“Too much is never enough”

Psychological studies of substance misuse and other excessive behaviors

UNIVERSITY OF GOTHENBURG

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Människan behöver hjälp

Människan är innerst god. Människan vill innerst leva i fred, gå till mjölkbutiken, prata bort sin dag med en granne, klappa en hund i parken, spänna oxar för plogen, ta familjen till zoo, arbeta och få sin lön, köpa en flaska vin och gå hem. Människan vill organisera sig på bästa sätt utåt och inåt, med demokrati, vänskap, medinflytande, ringa på och låna socker, gifta bort barnen och hålla kalas, dansa och sjunga, gunga i sitt nätverk som i en hängmatta livet ut, få sällskap till graven, vila ut i vigd jord. Det är vad människan vill, överallt vill människan och önskar hon det goda, se fjärilar, fåglar, hjortar, himlar.

Men människan är ytterst ond. När hon vill ha, när hon vill ha mera, när det går henne emot, när hon inte får som hon vill, när det rinner till, när hon ser blickar i ögon, när hundarna morrar, när trängsel uppstår, när hot kommer, när hon känner olusten, när hon blir främmande, när maten tar slut, tobaken tar slut, kläderna slut, allting slut, när hon tror att hon ser ont i luften, när någon är ond, när annan svarar med ont, när hon ser kråkor, korpar gamar, när hon hör muller. När hon är tränad, när hon är drillad, när hon låter generalerna bestämma, hormonerna bestämma, när hon vill hävda sig, när hon blir lurad, skamfilad, dumslagen, förvildad, fördjurad, självmördad. Då.

Och det onda är oförklarligt, men det goda är ett mirakel

Och det goda är regel, men det onda är inget undantag

Och människan är mest av allt osäker, ängslig, lättskrämd och svårtröstad.

Hon tror så lätt att det goda är ont, att det onda är gott.

Hon vet inte vad hon har, och ännu mindre vad hon får.

Inte ens när hon vill illa blir det som hon tänkt sig.

Människan behöver hjälp.

Thomas Tidholm

DOCTORAL DISSERTATION IN PSYCHOLOGY

Abstract

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Substance misuse (SM) as well as excessive food intake, sexual activities, exercise, and gambling is characterized by repeated use against one's better judgment and despite negative consequences. Moreover, SM and excessive behaviors (EB) might co-occur, and clients in substance abuse treatment who also have difficulties with EB are likely to relapse in SM and/or leave treatment. These clients benefit from a treatment that acknowledges both SM and EB, but EB might pass unnoticed in clinical practice. Researchers have suggested that there is a need both to investigate the occurrence of clients who experience EB, and enhance identification of EB among clients in substance abuse treatment. There is also a need to investigate how these clients perceive SM and EB, since their experiences are important for understanding the enactment of these behaviors, as well as how their difficulties might be handled in treatment. This thesis, based on four studies, investigated the co-occurrence of SM and EB among clients in substance abuse treatment, how these clients perceive SM and EB, and how SM and EB had been enacted against the client's better judgment. In *Study 1* a questionnaire was used to investigate the occurrence of clients in substance abuse treatment who reported difficulties with EB. The results showed that 67 % of the participants reported EB, and 67 % of those reported two or more EB. In *Study 2* and *3* interviews were used to investigate how clients with experiences of both SM and EB, viewed their SM and EB, and how they viewed themselves. *Study 2* showed that EB were attempts to ease a sense of deficiency, and of being unworthy. In these attempts dissociation was central. Moreover, excessive sexual activities were described as deeply distressing. This motivated a specific investigation of excessive sexual activities in *Study 3*. The results showed that excessive sexual activities were associated with overwhelming shame, and that troubled sexuality seemed to be an absent topic in treatment. In *Study 4* interviews were used to investigate how clients with experience of alcohol misuse viewed their SM, how they enacted SM against better judgment, and how they viewed themselves. The results showed that SM was perceived both as a disease, and as a response to painful experiences. There was also a sense that one had to live up to strict demands on oneself to achieve a sense of being worthy. This perception was eased through dissociation. To summarize, the results showed that EB are common among clients in substance abuse treatment, which points to the need to identify EB and integrate them in treatment. Specifically excessive sexual activities need to be addressed. Moreover SM and EB might be seen as attempts to ease distress connected to relational and affective needs, to a sense of deficiency, and to self-criticism. It seems important to acknowledge affective and relational needs, perceptions of deficiencies and shame, and individual self-perception and dissociation, in clinical practice with clients with SM and EB.

Keywords: Substance misuse, excessive behaviors, dissociation, self, sexuality, shame
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List of publications

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III. Punzi, H. E., Tidefors, I., & Fahlke, C. Excessive sexual activities among male clients in substance abuse treatment. An interview study. Manuscript submitted for review.

IV. Punzi, H. E., & Tidefors, I. (2014). It wasn't the proper me. Narratives about alcoholism and view of oneself: The impact of disavowed shortcomings and dissociation. *Alcoholism Treatment Quarterly, 32,* 416-432.

Svensk sammanfattning

Det är väl känt att missbruk av alkohol, droger och läkemedel ger en rad negativa konsekvenser, såväl för berörda individer som för deras närstående. Substansmissbruk åtföljs ofta av sociala svårigheter, fysiska åkommor och sjukdomar, samt olika former av psykiska besvär. Forskning har visat att individer som har svårigheter med substansmissbruk också kan ha svårigheter med att begränsa matintag, sexuella aktiviteter, fysisk träning, shopping, spel, och internetanvändning. Svårigheter med att begränsa sådana beteenden benämns ofta som missbruk, både i dagligt tal och i vetenskapliga sammanhang. Likheterna mellan substansmissbruk och beteendemissbruk är avsevärda, och riskfaktorerna för att utveckla substansmissbruk och beteendemissbruk är likartade. Till exempel har studier visat att det finns en ärftlig risk för att utveckla missbruk av både substanser och beteenden. Personlighetsdrag såsom impulsivitet och sensationssökande tycks också vara förknippade med missbruk av både substanser och beteenden. Studier har även visat att individer som utvecklar missbruk, i högre grad har upplevt känslomässiga, fysiska och/eller sexuella övergrepp, och bristande omsorg under uppväxten. Individer som har svårigheter med missbruk har inte sällan en negativ syn på sig själva och kan plågas av exempelvis ensamhet, nedstämdhet och ångest.

Studier har också visat att individer kan växla mellan att missbruka flera olika substanser och beteenden, och att dessa individer har omfattande behandlingsbehov. Dessvärre har det visat sig att beteendemissbruk inte alltid identifieras under utredning och behandling inom missbruksvården. Ett oidentifierat beteendemissbruk kan vara så allvarligt att det leder till att klienter återfaller i substansmissbruk eller avslutar behandlingen i förtid. Det har därför föreslagits att missbruksvården behöver kunna erbjuda en behandling där både substansmissbruket och beteendemissbruket behandlas integrerat.

I denna doktorsavhandling presenteras fyra studier som undersöker missbruk av substanser och beteenden. Syftet var dels att nå kunskap om hur vanligt det är att klienter i behandling för substansmissbruk också upplever sig ha beteendemissbruk, och dels att förstå hur klienter som är i behandling för missbruk uppfattar sina svårigheter, och sig själva, och i förekommande fall sitt beteendemissbruk. För att nå kunskap om detta har klienter i behandling för missbruk av alkohol och narkotika fått besvara en enkät där de fick ange om de uppfattar sig ha eller ha haft svårigheter med beteendemissbruk. Dessutom har klienter med ett tidigare alkoholmissbruk samt klienter med ett tidigare missbruk av alkohol och narkotika, och en rad beteenden, intervjuats om hur de uppfattar sina svårigheter och sig själva.

