<td>3</td>
</tr>
<tr>
<td>% abuse related</td>
<td>9.1</td>
</tr>
<tr>
<td>% addiction-related</td>
<td>36.4</td>
</tr>
<tr>
<td>% self-esteem, shame, isolation</td>
<td>18.2</td>
</tr>
<tr>
<td>% other stigma related</td>
<td>9.1</td>
</tr>
<tr>
<td>% other problem/undefined</td>
<td>12.1</td>
</tr>
<tr>
<td><strong>Process/Event</strong></td>
<td></td>
</tr>
<tr>
<td>% process</td>
<td>32.4</td>
</tr>
<tr>
<td>% event</td>
<td>52.9</td>
</tr>
<tr>
<td>% mixed</td>
<td>14.7</td>
</tr>
<tr>
<td><strong>Internal/External</strong></td>
<td></td>
</tr>
<tr>
<td>% internal</td>
<td>58.8</td>
</tr>
<tr>
<td>% external</td>
<td>29.4</td>
</tr>
<tr>
<td>% mixed</td>
<td>11.8</td>
</tr>
<tr>
<td>% Cognitive Shift</td>
<td>54.5</td>
</tr>
<tr>
<td><strong>End Status</strong></td>
<td></td>
</tr>
<tr>
<td>% advocate/employed in field</td>
<td>24.2</td>
</tr>
<tr>
<td>% person in recovery</td>
<td>24.2</td>
</tr>
<tr>
<td>% survivor</td>
<td>3</td>
</tr>
<tr>
<td>% well/healthy</td>
<td>18.2</td>
</tr>
<tr>
<td>% citizen roles</td>
<td>21.2</td>
</tr>
<tr>
<td>% undefined</td>
<td>9.1</td>
</tr>
<tr>
<td>% End Status Linked to Initial Identity</td>
<td>78.8</td>
</tr>
</tbody>
</table>
addict/alcoholic (36%), while only 15 percent identified themselves as a survivor of abuse and 9 percent as a mental health consumer with no one claiming a “criminal” identity. More importantly, 40 percent identified with roles not directly associated with the four under study.

For individuals with multiple life experiences, the characterization of the initial identity (i.e., the choice of the single identity among several possible) revealed interesting patterns. For instance, a respondent (Participant 20) who identified receiving psychiatric treatment, having an addiction and being a survivor of abuse focused on his (misdiagnosed) depression,

When I refused psych drugs in a state hospital I began to recover. I was suicidal and refused my heart medicine and all other medicines. A common side effect of Inderal was depression. When I refused drugs, I got better and from then on knew that I was misdiagnosed. I went on to seek appropriate healing from past physical and sexual abuse and recovered as I escaped from the MH system

A woman who had experienced abuse, addiction, and psychiatric treatment only wrote about her “mental differences.” As noted earlier, however, when addiction co-occurred with any other life experience, the primary initial identity was addict/alcoholic.

In some cases a respondent’s initial identity was tied to a particular problem such as depression, but in confronting the problem other experiences surfaced (i.e., abuse). One respondent (Participant 4) was in an auto accident that left her severely physically and mentally injured. During treatment for depression after the accident, she started to talk about the sexual abuse that occurred during childhood. This respondent stated, “I began therapy because of the auto accident, but soon was talking about the sexual abuse that happened when I was a child and like a full closet, thoughts and fears tumbled out of me.”

Understanding of the problem

The above example illustrates how a respondent’s understanding of his or her problem can be fluid and complex. The respondents’ understanding of their initial problem was also coded in order to trace the process of transformation. Where appropriate, the understanding of the problem was coded as directly related to the four options in the closed-ended survey questions; specifically mental health related, criminal, physical/sexual abuse related, and addiction related. For the remaining respondents, the understanding of the problem was indirectly related to the initial identity, and is better understood as the underlying problem that often engendered the stigmatized identity. These codes included such things as self-esteem, shame, and isolation. For example, one
woman (Participant 31) stated that her change began with,

The realization that I was repeating family patterns of behavior; the acknowledgement that my childhood was damaging to me, as well as [to] my brother and sister. That abuse of alcohol was symptomatic for me of high levels of shame and low self esteem.

