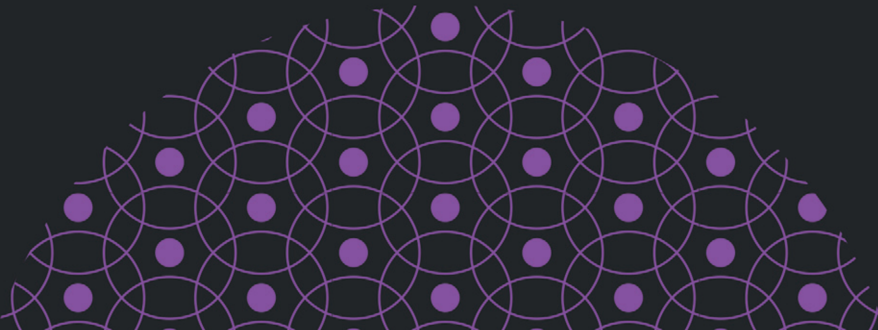
STORIES OF ADDICTION RECOVERY

The G-CHIME Model

LISA OGILVIE
JEROME CARSON

Foreword by Professor Kevin Gournay, CBE



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The G-CHIME Model

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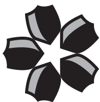

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INVESTOR IN PEOPLE

Dedication for Lisa.
This book is dedicated to my husband David, and my children, Esmee, Chloe and Jamie.
Dedication for Jerome.
This book is dedicated to my Aunt Teresa and my Aunt Bernadette.

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ABOUT THE AUTHORS

Lisa Ogilvie, MSc, is a doctoral student at the University of Bolton. Her specialist area of study is addiction recovery, specifically in how positive psychology can be combined with knowledge of the recovery process to improve the wellbeing of people in addiction recovery. She has developed a programme of work known as positive addiction recovery therapy, which has been shown to increase recovery capital, improve wellbeing and set a foundation for people to flourish. In addition to this, Lisa curates a series of addiction recovery stories for the journal *Advances in Dual Diagnosis* which narrates the story of recovery through the G-CHIME model. Lisa is also a qualified counsellor working at an addiction treatment centre.

Jerome Carson, PhD, is Professor of Psychology at the University of Bolton. His main research interests are positive psychology, recovery from mental health problems, alcohol addiction, bereavement and autoethnography. Jerome is a qualified clinical psychologist and worked in the NHS for 32 years. He has been Professor of Psychology since September 2012. He is the editor-in-chief of the Emerald journal *Mental Health and Social Inclusion* and along with Dr Michelle Tytherleigh he is the series co-editor for the Emerald Positive Psychology Collection.

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FOREWORD

Between 1976 and 1978 I was a trainee nurse therapist on a full-time experimental programme, directed by Professor Isaac Marks at the Maudsley Hospital. This programme provided me with the core skills in evidence-based psychological treatments that I have used over the decades. Our unit was based at 99 Denmark Hill, a Victorian building, adjacent to the Maudsley Hospital and the Institute of Psychiatry. The top floor of 99 Denmark Hill was occupied by Dr DL Davies, at that time one of the leading authorities on alcohol addiction. He was an avuncular figure who clearly believed in the application of scientific methods to the study of addiction. In 1962, Davies published a paper that appeared to show that normal drinking could be resumed in some alcohol addicts (Davies, 1962). The paper reported that, at follow-up, 7 out of 93 alcohol addicts were found to have been drinking socially for continuous periods between 7 and 11 years after discharge from an alcohol treatment unit. This paper led to years of research on 'controlled drinking.' However, over time, it became clear that for those who become physically and mentally dependent on alcohol, the goal of social drinking was, to say the least, not to be recommended. My interest in the research on alcohol addiction was reignited in my subsequent clinical career and during my PhD, central to which was a randomised controlled trial of treatment for agoraphobia (Gournay, 1989). In the course of this study, I came across a very significant proportion of my patients who, in addition to their agoraphobia, had significant problems with alcohol. Indeed, a study by Mullaney and Trippett (1979) showed that of consecutive admissions to an alcohol treatment unit, 13% of men and 33% of women had clear agoraphobic symptoms.