I *studie 1* deltog 83 män och kvinnor som var klienter vid öppen och slutenvårdsmottagningar inom den offentliga missbruksvården. Dessa mottagningar riktade sig till vuxna individer med missbruk av alkohol, illegala droger, samt icke förskrivna läkemedel. I studien fick deltagarna besvara en enkät med frågor om substansmissbruk, exempelvis vilka substanser de använt, under hur många år de använt substanser, och omfattningen av substansmissbruket. De fick också svara på huruvida de uppfattade sig ha, eller ha haft, ett missbruk av mat, sexuella aktiviteter, spel och/eller träning. Dessutom fick de svara på om de tyckte att deras eventuella beteendemissbruk hade uppmärksammats i missbruksvården. Resultaten visade att en majoritet av deltagarna hade ett dagligt missbruk innefattande illegala substanser, och att de använt ett flertal substanser. Deltagarna representerar således en grupp med så kallat tungt missbruk. Det framkom att 67 % av deltagarna uppfattade sig ha eller ha haft ett beteendemissbruk. Av dem som rapporterade beteendemissbruk, rapporterade 67 % svårigheter med två eller flera beteenden. Både män och kvinnor rapporterade svårigheter med matintag och sexuella aktiviteter i högst grad. Det visade sig också att personal inom missbruksvården kan bli bättre på att uppmärksamma beteendemissbruk och integrera sådana svårigheter i behandlingen. Sammantaget pekar resultaten på att en avsevärd grupp klienter inom missbruksvården använder ett antal substanser och också uppfattar sig ha ett mer sammansatt beteendemissbruk. Det tycks därför som att man inom missbruksvården bör utveckla förmågan att identifiera beteendemissbruk, så att integrerad behandling vid behov kan erbjudas.

I *studie 2* intervjuades fem män och en kvinna som tidigare hade haft svårigheter med missbruk av både substanser och överdrivna beteenden. Deltagarna hade växt upp med åtminstone en förälder som haft ett allvarligt missbruk och i vissa fall hade en eller båda föräldrarna också haft en kriminell livsstil och/eller allvarliga psykiska problem. Deltagarna hade under barndomen utsatts för känslomässiga, fysiska och/eller sexuella övergrepp. De representerar således en grupp klienter som har svåra barndomserfarenheter och som har upplevt avsevärt lidande. I intervjuerna beskrev deltagarna att de var kritiska mot sig själva och denna negativa självuppfattning var associerad med självförakt och självdestruktivitet. De beskrev också svårigheter med känslor och relationer och berättade att de sedan barndomen upplevt en gnagande känsla av brist. En av deltagarna uttryckte det med följande ord: ”*Missbruk är en bristsjukdom. Det är brist på kärlek i barndomen. Och det är det jag försöker fylla, tomheten inuti… Ett begär som jag tillfredsställer. Eller inte… för det är samma frustration. Det funkar inte”.*

Bristkänslan och självkritiken hade de försökt lindra med hjälp av substanser, sexuella aktiviteter, mat eller andra objekt. De var medvetna om att substanser och beteenden skulle öka otillfredsställelsen och tomheten, och att den ökande otillfredsställelsen och tomheten skulle leda till ytterligare konsumtion. Samtidigt beskrev de att genom missbruket av substanser och beteenden upplevde de sig ha kontroll över sina känslor, och även över sig själva. Dessa upplevelser stod i kontrast till de känslor av otillräcklighet och självkritik som hade plågat dem under livet. Genom missbruk av substanser och beteenden kunde deltagarna således tillfälligt skydda sig från känslor av otillräcklighet och självkritik. Samtidigt kunde missbruket tillfälligt skapa upplevelser av att ha kontroll och av att duga, därför upprepades missbruket om och om igen.

Deltagarna beskrev även att de behövde förstå sitt missbruk och sig själva. Att förstå uppfattades som en förutsättning för att kunna ändra sina beteenden och sitt liv i en positiv riktning. Baserat på deltagarnas beskrivningar av sina svårigheter och av sig själva tycks det som att man inom missbruksvården behöver beakta att klienter kan plågas av stark självkritik och självdestruktivitet och att sådana upplevelser har betydelse för missbruket av substanser och beteenden. Man behöver också beakta att klienter kan uppleva en känsla av brist som de försöker undvika med substanser och beteenden. Deltagarna beskrev förståelse som väsentlig för förändring. Resultaten indikerar att man inom missbruksvården kan behöva stödja klientens förståelse av sig själv, och känslan av brist så att svårigheter som är kopplade till självkritik och känslomässig brist inte ageras ut i missbruk av substanser och beteenden.

De manliga deltagarna i *studie 2* uppfattade sitt missbruk av sexuella aktiviteter som den svårighet som plågade dem mest. Därför fokuserade *Studie 3* på de manliga deltagarnas svårigheter att begränsa sexuella aktiviteter. Ytterligare intervjuer gjordes med de fem männen i syfte att förstå mer om hur de såg på sig själva, sina relationer, och sina sexuella svårigheter. Deltagarna beskrev att de sexuella svårigheterna dels hade föregått substansmissbruket, och dels hade varit svårare att avsluta. Sexualiteten var konfliktfylld för dem och de kunde känna hat och motvilja inför sina kroppar, sin sexualitet och sig själva. Paradoxalt nog innebar denna motvilja en överupptagenhet med sexualitet och sexuella aktiviteter, vilka utövades om och om igen. Det fanns exempelvis beskrivningar av hur man onanerat så att man blev blodig, och att man förmått flickvänner att ha sex upp till tio gånger på en dag. Sexualiteten var därmed förknippad med skamkänslor inte minst för att man förmått tidigare flickvänner att delta i aktiviteter som man själv innerst inne ansåg vara olämpliga, och egentligen inte ville utföra själv. Deltagarna beskrev att känslor av

otillräcklighet och motvilja mot sig själv hade drivit på de sexuella aktiviteterna. De beskrev samtidigt att när de utövade sexuella aktiviteter kände de sig som ”riktiga män” och därmed som åtråvärda. Genom att utföra sexuella aktiviteter kunde de undvika känslor av otillräcklighet, känslomässig sårbarhet, och motvilja mot sig själva. Istället uppfattade de tillfälligt att de var behovslösa, att de kunde kontrollera sig själva och sina känslor, och även att de kunde kontrollera andra. Deltagarna brottades med skamkänslor som var kopplade till att man hade skadat andra genom sina överdrivna sexuella aktiviteter. De uttryckte även att det varit svårt att ta upp ämnet i behandling eftersom de tidigare sexuella aktiviteterna väcker skam. De beskrev att de hade försökt ta upp sina svårigheter med sexualitet i samtalen med behandlare inom missbruksvården, men det tycktes som att behandlarna inte hade uppfattat deras försök och sexualitet blev ett frånvarande ämne i behandlingen. Det tycks därför väsentligt att man inom missbruksvården förbättrar förmågan att identifiera och uppmärksamma sexuella svårigheter och stödja patienter att tala om sådana erfarenheter. Det tycks också väsentligt att beakta att män genom att utföra sexuella handlingar kan känna sig som ”riktiga män” och uppnå en känsla av kontroll och behovslöshet. Människors uppfattning om sig själva som sexuella varelser påverkas av sociala föreställningar om kön och sexualitet. Det tycks därför väsentligt att uppmärksamma sociala föreställningar om sexualitet, exempelvis synen på män som ständigt sexuellt aktiva och redo, eftersom sådana föreställningar kan bidra till att män utför sexuella handlingar de innerst inne vill avstå ifrån.