The nature of the problem was closely linked to the initial identity, but not in all cases. Thus, in terms of the 20 respondents whose initial identities fall within one of the four target categories (see Table 2), 16 cite a problem directly related to this status. For example, Participant 33 states,

After countless years addicted to cocaine, heroin and alcohol. After many treatments ... I was introduced to my first alternative sobriety group, Secular Organizations for Sobriety. It was at my first meeting that I had my ‘Ahah’ experience.

Thus, the initial identity was “addict/alcoholic” and the problem was addiction. A substantial percentage (39%), however, state that the primary problem was not related to any of the four target issues.

Moments of transformation

The moments of transformation were coded into three distinct aspects of the transformation process: (1) whether the “moment” is a single event or a longer, multiple event process, (2) whether the catalyst for change came from within the person or from an outside source, and (3) whether the respondent noted that he or she changed the way he or she thought about him/herself or the problem.

The first aspect of transformation was whether the respondent described a specific event or a process. Many people have stories of dramatic change resulting from a single moment. These types of transformations were expected to be in respondents’ narratives, and, in fact, 53 percent of them do highlight a specific event. For example, one person (Participant 8) claimed that the birth of his daughter was the turning point. He wrote, “I held her strung out on cocaine and God spoke to me...” Similarly, another person (Participant 3) wrote, “the most significant turning point in my life was hearing an adult survivor of child abuse...talk about her own experiences. It helped me to understand that I was not alone.” Another (Participant 21) said, “I was drinking heavily and had a fall. The next morning my son did an imitation of me. I felt ashamed and call(ed) AA.” And one respondent (Participant 1) described a specific event as follows. “I was lis-
tening to Dr. King's speeches, tears just streaming down my face, feeling scared, ashamed and embarrassed by what and who I had become.” This was her salient moment, and, as a result, she initiated the change in her life.

For others (32%), the change was the result of many steps. One of the best examples of a process comes from Participant 28. She remembers,

I was a teenaged run-away. I entered a life of prostitution through manipulation of a pimp. I lived in a house with six other women of various ages that were doing the same thing. It was a strict rule of this pimp not to do drugs and alcohol. When I was nineteen I left this pimp with the guidance of a married man who wanted to use me for my money. I left that man after a short time. I began to drink and do cocaine with a woman I met while still working in the sex industry. I eventually started doing heroin. I ended up with paranoia from using cocaine and with the help from my family entered a detox. While at the detox/rehab I heard my first A.A. commitment. I entered more than 20 detoxes over the courses of treatments. I changed the behavior of working in the sex industry. But could not remain abstinent from using drugs. I did six-month in jail for assault and battery with a motor vehicle. Upon release I returned to my family and got a ‘straight job.’ I did eventually stop using substances. I entered detoxes, halfway houses, therapeutic communities, and a sober house (each of these treatments is meant to be plural). I eventually began working in the office of the Sober House as an administrative assistant and women’s housing coordinator.

Another respondent (Participant 19) said,

In 1981, I found AA, which was the beginning of (a) life long healing process. Not long after putting down drugs and alcohol, memories of childhood sexual abuse started coming to me. Four years into recovery, I sought therapy for these sexual abuse issues, and because of my sobriety I have been able to continue to heal.

In both of these cases, the change began with addressing one problem, only to face and address another problem. The remaining 15 percent of respondents wrote about both an event and a process. For example, Participant 4 said that a car accident, an event, started the process. In her case, however, she started at a non-stigmatized identity. Her reactions to the car accident were debilitating, and she sought help, received a diagnosis (i.e., PTSD) and medications. She attended a support group for depression, but soon found herself talking about her childhood sexual abuse. “Had I not been involved in that terrible accident, I never would have received the help I needed all my life.”