Over time, I have continued to work in the addictions field. From 1994 until 2019, I enjoyed a range of collaborations with the National Drug and Alcohol Research Centre in Sydney. Since 2019, I have continued to work in what is arguably the world's leading centre for studies on comorbidity, the Matilda Centre at the University of Sydney. I was recently a co-author of Australian Federal Government Guidelines on the Management of Co-occurring Drug and Alcohol Problems and Mental Health Conditions (Marel et al., 2022). Our recent guidance contained no less than 1,995

references; just a very tiny proportion of an enormous literature on drug and alcohol addiction.

So, what have I learnt from this experience over several decades?

I think I have learnt a great deal about the factors that predispose one to drug and alcohol addition, be those that are genetic, developmental, environmental or traumatic. I have also learnt a great deal about short-term interventions that may be effective in the weeks and months after a problem is identified. However, what else have I learnt? I have learnt that the literature on long-term outcomes is sparse indeed and largely confined to a focus on mortality and morbidity. Such papers conclude with the obvious; i.e. that addictions have multiple adverse consequences, not least many lost years of life. I have also learnt that high-impact journals tell us nothing about people who recover from their addiction(s) and in particular anything of their individual journeys.

I will turn now to the book and something of what I have learnt from the 10 stories that form the centrepiece of this work. The book includes the contributors' responses to questions and an erudite analysis by the book's authors, who themselves have had lived experience of addiction. In each story I have learnt something new and been provided with fascinating insights into the recovery process. One striking impression is the very clear message that professional treatments, while being helpful in the short term, have an insignificant part to play in the longer-term recovery process.

Over and over, across these stories, the matter of '12-step programmes' is mentioned; paying tribute to the founders of Alcoholics Anonymous (AA), Dr Bob and Bill W; both hopeless alcoholics who had been unable to find any solution to their addiction (alcoholism). Bob and Bill supported each other in their steps to sobriety and went on to gather together groups of alcoholics with the same goal. Gradually, Bob and Bill recognised that stopping drinking was, in a sense, easy. However, staying stopped required a sustained process of reflection and change. In addition, it became clear that recovery from alcoholism required support from other alcoholics. Four years later, the book *Alcoholics Anonymous* (often referred to as the 'Big Book') was published and explained how the 12-step programme worked. This process was exemplified in the book's third edition (Alcoholics Anonymous, 1976) by the telling of some 43 'personal stories' of recovery. The authors of these stories were men and women drawn from diverse backgrounds. The purpose of making these stories a centre piece of the book was simply that of a device, to ensure that any alcoholic could identify with one, or more, of these very honest accounts and thus find hope and inspiration. While by definition, because of the central principle of anonymity, AA has never been subject to scientific study, the vast

anecdotal evidence of its effectiveness can be seen in virtually every country in the world. Somewhere in the AA literature is the message that AA is a simple programme for complex people – Amna says exactly that in her story Chapter 6.

Each of the 10 stories left me wanting to know more about the individuals' lives and the minutiae of their recovery. Something that was reinforced in these stories was the message that the growth process that is integral to recovery takes years: not weeks or months. It also became clear that 12-step programmes were not for everyone in the later stages of recovery.

A number of themes appeared central across all 10 accounts. John, in Chapter 3, describes a healing process and the taking up of activities not linked with alcohol consumption. Indeed, John says that after 3½ years in recovery he decided to 're-enter' the world. Another aspect of recovery, mentioned in other stories is that of an ongoing process of honest reflection, with Kelly in Chapter 5 mentioning still having a lot to learn; something that came through in other stories.

I really hope that this book is read by not only professionals but also those struggling with addiction in the general population. I believe that the vast majority of addicts will see something of themselves in many of these stories. Perhaps, these stories may begin to instil hope in those who are currently in a state of surrender to their condition.

Lisa and Jerome should be congratulated on drawing together these stories and identifying the need for researchers, in the addiction field, to place such stories side by side with the 'hard data' found in surveys and outcome studies. To assist both the professional and lay reader to identify some of the key elements of recovery, they have described the CHIME model (Connectedness, Hope, Meaning, Identity and Empowerment). However, the book also makes it clear that Growth is the sixth essential variable in the recovery process and arguably something more than the result of adding together the aforementioned five elements. Thus, G comes first in G-CHIME.

Like Kelly, I have, by reading this book, learnt a great deal.