I studie 4 deltog fyra män och en kvinna som tidigare varit på behandlingshem för alkoholmissbruk, och som nu deltog i eftervård. Deltagarna intervjuades om sin syn på hur de kom att utveckla alkoholmissbruk, och hur de såg på sig själva. Det visade sig att deltagarna förstod sitt alkoholmissbruk utifrån flera perspektiv. Exempelvis uppfattade de alkoholmissbruket som en medfödd sjukdom, men samtidigt betonades att missbruket inte kunde förstås om man inte beaktade deras livserfarenheter och svårigheter i livet som lett fram till missbruket. De beskrev också att de hade haft orimligt höga krav på sig själva. De hade strävat efter att vara kompetenta och hade haft svårt att medge begränsningar och se misslyckanden som en del av livet. Drickandet blev ett sätt att slippa dessa krav. Samtidigt såg de drickandet som jag-främmande, och beskrev att det kändes som om en annan del av en dem själva tog över och drack alkohol. Eftersom deltagarna uppfattade att det inte var de själva som drack blev det svårt för dem att förstå och beskriva hur de mot bättre vetande kom att öka sitt drickande så att de utvecklade ett alkoholmissbruk. Det ökande drickandet uppfattades som ett misslyckande men eftersom man hade svårt att medge misslyckanden blev uppfattningen om att det inte var man själv som drack ett skydd mot den plågsamma

insikten att man misslyckats. Med andra ord var drickandet en flykt från krav, men flykten uppfattades som ett misslyckande, och eftersom misslyckanden vara så svåra att medge kom de krav man ställde på sig själv att öka. Deltagarna beskrev en ond cirkel av krav, flykt från en känsla av misslyckande, och drickande. Utifrån vad deltagarna beskrev föreslås det att patienter i behandling för alkoholism får stöd i att nyansera sin syn på sig själva så att de kan acceptera sig som individer med begränsningar och erfarenheter av misslyckanden, istället för att fly från sådana upplevelser med hjälp av alkohol.

Sammanfattningsvis framkom det att individer som är i behandling för tungt substansmissbruk också kan ha svårigheter med andra typer av missbruk. Vidare framkom att svårigheter med beteenden inte uppmärksammas i tillräcklig grad, och därför inte heller kan integreras i behandlingen. Det är väsentligt att personal inom missbruksvården utvecklar förmågan att upptäcka och tala om beteenden. Det gäller inte minst sexuella aktiviteter som kan vara förknippade med skamkänslor och som klienterna därför själva har svårt att ta upp.

Det framkom också att deltagarna uppfattade att missbruket var kopplat till känslor av brist, och självkritik. Det gällde både deltagare som upplevt avsevärda svårigheter under barndomen och som utvecklat missbruk av beteenden och substanser tidigt i livet, och deltagare som hade ett socialt etablerat liv och utvecklade ett alkoholmissbruk i vuxenlivet. Samtidigt fanns det skillnader mellan de deltagare som hade upplevt avsevärda svårigheter under barndomen och vars missbruk började tidigt, och de som utvecklat missbruk av alkohol senare i livet. En väsentlig skillnad var att de deltagare som utvecklat missbruk tidigt i livet hade känt motvilja, och till och med hat och självdestruktivitet gentemot sig själva. För dem kunde missbruket vara ett sätt att hantera denna motvilja. Deltagarna i *studie 4* kände däremot att de var tvungna att vara kompetenta, och uppfylla egna och andras krav för att känna sig nöjda med sig själva, och hade därför svårt att acceptera misslyckanden. För dem blev drickandet ett sätt att slippa övermäktiga krav. Sammanfattningsvis tycks individer som har utvecklat missbruk av substanser och/eller beteenden vara en heterogen grupp, bestående av individer med olika bakgrund samt skilda svårigheter och möjligheter. Alla individer har också sin unika uppfattning om sig själv, och sin personliga historia vilket missbruksvården behöver kunna anpassa sig till.

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* * *

My deepest appreciation and admiration goes to the participants. They have contributed with their time, patience, trust, and experiences, which I hope I have reflected on without too many misunderstandings. I apologize to them all for not being able to portray the richness of their narratives. Above all, the participants have contributed with themselves, and had the courage to articulate their innermost shame and shortcomings, their vulnerability and deepest needs, the suffering they have been through, and the ways in which they nevertheless had continued to struggle. These are topics that most of us are prepared to do almost anything to avoid talking about.

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Preface - A clinical vignette

My interest in substance misuse and other excessive behaviors arose during my work as a clinical psychologist in a substance abuse treatment unit aimed at clients with poly substance misuse, psychiatric symptoms, and/or social problems. I have therefore chosen to begin this thesis with a description of two clients typical of those I met during my clinical work. They are aggregates of different people, in order to protect the privacy of the clients.

One young female client managed to quit her misuse of amphetamines, alcohol, and tranquilizers, and staff members at the treatment unit praised her for this. After six months she started using amphetamines again. She was referred to the psychologist, in this case me, and I asked her about what had happened. She told me that when she was a young teenager she hated her body and herself, and felt insecure and insufficient. She had simultaneously punished and comforted herself with binge eating, and vomiting. When she started using substances she stopped being bothered by her body, and both the self-hate, the insecurity, and the binge eating disappeared. After she quit using substances these difficulties returned with increased power. "*I couldn´t cope with vomiting all the time",* she said, and showed me her hands that were bruised because of her teeth literally eroding them, every time she put her hands in her throat to throw up. She left the treatment unit and did not return.

Another client, a man in his forties, quit using cocaine and alcohol and was similarly praised for this. However, after about six months he started using substances again. He explained that he had difficulties with gambling and excessive sexual activities. When he gambled or enacted sexual activities, he felt powerful and attractive, which was a significant difference to the feelings of unworthiness, failure, and isolation that constantly plagued him. When he used substances, the gambling and the sexual excess disappeared. After he quit using substances, he started gambling again, and ended up owing a substantial amount of money to a criminal gang; he then had to "work for them", and thus became increasingly involved in criminal networks. He had also had been sexually involved with women who these criminal individuals considered as "theirs". His whole life became chaotic and dangerous and he started using substances again and left town.

These two clients were surrounded by a whole team of professionals, including me, who were supposed to understand the clients' difficulties. In clinical practice, it is known that substance misuse might be accompanied by for example excessive food intake, sexual activities, and gambling. However, we did not ask these clients about such difficulties, and hence these difficulties were not acknowledged in treatment.

I continued to think about these clients, their vulnerability, and the distress they must have felt. They were, for a period of time, moving towards a more satisfying life and demonstrated willpower when they entered treatment, refrained from substances and remained abstinent for about six months. I realized that the clients we worked with experienced a suffering, and a tendency to enact destructive behaviors, that exceeded our knowledge. I also wondered whether we could have supported them in a more appropriate way if we had been aware of their behavioral difficulties, and how they perceived themselves. I wanted to understand more about how the individuals concerned experienced both substance misuse and excessive behaviors, which motivated me to start the work presented in this thesis.

Introduction

On a conscious level, people often know how to act in order to be productive, satisfied, and proud of themselves, and to live gratifying lives without unnecessary suffering. At the same time, individuals make the same mistakes over and over again, even though they know perfectly well that it means repeated, and even increasing, suffering.

Misuse of substances is one example of how individuals act against their better judgment, in ways they know mean repeated suffering (Kellog & Tatarsky, 2012; Miller & Rollnick, 2002; Wilson, 2002). Misuse is characterized by for example excessiveness and eagerness, and a tendency to use one or several objects against one's better judgment and despite awareness of considerable negative psychological, social, and/or physical consequences connected to using the object (Larkin & Griffiths, 2002).