The actual catalyst for change took many forms. Seven of the respondents described the be-
ginning of their change being a result of treatment or self-help groups. Interestingly, Participant 25 had checked all four statuses, but found the primary help in holistic healing outside any treatment related to any of these statuses. Two respondents tracked the change to when they rejected treatment. Participant 9 wrote, “When in state hospital, I got angry and refused all medication, including my heart medication. My depression immediately started to clear...” Seven respondents stated that a change in perspective was the moment of change. This cognitive shift took various forms, including things such as understanding the parent who had hurt the respondent, understanding the impact of childhood abuse, realizing that there was a problem, and realizing that recovery was possible. Children were the reason for three respondents’ transformations; a birth, a loss of custody, and shame. Two said that a supportive person (non-professional) made a difference for them, two were inspired by others, and two believed that God intervened to change them in a positive way. Five others noted very specific events, including a trip to Thailand, getting a job, the ability to run again, a car accident, and jail, were the catalysts for change. In three of these last five cases (positive experiences), the experience proved to the person that he or she was a competent human being; in the other two cases (negative experiences), the events started a cascade of other events.

In addition to the nature of the catalyst, narratives were coded by whether the change was initiated by the respondent or whether the respondent changed due to an external agent acting upon the individual (i.e., internal and external locus of control). In over half of the cases (59%), the moment of transformation was a result of the individual doing something, making a decision or changing perspective (i.e., internal locus of control). For example, Participants 9 and 16 exercised autonomy in refusing medication and treatment; Participants 19, 21 and 25 sought out help; and Participants 3, 24, 26 and 27 discovered something new about themselves. In 29 percent of the cases, the respondent was a more passive participant where external forces created the impetus for change. In many cases this involved a therapist and/or treatment program being the primary actor (e.g., Participants 5, 32, 33), or was the result of a series of external events commonly including jail and multiple treatment episodes (e.g., Participants 15, 28, 34) or divine intervention (e.g., Participants 30, 35).

In over half of the cases, the respondents stated they experienced a specific cognitive shift. For example, about hearing an adult survivor of abuse speak, Participant 3 states, “It helped me to know I was not alone, and it empowered me to talk about my own experiences...which has lifted from me the weight of secrecy and shame that formerly oppressed me and kept my self-esteem low.” After going to AA meetings, Participant 21 says that she really “felt that there was a way to stop drinking.” And Participant 22 told a story about a teacher. She recalled, “One of the most
important things he said to me was ‘you are not your family,’ meaning that I had the ability to overcome.” To understand the depth of change in perspective, Participant 24, a survivor of childhood abuse, wrote,

I went to visit my father’s home town,... and I understood for the first time how far he had come in his life and what courage it had taken him to marry my mother and it helped me forgive him for a lot, because I found out from his great aunt what he had been through himself.

End status

Finally, the respondents’ end status was analyzed. The end status was the role(s) respondents specifically identified as a result of their transformation (that is, how did the transformation affect the respondent’s later life). Some respondents made simple statements about this conclusion state, such as, “I am still clean 17 years later” (Participant 1) and “I became an advocate” (Participant 20).

Others describe a broad range of roles and identities. Participant 2 stated, “I have a job, friends and an extended support system. I am a mental health advocate and a public speaker, [I] am off benefits, and have self-respect.” And Participant 32 wrote,

[The positive event] has changed my attitude about myself and those close to me immensely. It has led me back to school to get a graduate degree; to get an advanced degree that will lead me to a somewhat belated (age 57) career in substance abuse/alcoholic counseling. I have also rediscovered old hobbies like songwriting, and scholarship in a variety of fields.

In some cases, the transformation helped the person resist the negative label and to move beyond the label’s implicit limitations. Participant 22 stated, “I believe that it helped me to see that I had something to contribute to the world. Although I had some negative experiences, they did not define me.” And Participant 27 said,

It made me more focused on my independence, and in getting the most out of my experiences. Challenging myself in ways that mocked tradition and prioritized learning became a priority. Currently I am more involved in “causes” and art than ever before, and I hold on to my independence with a particular tenacity. I hope to go on another adventure next year—for my 40th birthday, 10 years after the adventure that set me free and enabled me to throw myself at new challenges. This year I completed a 130-mile fundraising bike ride for AIDS, and had energy for 20 miles more! I’m even contemplating a cross-country bike ride as a fund-raiser for mental
health—proving to the nation that ‘Lunatics can do great things!’