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1

THE VALUE OF STORIES

INTRODUCTION

The therapeutic value in sharing a personal narrative of hardship can form an important part of an individual's healing process. It is here that growth can be achieved through finding meaning in events, that whilst grounded in the past can be constructively interpreted to influence present opinion and thoughts of the future (Mullet, Akerson, & Turman, 2013). From the perspective of the author, the re-telling of a self-reported account of adversity can help them move forward by making sense of what has happened. Here, the facts of the account do not change, but the way they are reflected on does. In this sense, the story becomes a powerful literary instrument that can help accept past hurts, give a voice to often suppressed aspects of self that are difficult to face and help identify moments of hope and courage that promote resilience (Mullet et al., 2013; Nurser, Rushworth, Shakespeare, & Williams, 2018).

The value in re-telling stories of hardship that conclude with the protagonist experiencing a healing process, not only benefits the author. In fact, the sharing of such accounts serves to normalise the experience for others, offering relatable examples that can reduce feelings of self-shame, as well as raising awareness of the recovery process in areas often discounted as unimportant, due to the inherent negative bias surrounding them, for example mental illness and addiction (Conyers, 2021; Nurser et al., 2018; Stuart, 2016). The first-hand accounts of others, their experiences, the lessons they learnt and the growth they achieved can highlight to others what is possible as well as revealing shared, and important aspects of the recovery process.

HOPE AND GLORY: WHAT'S YOUR STORY?

We all have a story to tell. There are the 10 stories told in this book, then there are the stories of the two authors. The common denominator of each of the stories is addiction. All the contributors to this book have struggled to overcome an addiction. There are of course millions of such stories. So, what makes the stories in this book so special? It is partly how we have chosen to frame the stories. We have used a model called G-CHIME (see Chapter 2, and each of the stories). This means it is easier to compare all the stories and to draw out common elements. There is a consistency of style across all the stories, each remarkable. Stories of recovery are something Jerome has worked on for many years with many amazing people who were prepared to share their stories with others. This is how it began.

RECOVERY HEROES

In a book co-edited with Sophie Davies, Elizabeth Wakely and Sarah Morgan (2011), Jerome outlined where the idea of recovery heroes had come from. First, there was the heroic literature in storytelling, going back to Greek mythology and even before this probably (Catford & Ray, 1991). Catford and Ray claimed we could compare all our stories to those of the 'hero's journey'. They argued that all of us face five major challenges in life. These are finding and discovering our true purpose; bringing love into our lives; living stress free in the here and now; achieving personal and professional balance and finding our way to prosperity. The second major influence came from the American clinical psychologist and activist, Dr Patricia Deegan. She suggested we ought to see the individual suffering with a major mental disorder as a hero (Deegan, 1996). She asked, 'Could you have survived what they have survived?' The third influence was the mental health educator Premila Trivedi. In a training workshop Premila revealed that she had four mental health 'recovery heroes'. These were the Americans Mary Ellen Copeland and Patricia Deegan and the British psychologists Rachel Perkins and Peter Chadwick. My original definition of the term 'recovery hero' was '. . .individuals whose journey of recovery can inspire both service users and professionals alike' (Sen, Morgan, & Carson, 2009). My simple idea was 'to gather' these stories, rather like Julie Leibrich had done in New Zealand, a decade earlier (Leibrich, 1999). I hoped these accounts would inspire people

living with long-term mental health problems, as well as their carers and the professionals who worked with them. After a short digression to consider historical recovery heroes (Wakely & Carson, 2010, 2011a, 2011b, 2011c), I returned with a similar concept, but this time labelled it 'Remarkable Lives'. This led to a decade of papers co-authored with individuals, who had battled mental health problems.

In trying to distil what the key elements of mental health recovery might be, Robert Hurst and I started analysing all the Recovery Heroes and Remarkable Lives stories, in terms of the CHIME model (see Chapter 2). The CHIME model had been inspired by the work of the Australian researchers Retta Andresen, Lindsay Oades and Peter Caputi (2003). They had identified four major components of recovery from examining lived experience narratives. These were *H*ope, *M*eaning, *I*dentity and *E*mpowerment. Professor Mike Slade and his colleagues expanded this model to include *C*onnectedness and came up with the acronym, CHIME. Robert and I first analysed student narratives of recovery using the CHIME framework (Hurst & Carson, 2021), then along with other colleagues we looked at the other narratives in the series (Hurst et al., 2022). As we studied these accounts, Robert felt that there was an element behind successful recovery which he intuited was missing from the existing CHIME framework, which he thought was creativity. From my own clinical experience, I realised that a lot of the participants in a recovery group I facilitated in South London were very talented people, including artists, teachers, writers, poets and actors (McManus & Carson, 2012). We decided to publish our insights in an editorial announcing the C-CHIME model (Carson & Hurst, 2021).