There are varying definitions regarding the excessive use of substances. The fifth edition of the Diagnostic and Statistical Manual for Mental Disorders, (DSM-5) (American Psychiatric Association, 2013) incudes a category for "Substance related and addictive disorders", and categorizes substance use disorders on a continuum from mild to severe. When a substance use disorder is established, it becomes manifest as a specific condition with characteristics such as tolerance, symptoms of withdrawal, a preoccupation with the substance, and continued use despite knowledge of negative psychological, social and/or physical consequences. The aim of the diagnostic categorization of substance use is to provide an objective description of substance misuse, so that the condition is not diagnosed arbitrarily.

Some researchers use the term "addiction" and/or "addictive" in line with the DSM-5 categorization but they use the words without connection to the word disorder, when studying the tendency to go to excess and use objects despite negative consequences (Beveridge, 2008; Goodman, 2008; Holden, 2010; Orford, 2001). The term addiction has become increasingly used in research and theory, as well as in popular media, and is used with respect not only to substances but also to excessive food intake, gambling, sexual activities, and Internet use (Elam, in press; Essig, 2012; Mudry et al., 2011). However, this term has been criticized for being associated both with a medicalization of human behaviors, indicating a loss of willpower and with essentialism, which means that addiction is viewed as an inherent personal characteristic rather than as a behavior that might be terminated (Bailey, 2005; Elam, in press; Essig, 2012; Vrecko, 2010). Researchers attempting to avoid association with medicalization, loss of willpower, and essentialism,

tend to use terms such as “repeated use”, “chronic use”, “behavioral problems”, or “misuse” when discussing destructive use of substances and/or behaviors (Director, 2005; Essig, 2012; Levine, 2010). The term misuse implies a sliding scale, from mild to severe misuse, like the “Substance related and addictive disorders” category in the DSM-5 (2013) but without connection to either the concept of disorder or a system of classification. The sliding scale illustrates that the object can be misused on singular occasions, regularly, periodically, or constantly. Misuse thus includes both quantity (i.e. the object is used to an extent that is beyond what is experienced as tolerable or desirable) and quality (i.e. the object might be used for misdirected reasons, and/or with negative consequences). Since the concept of misuse covers both quantitative and qualitative aspects of consumption despite awareness of negative consequences, this thesis uses the term substance misuse. There is also a linguistic reason for using the term misuse. It is a word that might be used as both a noun and as a verb, and does not necessarily imply essentialism; it might therefore be used to describe both a state and a behavior.

Substance misuse has been defined as a repetitive and paradoxical consumatory behavior that is enacted against one’s “better judgment”, to an extent beyond what is experienced as tolerable and desirable (Larkin & Griffiths, 2002). This definition emphasizes that substance misuse is ambiguous and paradoxical. One example of ambiguity and paradox is that substance misuse is characterized by simultaneous and contradictory wishes both to resist, and to give in to using the object concerned (Miller & Rollnick, 2002; Rothschild & Gellman, 2009). In the present thesis, the definition of Larkin and Griffiths (2002) is used, since it opens up for an understanding of the subjective experiences and the ambiguities in substance misuse.

There is an ongoing discussion regarding whether terms such as addiction, dependence, and misuse should be reserved for substances, or whether they should also include excessive behaviors like gambling, food intake, sexual activities, exercise, online gaming, Internet use, and shopping (Essig, 2012; Giugliano, 2008; Holden, 2010; Mudry et al., 2011; Orford, 2001; Sussman et al., 2011; West, 2006). Recently, gambling addiction has been included in the category “Substance related and addictive disorders” in the DSM-5 (American Psychiatric Association, 2013), as a so-called behavioral addiction. The reason for this inclusion is that both gambling and substance use disorders are characterized by aspects such as tolerance and perceived loss of control, and moreover the two conditions tend to co-occur (Peles, Schreiber & Adelson, 2009; Svensson, Romild, Nordenmark & Månsdotter 2011; Toneatto & Brennan, 2002; Walther, Morgenstern & Hanewinkel, 2012).

Excessive food intake has also been found to co-occur with substance misuse (Cowan & Devine, 2008; Karim & Chaudhri, 2012; Nökleby, 2013). Excessive food intake is included in the DSM-5, even though it is not labeled as a behavioral addiction but as Binge eating disorder (American Psychiatric Association, 2013). The diagnosis describes repeated episodes of eating considerable amounts of food in a short period of time. The eating is not primarily connected to hunger, and is furthermore connected to overwhelming affective experiences of for example guilt and shame.

There is an ongoing debate regarding the terminology for excessive behaviors (Karim & Chaudhri, 2012; Mudry et al., 2011; Schuckit, 2013). The term behavioral addiction is commonly used, but has been criticized since like the term substance addiction, it might imply medicalization, loss of willpower, and essentialism (Essig, 2012; Vrecko, 2010). Some researchers prefer the terms compulsion or impulse control disorder (Costorphine, Waller, Lawson & Ganis, 2007; Fernandez-Aranda, et al., 2006; Hartman, Ho, Arbour, Hambley & Lawson, 2012). Researchers who study excessive sexual activities for example frequently use the term compulsion (Hartman et al., 2012; Roller, 2007). Yet other researchers avoid terms that are connected to psychiatric terminology and instead use the term excessive appetite (Orford, 2001), or excessive behaviors (Mudry et al., 2011).

During the development of the DSM-5, researchers were involved in discussions regarding which behaviors that should and should not be included as behavioral addictions (Holden, 2010; Mudry et al., 2011; Schuckit, 2013; Walther et al., 2012). It was proposed that excessive sexual activities should be labeled as an addictive disorder, and as such included in the DSM-5 (Garcia & Thibaut, 2010; Hartman et al., 2012). There were also proposals for labeling excessive use of the Internet, including online gaming, as addictive disorders (Essig, 2012; Karim & Chaudhri, 2012; Walther et al., 2012). Proponents for including these behaviors in the "Substance related and addictive disorders" category argue that a diagnosis acknowledges the existence of the difficulties and thereby decreases the risk that such difficulties will pass unnoticed and enhances the development of treatment interventions (Garcia & Thibaut, 2010; Levine, 2010). On the other hand, researchers have argued against labeling excessive behaviors as addictive disorders, since a diagnostic label might induce neglect of underlying psychological processes, as well as a foreclosure regarding knowledge about excessive behaviors (Essig, 2012; Giugliano, 2008; Levine, 2010; Schuckit, 2013). Moreover, researchers suggest that diagnostic criteria might scaffold the influence of the contemporary cultural context, with increasing consumption as a central part of what it means to be a human being, and that unique individuals with excessive

behaviors are enacting these contextual prepositions and expectations (Bailey, 2005; Kacen, 2000; Karim & Chaudhri, 2012; Vrecko, 2010).

With awareness of the varying perspectives, definitions, and terms that are used with reference to excessive use of a range of objects and behaviors, such as sexual activities, food intake, Internet use and exercise, the term excessive behaviors is used in the introductory part of this thesis. This term is in line with Larkin and Griffith's (2002) view of misuse, since it is not loaded with diagnostic meaning or any specific theoretical approach. Concerning treatment, the term substance abuse treatment will be used throughout the thesis, since it is an established term for the treatment the participants in the studies were involved in.