And

I became an advocate because I couldn’t believe how dead wrong I was about the two things that had come to matter most in my life; my disease and the resources to overcome it. I couldn’t believe how much ignorance and misunderstanding, stigma and discrimination exists about heroin addiction and methadone maintenance treatment and recovery, so I set about changing the world. (Participant 26)

The categories that emerged from the narratives for end status were: advocate/employee in the field, person in recovery, survivor, well/healthy, and citizen roles. Many of the transformations led the respondents to advocacy or service to their group affiliation. Twenty-four percent were either an advocate (professional or volunteer) or worked in the field (e.g., counselor). Twenty-seven percent identified as persons in recovery or survivor, both of which are the positive labels of a stigmatized group (i.e., addict/alcoholic -> person in recovery; victim -> survivor). Nearly 40 percent claimed identities that were not associated with any of the four stigma groups; although 18 percent stated simply that they were well, whole, or healthy, thus tying their end status to a problem that had to be overcome. For example, Participant 30 stated, “Since 1986, I have been ‘living,’ instead of ‘existing.’ The other 21 percent claimed independent citizen roles without an acknowledgement of what they had overcome (e.g., self-employed/employed, Christian, own home, parent). This reflects the percent of respondents (21%) whose end identity differed from their initial one.

Discussion

Clearly, personal narratives differ from what outsiders might call “factual” or objective history. It is this very fact that makes the resulting stories so important. What people choose to remember, how they create a story around an event imbuing it with meaning that may not have been present in the moment, what is important to include and what has been left unsaid all are meaningful pieces of information (Gadd & Farrall, 2004). A narrative is after all a selective retelling of a life segment that justifies or gives support to the present identity. The “facts” in the history don’t even need to be factual. One could even go so far as to say that the facts are not important.

Experience and identity

This is nowhere so true as in the discrepancy between experiences (i.e., the checked status box-
es) and the salient identities reflected by the narratives. In over half of the cases (57%) the problem described in the narrative was not even in the domain of the initial identity\(^7\). The life experiences believed to be key in forming master (and stigmatized) identities, and, therefore, the identities that are considered most important by outsiders may not be the identities most important to those with particular lived experiences. For example, one person has acknowledged a history of psychiatric treatment and physical and/or sexual abuse, but the “problem” is described as profound isolation due at least in part to being gay.

From the public’s perspective, stigmatized statuses become master statuses, meaning that all information about, and interactions with, those so classified are organized around the status. This is a reinforcing system, making it difficult to break free of the stigmatized identity and move beyond or even to integrate the attendant roles within the many s/he currently occupies. In many cases, when outsiders impose a stigmatized status upon an individual (e.g., treatment providers label through diagnoses), the individual adopts attitudes, beliefs and behaviors consistent with the stigmatized role. This is particularly true of addicts/alcoholics in these narratives. In other cases, the labels are applied, but the narratives suggest that some individuals never fully accept and resist the implicit meaning of the label. This resistance may be more successful in situations in which the narrator claims multiple and complex identities.

Agency, self-efficacy and change

Yet people do change, and they are successful in shedding much of the negative. In this study, the changes described in the narratives varied considerably in content. While there are some thematic similarities, (e.g., children and treatment were the cause of change in several cases), each story is unique. The reasons cited for change were so many and so varied that it would be virtually impossible to create a single method of help or support. This is also the likely reason for the growing trend toward acknowledging that there are many pathways to recovery (Faces and Voices of Recovery, 2007). While the content differs from person to person, there is greater similarity in locus of control, self-efficacy and agency, and cognitive recognition of turning points than expected.