When I introduced Lisa to the concept of C-CHIME, it was not long before she felt that the missing element for people trying to recover from addiction was Growth. This led us to suggest G-CHIME as a model for addiction recovery. We managed to persuade the editors of the journal *Advances in Dual Diagnosis* to commission a series of papers on 'Addiction Recovery Stories', to parallel the earlier 'Remarkable Lives'. This is turn led to the production of this book.

The most famous story in the history of recovery is when Bill, a stock-broker, met Dr Bob in Akron, Ohio, and Alcoholics Anonymous (AA) was born (Alcoholics Anonymous Big Book, 1939/2006). While Jerome has never attended a single AA meeting, he believes that it is the most successful self-help, mutual aid organisation ever established. In the Foreword to *The Big Book* it states, 'We, of Alcoholics Anonymous, are more than one hundred men and

women who have recovered from a seemingly helpless state of mind and body. To show other alcoholics precisely how we have recovered is the main purpose of this book' (AA Big Book, p. 6). *The Big Book* ends with 11 stories, 10 of these written by alcoholics and 1 by the wife of an alcoholic. These stories are unstructured, of varied length and quality, but they all testify to the power of joining AA.

The main purpose of our own book is to present 10 new stories, and in doing so demonstrate how the components in the G-CHIME model can be instrumental to leading a meaningful and empowered life beyond addiction. The willingness the contributors have shown in sharing their stories with such candour and courage upholds a long-standing tradition of conveying hope in the recovery process so that the next person may benefit (Alcoholics Anonymous Big Book, 1939/2006). The stories within this book are a testament to the therapeutic value found in sharing the personal narrative of hardship, a tradition which has served so many in their recovery since the formation of the first mutual aid meeting in 1935.

LISA'S STORY

For too many years I knew my relationship with alcohol was troubled, yet I capitulated, regardless of the dismal consequences this liaison wrought. Towards the end of my drinking, it is accurate to say that the consequences were amounting exponentially. There was nowhere left to go, and only one rational thought left. I had to concede my life with alcohol in it was failing, catastrophically. This was terrifying, and yet the most freeing moment I believe I will experience. It marked the start of my recovery, the point from which I grew, a process that has not stopped. I have achieved what I thought impossible. In this I am not talking of accomplishments that come with accolade, but peace of mind and happiness.

My recovery, at the time of writing, has brought me the most enjoyable, rewarding and happy years of my life. It has empowered me to want to live, to truly live, to make the most of the precious moment's recovery affords me. Perhaps, the most treasured gift it will bring is that my incredible Mum got to see me happy and well before she died. I was able to appreciate her strength, kindness and humour and enjoy her company and conversation. For this I have an abundance of gratitude which continues to help me see the value in

what I have. It is my responsibility to make my recovery matter. I have this opportunity, and it is miraculous.

JEROME'S STORY

At the time of writing, I am now 65. I stopped drinking at the age of 59. Looking back on my drinking history it seems incredible to me that I failed to confront my drinking problem until so late in my life. It is also bizarre that I was unable to use my professional skills as a clinical psychologist to tackle my own drinking. It is tempting to blame my genes and my upbringing. My late father was an alcoholic. He died after suffering complications from cirrhosis of the liver in 2001, aged 68. He managed to give up a 40 cigarettes-a-day smoking habit and he also successfully battled obesity. Alcohol was one addiction too many. The reader might have thought that seeing him dying in a hospice bed of his long-term alcohol problems, might have persuaded me to stop drinking. Yet it was to be another 15 years until I gave up on alcohol.

Looking at my life now I can see the benefits of recovery. For the first few years of abstinence, I did not feel I was flourishing and indeed felt I was probably a more miserable person (Carson & Makin, 2021). Yet now I can see that I am in one of the most productive and 'creative' phases of my entire career. I also believe that I am 'growing' as a person. I have begun to see life from a different perspective. The money I used to spend on fine wines and dining can now be used to help others less well off. I am genuinely excited about the potential of the years ahead. While I hope to continue full-time working until I am 70 (health permitting), I have no intention of stopping my academic work and writing. I am determined to make these years the best of my entire life.