Psychology as a human science

Psychology is a discipline that might be viewed both as a natural science and as a human science (Frie, 2010; Keen, 2012). When psychology is viewed as a natural science, focus is primarily on explaining for example the connections between cause and effect, registering of observable phenomena, on making predictions, and on evaluating general treatment principles for groups of clients (Biesta, 2010; Falkum, 2008; Parker, 2004). When psychology is viewed as a human science, the focus is primarily on understanding individuals and their affects, reactions, and experiences, as well as on how individuals understand themselves in a given context (Ashworth, 2008; Falkum, 2008; Frie, 2010). The focus on understanding is fundamental when encountering individuals who are troubled by difficulties that are ambiguous and hard to define, regardless of whether these encounters occur during research or in clinical practice (Hunter, 2005; Schön, 1983). In clinical practice, the individual concerned is in focus, and practitioners therefore need to understand the conditions of the unique individual and strive to understand what the difficulties are about, before thinking about how difficulties might be labeled or solved (Schön, 1983; Sharpless & Barber, 2009). In order to understand individuals and their perceptions and experiences, it is necessary to centralize communication and what is being revealed or veiled in the communication (Ashworth, 2008; Frie, 2010). From the perspective of human science, it is thus assumed that understanding, and knowledge of the studied topic, is achieved through dialogues with individuals who have a variety of experiences and difficulties (Falkum, 2008; Keen, 2012). Moreover, in the tradition of human science, the studied phenomena are seen as paradoxical, ambiguous, and overlapping, whereas in the

tradition of natural science, there is a striving towards defining categories and phenomena so that definitions and categories are unambiguous and mutually exclusive (Hunter, 2005; McAdams, 1993).

From a pragmatic scientific view, the sources of data, and the methods used to analyze them are secondary to the research question, and thus sources of data, methods, and views of knowledge, are beneficially combined in order to investigate the studied phenomenon (Biesta, 2010). This means that qualitative as well as quantitative data and methods might be used in the research process (Biesta, 2010; Giorgi & Giorgi, 2008). Since this thesis concerns the understanding of experiences of substance misuse and other excessive behaviors, it is written from the perspective of psychology as a human science, using both quantitative and qualitative data and research methods.

Psychology as a human science is connected to the tradition of hermeneutics, in which interpretation is central (Falkum, 2008; Mills, 2005). Hermeneutic knowledge is about revealing the multiple and ambiguous world of human life through interpretation, and thus knowledge is seen as reflective and pluralistic (Frie, 2010; Mills, 2005). Therefore, when the word understanding is used, it does not imply total understanding, or the perception that "the truth" has been achieved. The implication is rather that each perspective and interpretation contributes increased insight into the phenomena of interest.

Situations and phenomena that are lived through by individuals in their everyday lives are hard to capture with clear-cut definitions, but might be revealed in communication (Giorgi & Giorgi, 2008; Hollway & Jefferson, 2008; McAdams, 2001). The psychodynamic tradition is a psychological perspective grounded in the hermeneutic tradition in which human communication and individual perception and experience are the core of the investigations (Mills, 2005; Yeomans & Delaney, 2008). In psychodynamic research and theory, the center of attention is on ambivalence, contradictions, defense mechanisms, seemingly irrational affects, reactions and behaviors, as well as on unconscious motives (Billig, 1997; Hollway & Jefferson, 1998; Khantzian, 2005). Such phenomena have also been identified as important in other theories and research traditions that seek to understand substance misuse and excessive behaviors (Adams & Robinson, 2001; Kellog & Tatarsky, 2012; Reid, Harper & Anderson, 2009). Traditionally, researchers working in the psychodynamic tradition have not taken a specific interest in investigating substance misuse (Ramos, 2004; Rothschild & Gellman, 2009). However, during recent decades there has however been an increasing interest in research and theory regarding substance misuse, grounded in psychodynamic theory (Director, 2002; Rothschild & Gellman, 2009).

Simultaneously, psychodynamic research and theory have been influenced and developed by findings from other disciplines, for example neuro-developmental and neurobiological research and discoursive thinking (Diamond, 2009; Fosha, Siegel & Solomon, 2009; Goodman, 2008; Schore, 1994; Solms & Turnbull, 2002; Zizek, 1994). Researchers investigating substance misuse from perspectives other than the psychodynamic have likewise incorporated findings from psychodynamic investigations in their research and theories regarding both substance misuse and excessive behaviors. One example is that the theory of self-medication with its specific acknowledgment of affective dysregulation (Khantzian, 1997), has become accepted and used as a general concept for understanding the tendency to use objects despite better judgment (Bernstein, 2000; Cowan & Devine, 2008; Reid et al., 2009; Roller, 2007). Psychodynamic concepts such as defense mechanisms and affect regulation have likewise been incorporated in theory and research regarding excessive behaviors (Levine, 2010; Parker & Guest, 2003; Reid et al., 2009). Thus, contemporary researchers seem to be influenced by a multi-disciplinary approach when investigating substance misuse and excessive behaviors, and contemporary psychodynamic researchers tend to have an eclectic approach in understanding these phenomena (Goodman, 2008; Khantzian, 2003; Rothschild & Gellman, 2009). This thesis is in line with this approach. This means that even though the thesis is written from a hermeneutic psychodynamic perspective, other perspectives and theories are acknowledged and referred to, since a range of perspectives contribute with pieces of knowledge concerning the human capacity to repeatedly use objects against better judgment.

Psychodynamic theory is rooted in psychoanalytic theory. These two traditions are sometimes seen as positions on a continuum, and sometimes referred to as different domains (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989; Rangell, 1954). The reason for viewing psychoanalytic and psychodynamic theory, research, and practice, as positions on a continuum is the common emphasis on unconscious processes, and defense mechanisms. Despite awareness that there are arguments for making a distinction between the psychoanalytic and the psychodynamic tradition, the term psychodynamic is used as a general term throughout this thesis. It refers to a theory of the human psyche, and psychological processes, as inherently connected to unconscious conflicts that are mitigated through defense mechanisms (Freud, 1915/1957; Zamanian, 2011). Since the term psychodynamic refers to a tradition that acknowledges the unconscious parts of the human psyche, it is assumed that individual perceptions, experiences, affects, motives, and behaviors have to be understood beyond the overt enactment and the overt communication

(Freud, 1915-1916/1961; 1916-1917/1963; Khantzian, 2003). In addition, psychodynamic psychotherapy with individuals in substance abuse treatment is an established treatment intervention, and thus the term psychodynamic is established in the clinical context (Socialstyrelsen, 2014).

This thesis is based on four studies. In *Study 1* a study-specific questionnaire was used to investigate whether clients in substance abuse treatment considered themselves as having experienced excessive behaviors. *Study 2, 3,* and *4* were based on interviews concerning the participants' experiences of misuse, and used contemporary psychodynamic theory and concepts in the analysis in order to understand the experiences of substance misuse and excessive behaviors as they were communicated.

Substance misuse and other excessive behaviors

Substance misuse is a phenomenon that has considerable negative consequences both for the individual concerned, and for their relatives and associates (Rothschild, 2010; Socialstyrelsen, 2014). It is also the concern of diverse institutions in society such as the justice system, social services, and public health care, and is associated with negative consequences and costs for the society (Andlin-Sobocki & Rehm, 2005; Beveridge, 2008). Accordingly, substance misuse is a phenomenon that is defined and investigated from a variety of perspectives. Substance misuse might for example be regarded as a medical disorder, as a deviant behavior, or as a socially constructed concept that serves to establish discipline over individual citizens and their desires (Vrecko, 2010).

From a psychological perspective it has been emphasized that psychological distress often accompanies substance misuse, and psychiatric symptoms such as anxiety, depression and dissociative syndromes, as well as relational difficulties, self-destructive behaviors, and suicide attempts are relatively common among individuals with substance misuse (Castel, Rush, Urbanowski, & Toneatto, 2006; Keaney, 2006; Khantzian, 2003; Schuckit, 2006). A history of childhood trauma such as neglect, and emotional, physical, and sexual abuse is also commonly seen among individuals with substance misuse (Bernstein, 2000).