Most importantly, where there is evidence of a cognitive shift, 89 percent of the respondents also had an internal locus of control. Where no evidence of cognitive shift exists, 100 percent of the respondents had a narrative that suggested change was due to external forces. Similarly, when the narrative describes an event, the locus of control tends to be internal (72%) compared to when the transformation is described as a process (46%). This suggests that narrative descriptions
of moments of transformation tend to fall into one of two patterns: (1) events that create a change in perspective followed by some concrete action that results in the shedding of the stigmatizing label, or (2) long processes sometimes occurring over many years that are driven largely by external events and factors resulting in the shedding of the stigmatizing label.

Role residual and altruism

Of the four stigmatized groups, three, addiction, mental illness and incarceration, are commonly visible to members of small communities and social groups (n.b., being a survivor of abuse may remain hidden, or if known, is less stigmatized) and are highly stigmatized. The nature of the problem, the formal process of labeling (either through arrest and conviction or through diagnosis and treatment), and the lack of anonymity in small groups mean that these stigmas are difficult or impossible to conceal. Goffman (1963) suggests that once a stigmatized role is acquired, it cannot be shed. Even when the person overcomes the limitations imposed on the individual by the status, social interactions are still constrained by the status. These persons are not granted full access to the privileges (or responsibilities) of the society of “normals,” but rather tolerated (Goffman, 1963). People with a stigma tend to use one or more strategies to survive in social settings. They may limit their exposure to those without the stigma, spending most of their time with others of the same or even other stigmatized statuses and the professionals. They may “pass” for “normal,” keeping their stigma secret or they may “cover,” that is, use strategies to minimize the effects of the stigma sometimes by drawing attention to the stigma (Goffman, 1963). In this case, the goal is to publicly acknowledge the stigma and thereby reduce the ambiguity and discomfort in interpersonal interactions with “normals.” The narratives in this study tend to indicate that, for some, wellness means desiring and achieving the life goals of any “normal” citizen. For these people, they appear to be rejecting the stigmatized label. The strategies they use to do so are not clear. They may or may not hide their experiences from others.

Nearly one quarter of the respondents stated that they are currently employed in a helping field or are an advocate. This phenomenon is strongly related to those with addict/alcoholic identities. Of the eight who became advocates/employees in the field, six identified initially as addicts/alcoholics. In 52% of the cases, persons who claimed a stigmatized identity in the beginning of their narrative had an end identity that was directly linked to the initial one. The words they used to describe this final identity were positive (e.g., person in recovery), but nevertheless connected them to their problem. To a large degree they acknowledge that they have a known stigmatized identi-
ty. They are actively renegotiating the meaning of that identity. This reflects both what Ebaugh and Goffman claim, stigma, once acquired, cannot be fully shed. The full inclusion in “normal” society requires disclosure of the failing and evidence of rehabilitation and good faith efforts. Hiding the past (“passing” as Goffman states) puts the person at continual risk of being revealed, embarrassed and rejected.

In these narratives, the positive transformed identity still carries with it residual stigma. However, claiming the identity of an “ex” (Ebaugh, 1988) is a way of transforming the thing that was so hurtful into a strength and resource. Being an “ex” is accompanied by a unique skill set that “normals” do not possess and that creates an employment niche assisting others who find themselves in similar situations (Brown, 1991; Koski-Jännès, 2002; Maruna, 2001). Thus, for some, this renegotiated identity appears to give the stigmatized individual a special place.

Implications for treatment

The contrast between life experiences and salient identity has profound implications for treatment and service providers. Clinicians rely heavily on treatment history and diagnosis to identify the presenting problem to be treated. However, even when the identity is consistent with the experience, the “problem” is not necessarily related to the symptom set from a professional perspective. If the professional focuses solely on the symptoms related to a diagnosed illness or problem (including criminality), the professional will not necessarily address the issues of most concern to the patient/client. As a result, the patient’s and expert’s goals will conflict.