SUMMARY

In this chapter we have introduced the concept of therapeutic stories. Each of us has our own unique story to tell. The contributors to this book, including the editors, have all had suffered greatly through addiction. It has had devastating effects on their own lives and that of their families. For each, the solution has been to find a new way, to grow as individuals and embark on a life of possibility. This book contains inspiring stories of

how your life can be transformed, sharing the positive message that without drugs and alcohol we can live lives that are fulfiling and full of meaning and purpose. Patricia Deegan (1996) commenting about recovery said that its aim was as follows,

> *The goal of recovery is to become the unique, awesome, never to be repeated, human being we are called to be.*

The real benefit of recovery is that this goal, of being the best possible person we can be, is now within our grasp. Carpe diem. Seize the moment.

2

G-CHIME, A MODEL OF ADDICTION RECOVERY

Addiction was formally classified as a primary mental health disorder in the third version of the Diagnostic and Statistical Manual of mental health disorders (DSM). Now in its fifth edition, the DSM-5 informs contemporary clinical understanding on the behavioural and psychological effects of addiction and substance use disorder (Robinson & Adinoff, 2016). Models of mental health recovery highlight the components considered important to the process of overcoming the detrimental effects of a mental health disorder, being concerned with the resources that an affected individual has and can develop to help them function successfully. The recovery model approach challenges the reliance on pharmacology alone to abate the symptoms of mental illness, instead advocating an individual can accomplish behavioural and psychological change using their own self-actualising potential (Davidson, Rowe, Bellamy, & Delphin-Rittmon, 2021). There are many benefits to this. It offers a safer treatment profile, stops protracted reliance on medication, eliminates medication side effects and can provide tools that promote and safeguard future wellbeing (Dell, Long, & Mancini, 2021).

Research into what makes mental health recovery successful has consistently identified elements that are common to the process. These include, having a positive view of self, a sense of belonging, developing autonomy and accepting illness (Dell et al., 2021). This has drawn on knowledge accumulated from addiction recovery specifically, where the substance abuse and mental health services administration (SAMHSA) in the United States conceptualised a person-centred recovery-oriented system of care that builds on the strengths and resiliencies of an individual and the internal and external resources they develop. Advocating that active engagement is necessary to implement the changes required to achieve a sense of mastery over SUD (Davidson et al.,

2021; Ellison, Belanger, Niles, Evans, & Bauer, 2018). Here, the link between recovery and wellbeing becomes clear, where recovery is synonymous with positive functioning, where factors involved with this have strong commonality with wellbeing. For example, subjective wellbeing looks at life satisfaction, positive affect and attenuation of negative emotions, and psychological wellbeing considers components such as meaning, purpose, personal growth and supportive relationships. Recovery models take knowledge of wellbeing and positive functioning to provide a framework that explains the recovery process, through the components an individual needs to achieve it (Davidson et al., 2021; Dell et al., 2021).

The G-CHIME model recognises the importance of growth, connectedness, hope, identity, meaning in life and empowerment to the recovery process and the long-term wellbeing of people in recovery. It has been used with effect to explore common features in the first-hand accounts of addiction and recovery (Holmes & Ogilvie, 2023), as well as in the design of interventions in a programme of work known as positive addiction recovery therapy (Ogilvie & Carson, 2022). It is an adaptation of the CHIME model of mental health recovery (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011) that introduces a component for growth, which is considered necessary in addiction recovery specifically. The significance of each component to addiction recovery is discussed below.

GROWTH

The change an individual goes through in reaching recovery is well explained by the transtheoretical model of change (Prochashka & DiClemente, 1986). This model describes the transformative process an individual travels through, from having no awareness of problematic substance use, through acknowledging the consequences of addiction, to taking the necessary action to reach an end point where recovery can be maintained. During this time an individual experiences a period of growth (Ogilvie & Carson, 2021), where healthier strategies are established to improve wellbeing and support a successful recovery (DiClemente, 2018; Prochashka & DiClemente, 1986). This is considered to be a long-term endeavour requiring continued effort to nurture and protect the state of recovery (DiClemente, 2018; Marshall, Albery, & Frings, 2018; Melemis, 2015). Adopting an adaptive mindset that facilitates continued growth through experience, both good and bad, is crucial to this process.