Excessive behaviors, with considerable negative consequences, seem to co-occur relatively often with substance misuse (Hartman, et al., 2012; Karim & Chaudhri, 2012; Shaffer et al., 2004; Sussman et al., 2011). For example, individuals who misuse substances may also experience difficulties with excessive food intake, exercise, sexual activities, shopping, Internet use, and/or gambling (Christo et al., 2003; Goodman, 2008; Hartman et al., 2012; Holden, 2010; Nökleby, 2013; Plant, Miller & Plant, 2005; Potenza, 2005). Moreover, individuals who use a range of different substances may also engage in a range of excessive behaviors, alternately and/or simultaneously (Hartman et al., 2012; Holden, 2010; Kausch, 2003; Orford, 2001; Shaffer et al., 2004; Sussman et al., 2011).

There are several theories regarding the similarities and common risk factors for substance misuse and excessive behaviors. For example, studies show that personality traits like sensation seeking and impulsivity are associated with both substance misuse and excessive behaviors (Fernandez-Aranda et al., 2006; Fischer & Smith, 2008; Nower, Derevensky & Gupta, 2004; Walther et al., 2012). Other researchers have shown that substance misuse and excessive behaviors are both related to dysfunctions in parts of the central nervous system that regulate for example motivation, reward seeking behaviors and

the capacity to inhibit activities (Goodman, 2008; Holden, 2010; Karim & Chaudhri, 2012; Volkow, Wang, Tomasi & Baler, 2013). Furthermore, the impact of learning, conditioning, and social reinforcement, in the development of both substance misuse and excessive behaviors has been emphasized (Cannon & Bseikri, 2004; Wanigaratne, 2006). There also seem to exist a general vulnerability to both substance misuse and excessive behaviors that is connected to hereditary as well as environmental factors. For example, individuals with biological relatives who misuse substances, seem to be at significantly higher risk than the general population for developing difficulties with excessive sexual activities, gambling and/or food intake (Goodman, 2008; Harrop & Marlatt, 2010). However, other researchers acknowledge that substance abuse seems to increase the likelihood of developing excessive behaviors, and individuals thus might terminate substance misuse but instead develop difficulties with excessive behaviors (Cowan & Devine, 2008; Peles et al., 2009; Shaffer et al., 2004).

In comparison to the general population, individuals who develop substance misuse and/or excessive behaviors show greater exposure to traumatic childhood experiences such as neglect and physical, emotional and/or sexual abuse (Costorphine et al., 2007; Harrop & Marlatt, 2010). Such traumatic events might induce severe anxiety, dissociative states, and incapacity to tolerate and regulate affects, which in turn might imply vulnerability to developing substance misuse as well as excessive behaviors as ways to cope with the suffering (Bernstein, 2000; Beveridge, 2008; Carr & Szymanski, 2011; Costorphine et al., 2007; Holmes et al., 2005; Levine, 2010; Schore, 2002). Moreover, individuals who have been exposed to traumatic events during childhood might come to perceive that it is their fate to suffer, and thus continue to misuse substances and enact behaviors as a form of self-punishment, despite a conscious wish to refrain (Rothschild & Gellman, 2009; Valenti, 2002).

Social norms, for example concerning gender, are known to influence the expression of substance misuse and excessive behaviors, and thus are important for understanding these phenomena, in the context of the gender differences that have been identified (Bogren, 2011; Plant et al., 2005; Giddens, 1995). One such difference is the higher occurrence of gambling, including excessive gambling, among men compared to women (Svensson et al., 2011), and the higher occurrence of eating disorders among women compared to men (Cohen et al., 2010; Nökleby, 2013). Another difference between men and women is the higher occurrence among men of excessive sexual activities including use of sex workers and pornography (Levine, 2010; Wood, 2007). Such differences however need to be

understood with respect to the view of men as biologically predisposed to mate with many women and spread their genes; this is a view that creates its own reality which in turn implies that male sexuality is about performance and quantity whereas female sexuality is about quality (Lorentzen, 2007). Masculinity is thus seen as connected to sexual readiness. An individual man who lacks a vision of his own sexuality as connected to intimacy and emotional pleasure might instead express his sexuality through excessiveness (Lorentzen, 2007). Social norms thus influence what individuals expect of themselves and the kind of experiences they expect that enacted behaviors will provide. The impact of expectancies have been shown by Fischer and Smith (2008) who found that personal expectancies about positive experiences regarding substances, gambling and food intake increase the risk to develop substance misuse, and excessive gambling and food intake.

One important difference between substance misuse and excessive behaviors should however be noted. Substances have a thorough and potentially long-lasting impact on neuropsychological functions such as planning, judging and evaluating actions, as well as on, memory, endurance, inhibition, and attention (Hanson, Medina, Padula, Tapert & Brown, 2011; Lundqvist, 2009; van der Plas, Crone, van den Wildenberg, Tranel & Bechara, 2009). Concerning excessive behaviors, individuals might become so preoccupied with certain behaviors so that they perceive that their capacity to plan, judge and evaluate actions becomes impaired, and thereby they enact behaviors against their better judgment and despite a conscious wish to refrain (Goodman, 2008; Hartman et al, 2012; Orford, 2001). However, even though behaviors influence the activity of the neurotransmitter dopamine, excessive behaviors do not however have the same impact as substances on neuropsychological functions as substances have (Holden, 2010; Schuckit, 2013). Some researchers have suggested that excessive behaviors are particularly interesting to study since the repeated enactment against better knowledge cannot be explained by impaired neuropsychological functioning due to effects of substances (Essig, 2012; Griffiths, Parke & Wood, 2002; Orford, 2001; Shaffer et al., 2004; West, 2006). These researchers emphasize that knowledge about psychological phenomena such as expectactions and attributed meaning regarding substances and behaviors is important for understanding substance misuse and excessive behaviors and the similarities they share. Such psychological processes might become veiled by the impact of substances on neuropsychological functioning, but become visible and possible to investigate when both substance misuse and excessive behaviors are studied (Griffiths, 2005; Larkin et al., 2006; Orford, 2005).

Co-occurring substance misuse and excessive behaviors in clinical practice

Excessive behaviors tend to complicate the process and impair the outcome od treatment for substance misuse, and clients with co-occurring excessive sexual activities, excessive shopping, excessive food intake, and substance misuse have extensive treatment needs (Costorphine et al., 2007; Fernandez-Aranda et al., 2006; Harrop & Marlatt, 2010). For example, clients in methadone treatment, who also engaged in pathological gambling, are more likely to relapse in substance use during treatment, and are also more likely to drop out from the treatment program, compared to clients without pathological gambling (Ledgerwood & Downey, 2002). In line with these results, Toneatto and Brennan (2002) show that pathological gambling was a risk factor for relapse in substance use, and they therefore suggest that gambling needs to be identified, assessed, and considered during substance abuse treatment. Furthermore, researchers emphasize that a range of excessive behaviors need to be identified among clients in substance abuse treatment, since clients with both substance misuse and excessive behaviors are likely to benefit from a treatment that focuses both on the substance misuse and concurrent behaviors (Christo et al., 2003; Ledgerwood & Downey, 2002; Petry, 2000; Plant et al., 2005).

However, it seems that excessive behaviors might pass unnoticed in substance abuse treatment, and researchers have underlined that the capacity to identify excessive behaviors needs to be developed (Christo, et al 2003; Costorphine et al., 2007; Petry, 2000; Toneatto & Brennan, 2002). Self-rating questionnaires covering gambling and eating disorders are established and used in research, and sometimes in clinical practice, and new questionnaires are continuously under development (Gearhardt, Corbin & Brownell, 2009; Holtgraves, 2009; Karim & Chaudhri, 2012). Self-rating instruments covering excessive shopping, exercise, sexual activities, and/or Internet use have also been developed, but have not gained attention to the same extent as instruments covering gambling and eating disorders (Christo et al., 2003; Dowling & Quirk, 2009; Goodman, 1998).