Understanding how people become well, distinct from symptom free, has very specific implications for treatment interventions also. While a substantial proportion of people in this sample got better through the use of services and supportive therapists (and two rejected treatment in order to heal), most did so outside of formal treatment and without the intervention of some external agent. Quoting Rachel Naomi Remen, healing is “not an expert and problem relationship” (Seymour, 2005). It’s a process based in common human interaction. Treatment, on the other hand, seeks to identify the “problem” and fix it. The elimination of symptoms, however, does not guarantee that the individual is well or that the individual can now separate him/herself from the illness identity. Nor does the persistence of symptoms mean that the individual will continue to operate within the illness identity or be otherwise restricted in achieving human goals.

For the people who do use treatment to become well, it is important for providers to note that this may be a long-term process. Understanding the many ways in which individuals change, pro-
providers must be prepared to be co-experts in a person’s journey toward wellness. Essentially, the most treatment providers can do is to create conditions and an environment in which change is most likely to occur. That means creating authentic human connections, increased autonomy in treatment and other decisions, and working with the whole person acknowledging and using the many strengths and resources the person possesses.

A comment on corrections and criminality

U.S. corrections today, both community and custodial, have concerns for both security and offender rehabilitation. In this era of large re-entry populations, corrections agencies continue to seek ways to reduce the risk that offenders will commit new crimes after release. U.S. state and local corrections and federal justice agencies currently rely heavily on the principles of risk, need and responsivity factors associated with the evidence-based practices movement (Andrews & Bonta, 1994; Raynor, 2003). Cognitive-behavioral therapies (CBT) that address specific criminogenic thinking patterns, addiction, and other emotional/behavioral problems are gaining acceptance in corrections and do indeed reduce problematic outcomes (Clawson, et al., 2004). The premise by which CBT models work (i.e., CBT changes the way a person thinks about him/herself and the attendant behaviors) is in essence an identity project. This is an important endeavor, but alone is insufficient to create pro-social roles or to overcome the real barriers ex-offenders face when returning to their home communities. Focusing solely on problematic cognitions and behaviors, CBT treatment identifies the negative elements of an offender’s life and assists in modeling positive alternatives, but does not provide guidance on adopting concrete pro-social roles or create the opportunities for social reinforcement of pro-social roles within real community settings. Treatment, correctional or otherwise, brings people only halfway back. Stopping criminal behavior is only the beginning. Learning how to be citizens with valued roles should be the ultimate goal. How institutional and community corrections can help these same people create meaningful lives “after the illness” (Noordsy et al., 2004) remains undefined.

Conclusions

This study was a first step toward understanding how people with stigmatized identities overcome the barriers and restrictions imposed on them by society to become fully functional and integrated citizens. There are two lessons that can be taken from these collective narratives. First, people cannot be reduced to a set of experiences. Life experiences, alone, may have a profound impact on self-perception and the perceptions of others, and therefore, the nature of many interpersonal interactions. Having been arrested or having been publicly identified as having a psychi-
atri diagnostic in and of themselves produce negative capital, that is, these labels by their very na-
ture detract from the social capital a person might otherwise possess. Some people (i.e., those in
this sample) seem to resist the labels imposed on them. They sometimes resist the explanation
that they are different, or bad or sick, but rather describe their primary problems as those that are
common to human experience and/or the labels as being tangential to their true self.

Second, people who have negative life experiences that often stigmatize them do not necessarily
discuss recovery or healing from these experiences as central to their life narratives. In most cases,
the problems that the individuals in this study struggled with most are not directly related to
these events at all. The exception to this is the large proportion of those who are recovering from
addictions. In most cases, the problems included issues such as poor self-esteem, isolation and un-
employment; problems common to persons outside the formal correctional and treatment sys-
tems. The end status also was often achievements common to people in society at large, including
owning a home, being a parent, graduating from college and being employed in meaningful work.