Self-rating instruments are commonly used in research concerning the co-occurrence of substance misuse and excessive behaviors. Findings from such studies have presented different rates regarding co-occurrence of substance misuse and excessive behaviors. For example, it has been approximated that 4-58 % of clients in substance abuse treatment have difficulties with gambling (Peles, Schreiber & Adelson, 2009; Toneatto & Brennan, 2002). The discrepancy between 4 and 58 % is substantial, and the different percentages might be explained by what kind of population that has been examined, and how difficulties with

gambling have been defined. Regarding food intake, it has been reported that up to 46 % of women in substance abuse treatment also have eating disorders while the occurrence of eating disorders among men is more uncertain (Cohen et al., 2010; Harrop & Marlatt, 2010; Nökleby, 2013). A review covering 83 studies of co-occurring substance misuse and excessive behaviors, estimated a co-occurrence of 40 % between substance misuse and excessive sexual activities (Sussman et al., 2011). Although the literature search did not reveal any studies that examined substance misuse and excessive exercise, the authors found that up to 48 % of individuals with eating disorders also engaged in excessive exercise (Sussman et al., 2011). Harrop & Marlatt (2010) also emphasize that substance misuse and disordered eating might be connected to excessive exercise.

To summarize, it seems that despite some uncertainties regarding methodology and definitions of excessive behaviors, studies based on self-ratings indicate that excessive behaviors among individuals with substance misuse are not a marginal phenomenon (Costorphine et al., 2007; Karim & Chaudhri, 2012; Sussman et al., 2011). However, it is pointed out that few studies examine a range of excessive behaviors in the same sample, and therefore it is difficult to achieve knowledge about the general co-occurrence of substance misuse and excessive behaviors (Christo et al., 2003; Harrop & Marlatt, 2010; Sussman et al., 2011). To counteract this, studies should examine a range of substances and excessive behaviors in one and the same sample, since such an approach might contribute knowledge about the co-occurrence of substance misuse and excessive behaviors (Karim & Chaudhri, 2012; Sussman et al., 2011; Walther et al., 2012).

Excessive sexual activities

Sexuality and sexual activities seem to have multiple connections to substance misuse. For example, young women who have been exposed to sexual objectification (e.g., unwanted evaluation of their bodies, unwanted sexual contact, and sexual victimization) have a higher occurrence of substance misuse than women who have not been exposed to sexual objectification (Carr & Szymanski, 2011). Findings from other studies indicate that also men who have been sexually and physically abused during childhood are more likely than other men to develop severe substance misuse as well as to engage in excessive sexual activities (Aaron, 2012; Bernstein, 2000; Liebschutz, Savetsky, Saitz, Horton & Lloyd-Travaglini, 2002). Moreover, when individuals are under the influence of substances they

might enact sexual activities and take sexual risks that they on other occasions would refrain from (Hollway & Jefferson, 1998; Roller, 2007).

A childhood history of maltreatment and neglect, as well as emotional, sexual, and physical abuse, is frequently reported by individuals with substance misuse (Bernstein, 2000) as well as individuals who enact excessive sexual activities (Hunt & Kraus, 2009; Parker & Guest, 2003). Traumatic experiences are known to induce feelings of shame (Carr & Szymanski, 2011; Cook, 1988), and feelings of shame indeed seem to be salient both among individuals who have difficulties with substance misuse and among those who enact excessive sexual activities (Adams & Robinson, 2001; Fischer, 1988; Gilliland, South, Carpenter & Hardy, 2011). Moreover, individuals who struggle to change their life-course have to acknowledge events that they previously strived to avoid since they were perceived as shameful (Sachs, 2009; Scheff & Retzinger, 1997). This means that substance misuse and excessive sexual behaviors might both be connected to feelings of shame that preceded the misuse and the excessive behaviors, and simultaneously misuse and excessive behaviors might induce feelings of shame (Cook, 1988; Parker & Guest, 2003; Sachs, 2009). Therefore, shame needs to be acknowledged in the investigations of both substance abuse and excessive sexual activities. It should however be noted that excessive food intake and gambling might also be connected to feelings of shame. Just as shame might fuel substance misuse and must accordingly be acknowledged in substance abuse treatment, shame connected to excessive food intake also needs to be acknowledged in treatment (Bromberg, 2001; Cook, 1988; Luoma, Kohlenberg, Hayes & Fletcher, 2012). It has been suggested that clients who have difficulties with excessive sexual activities and other behaviors van benefit from a treatment that resembles substance abuse treatment, in the sense that initially the concrete activities need to be terminated, and then the underlying suffering, affective dysregulation, relational difficulties, and other potential symptoms might be acknowledged (Garcia & Thibaut, 2010; Goodman, 1998; Hartman et al., 2012; Karim & Chaudhri, 2012).

Concerning excessive sexual activities it has been suggested that symptoms of withdrawal as well as the eagerness for increasing amounts of sexual activities, should be acknowledged in an individualized treatment (Garcia & Thibaut, 2010; Goodman, 1998; Parker & Guest, 2003). These suggestions are in line with recommendations that substance abuse treatment needs to specifically address symptoms of withdrawal and tolerance in an individualized treatment that acknowledges how the individual client experiences and handles these symptoms (Kellog & Tatarsky, 2012; Sachs, 2003). With respect to the considerable co-occurrence of excessive sexual activities and substance misuse, (Hartman et

al., 2012; Roller, 2007; Sussman et al., 2011), the similarities between excessive sexual activities and substance misuse (Garcia & Thibaut, 2010; Hartman et al., 2012), and the impact of sexual experiences and perceptions on the development of substance misuse (Carr & Szymanski, 2011), excessive sexual activities will be given some priority over other excessive behaviors that are investigated and discussed in this thesis.

Psychodynamic approach towards substance misuse and other excessive behaviors

This thesis is written from the perspective that different psychodynamic approaches are beneficially combined in order to understand substance misuse and other excessive behaviors. During the last decades of the twentieth century, relational theory evolved as a perspective that is gaining increased attention (Berman, 1997; Director, 2005; Rothschild, 2010). Relational theory has been descried as an integration and a development of self-psychological and object relational perspectives, rooted in the British object relational theory, the work of American object relational theorists such as Kernberg, the interpersonal theory, and the self-psychology formulated by Kohut and colleagues (Berman, 1997; Reis, 2005; Zamanian, 2011). The self and human relatedness are central to relational theory, research, and practice, and postmodern thinking about the multiplicity of the self has been incorporated in the theory (Reis, 2005). For example Reis (2005) challenges the view of the self as a unitary entity, which is central in traditional self-psychology (Kohut, 1977), as well as the view of autonomy and stable identity as a goal for human development, which is central in the theory of for example Kernberg (1975). From the perspective of relational theory, the self is seen as inherently relational and the view of a unitary self is regarded as an illusion (Reis, 2005). The self is rather viewed as decentered, with multiple possible aspects that become visible in relations, and relational theory thus has been described as a two-person psychology (Director, 2005; Mills, 2005). In line with this, it is assumed that in the clinical interaction, the relation itself become the medium through which a troubled client might integrate and develop different self-states, and modes of relating (Berman, 1997; Director, 2002; Reis, 2005; Rothschild, 2010).

It has been suggested that misuse should be characterized as a relationship which might be directed towards a range of objects and activities such as substances, sexual activities and relationships, food intake, exercise, or any other object or habit that the individual becomes occupied with (Bromberg, 2001; Director, 2002; Khantzian, 2005; Wilson, 2002). In line with this characterization of substance misuse and excessive behaviors, it has been argued that relational theory contributes to the understanding of both substance misuse and excessive behaviors (Bromberg, 2001; Director, 2005; Rothschild, 2010).