These findings have profound implications for treatment and corrections professionals. At a
minimum, professionals must understand that the presenting problem may not be the issue of
most importance to those seeking help. Second, persons seeking help have multiple roles and
identities that can be mobilized to support the recovery process. The way individuals describe
their lives and their problems may influence the probability of overcoming those problems. At-
tending to these narratives may be as important a tool in the professional's armamentarium as any
medication, therapy, or intervention.

[Notes]
1) Role salience (Hoelter, 1983), role conflict and stress (Turner, 1978; Wheaton, 1990) have been noted as important factors in
identity. These are also likely to be important factors in role transition.
2) Recovery communities are best understood as groups of individuals (and their allies) with a shared problem that seek to use
shared knowledge and experience to overcome the identified problem. This generalized definition, then, includes people with
addictions, as well as those with mental illnesses, criminal histories or any other problem.
3) Lists for formerly incarcerated persons were difficult to find. Contacts with the NuLeadership Policy Group, a public policy
think tank founded and staffed by formerly and currently incarcerated people, were initially promising, but did not result in the
generation of lists to contact potential participants.
4) This study, "Identity Transformation in Stigmatized Groups," meets the federal standards for research involving human subjects
(IRB Protocol 06-322M, approved April 24, 2006).
5) This represents an unknown percentage of possible respondents. Of the 406 persons sent the invitation, approximately 50 per-
cent or 203 persons were estimated to be eligible. This is based on the estimate that 50 percent of attendees of the SAMHSA-
sponsored meetings were invited because of their expertise based in lived experience. Therefore, 37 respondents would reflect a
minimum of 18.2 percent response rate; small, but not inconsistent with other surveys of this nature.

6) These descriptions were applied to both Events and Processes where the process has a clear change point without which the other events in the series would not have occurred. Two cases could not be coded because the process did not meet this standard.

7) Three persons had an initial identity of mental health consumer and identified a mental health issue as the primary problem; 11 had an initial identity of addict or alcoholic and identified addiction as the problem; and two had an initial identity of victim/survivor and identified abuse as the problem. Thus 16 of 37 (43%) linked at least one of their life experiences to both their initial identity and their primary problem; leaving 57% who did not (results not displayed).

8) Only one started with a “citizen” identity to become an advocate/employee.

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変容の瞬間
——リカバリーとアイデンティティ変容のナラティブ——

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さまざまな分野の研究者が、病気から健康、アディクションからリカバリー、犯罪者から市民といえた、「変化」の本質に関する、類似した問いを問い始めた。こうした議論すべての本質にあるのは、アイデンティティ変容の概念である。これらの視座すべてが共有するのは、(1)公的システムが個人を変容するにあたっても限界、(2)文化的・個人的な変容体系に根ざす個人的アイデンティティの重要性、(3)欠点を強調しなくなってきたこと、(4)問題と解決の定義が上での社会的コンテクストの役割、(5)病気と健康における役割アイデンティティの重要性である。スティグマ化された役割から社会的望ましい役割へと続く道をたどり得た人々の変化のナラティブを収集し分析することを通じて、本研究は、変化の個人的意味、触媒として働く要因、この過程において最終的に得られる役割の性質を探求する。

本研究は、スティグマとなるような負の人生経験を持つ人々であっても、こうした経験からのリカバリーを試みを、自らのライフ・ナラティブの中心として、論じているわけではないことを明らかにした。多分の場合、回答者にとって最も重要な問題は、自尊心の不足、孤独、失業といった、公的な矯正・医療システムの外側にいる普通の人々と共通の問題であった。また、かれらの最終的な地位も、家をもつこと、親となること、大学を卒業すること、意味ある仕事をすることといった、社会全体の人々と共通の達成であった。

専門家は、眼前の問題が援助を求める人にとってもっとも重要な問題ではない可能性があることを理解しなくてはならない。さらに、援助を求める人々は、リカバリーの過程を支えるために動員し、多様な役割をアイデンティティを持っている。個人のライフ・ナラティブに耳を傾けることは、医療、セラピー、介人といった、専門家の装備における道具と同様に重要となるだろう。

キーワード: リカバリー、スティグマ、ナラティブ