Defense mechanisms

Among individuals who have difficulties with substance misuse and excessive behaviors, defense mechanisms tend to mitigate distress regarding non-coherence, vulnerability, and perceived lack of control. Defense mechanisms, and the processes and experiences that accompany them, are however not necessarily pathological. On the contrary, defense mechanisms are continually operating to assure that the individual is able to engage in productive and sustaining activities rather than being overwhelmed by distress (McWilliams, 2011). Under stressful situations such as life crises or traumatic experiences, everyone has the capacity to function according to primitive defense mechanisms. However, when primitive defense mechanisms are commonplace, the development and the relational capacity of the individual are hindered, and both affective and behavioral difficulties might persist (Kernberg, 1992; McWilliams, 2011; Ramos, 2004).

Primitive forms of denial, projection, and/or dissociation seem to be characteristic of individuals who have difficulties with substance misuse and/or excessive behaviors (Beveridge, 2008; Bromberg, 2001; Chapman, 1992; Coen, 1981; Director, 2002; Reid et al., 2009; Sachs, 2003). In dissociation, the individual experiences parts of the self as being located outside themselves, and these parts become perceived as not-me. This not-me state might imply a calming experience since the suffering, and/or the not-wanted part of the self becomes estranged (Holmes et al., 2005). During dissociation, the individual is thus shielded, not only from suffering, but also from parts of the self that are perceived as unacceptable (Bromberg, 2001). The cost of this shield is however a lack of coherence that becomes distressing in itself, and therefore in turn might fuel tendencies for substance misuse and excessive behaviors (Bromberg, 2001, Burton, 2005). In relational theories concerning misuse, and even outside the field of psychodynamic research and theory, lack of coherence and dissociative processes have gained considerable interest, both for understanding processes of substance misuse and excessive behaviors, and also for understanding the treatment needs of the clients concerned (Burton, 2005; Director, 2005; Holmes et al., 2005; Reid et al., 2009; Reis, 2005).

Since defense mechanisms are operating, it is not only the explicit content in human communication that needs to be acknowledged; absences must also be analyzed. What an individual says is thus regarded as important, but what is not being said is regarded as similarly, or sometimes even more, important (Billig, 1997; Fischer; 1988). Such

unconscious processes need to be understood in the light of ambivalence, a term that refers to contradictory approaches towards the same object (Dimen, 2005; Rosenzweig, 1938). This means that libidinal and aggressive drives, disparate motives, and/or disparate affects, are directed towards the same object. This is significant in understanding misuse and excessive behaviors, since misuse and excessive behaviors are characterized by ambivalent and paradoxical approaches towards the object (Bromberg, 2001; Miller & Rollnick, 2002; Wilson, 2002).

Unconscious processes, conflicts, and defense mechanisms influence everyone, and there is no perfect or final way to handle internal distress or ambivalence. It simply has to be dealt with, and during the life course obstacles will inevitably appear (Dimen, 2005; McDougall, 1995). From this perspective, individuals with substance misuse and/or excessive behaviors are not essentially different from other individuals. The human capacity to deliberately engage in destructive activities affects everyone, and misuse of substances and excessive behaviors is only one of many possible misdirected attempts to handle distress (Wilson, 2002).

Relational needs and affects

Contemporary psychodynamic research on substance misuse and excessive behaviors is concerned with relational needs and the capacity to regulate affect such as joy, sorrow, anger, and shame (Bromberg, 2001; Burton, 2005; Director, 2005; Khantzian, 2005). The capacity to understand and handle one's own needs and affects is not self-evident; an infant is not capable of understanding and regulating its own needs and affects (Schore, 2002: Tomkins, 1995). During childhood, the self-perception, like the capacity to engage in relationships and regulate needs and affects develop in a relational context. Relational needs, affects, and the emerging self-perception, thus become intertwined with each other. When caregivers have the capacity to tolerate and understand the needs and affects of the child and interpret them so that they are comprehensible for the child, the capacity to tolerate and regulate affects, and to understand oneself is developed (Schore, 2002; Solms & Turnbull, 2002).

If interaction with the caregiver allows the child to experience that distressing affects may begin, grow, even break out, and then extinguish, the child will develop the ability to identify, tolerate, and regulate affects and needs, as well as painful experiences and distress (Kohut, 1977; Schore, 1994; Stolorow, Brandchaft, & Atwood, 1987). In such a

relational context, the child will experience its own needs and affects as comprehensible, and the needs and affects become congruent with the self-perception (Fosha, Siegel & Solomon, 2009; Schore, 1994; Solms & Turnbull, 2002). However, if the relational interaction is repeatedly insufficient and/or distorted, the child will experience a sense of isolation and a perception that needs and affects are incomprehensible and unacceptable, and these perceptions become parts of the self (Schore, 2002). The child will consequently develop a fragile, non-coherent self that cannot understand, tolerate, or regulate needs and affects. A non-coherent self becomes prone to anxiety connected to terrifying experiences of losing oneself and one's boundaries. Tendencies to seek out sensations of excitement as a shield against such terrifying experiences might develop (Essig, 2012; Grosch, 1994; Kohut, 1977; Stolorow et al., 1987; Sweet, 2012). In such cases, the use of substances and/or behaviors such as excessive food intake and/or masturbation has a twofold purpose. Firstly, the sensation of excitement connected to using the objects becomes a shield against non-coherence. Secondly, a perception of being independent and able to control objects, needs, vulnerability, and affects is created through the use of substances and/or behaviors that are perceived as being at one's disposal (Director, 2005; McDougall, 1995; Reid et al., 2009).

Shame

Shame might be described as a fundamental sense of being unworthy as an individual, and a simultaneous fear of being exposed, since exposure would expose the unworthiness (Kaufman, 1974). Due to its nature as a "not wanting to be seen affect", shame tends to pass unnoticed, both in research and clinical practice, and perhaps also by the individual who feels ashamed (Dimen, 2005; Reid et al., 2009; Scheff & Retzinger, 1997, Shalev & Yerushalmi, 2009; Tomkins, 1995). However, shame is an affect that has gained attention in psychodynamic developmental theories (Kaufman, 1974; Kohut, 1977; Grosch, 1994; Schore, 1994; Tomkins, 1995). Shame has a paradoxical connection to interest and amusement, since it is one result of enacting activities that for some reason should have been curbed (Schore, 1994; Tomkins, 1995). Momentarily, the activity was perceived as desirable and perhaps appropriate, but afterwards when the individual looks at the enactment at some distance, he or she might conclude that the activity should have been refrained from (Lorentsen, 2007). In shame, a desire not to think about the enactment might

develop. The individual even tries to avoid others, which is reflected in the physical appearance; the head is lowered, the gaze is evasive.

Shame is fundamental for the capacity to inhibit impulses and unaccepted activities, and hence necessary for human development and socialization, even though it is momentarily experienced as negative and unwanted (Schore, 1994; Tomkins, 1995). In early development, mild shaming procedures are used to influence the child (Schore, 1994). However, if the affective interaction between child and caregiver is characterized by misunderstanding or distortion, shame becomes incomprehensible and its potentially positive aspects are overshadowed by the negative experience of shame (Grosch, 1994). If the interaction and the caregiver's reactions to the child for example are characterized by humiliation, the individual will experience persistent shamefulness and self-criticism (Bromberg, 2001; Fischer, 1988; Kohut, 1977).

Sexuality

From the psychodynamic perspective, the individual's perceptions of sexuality, how these perceptions shape the individual and the enacted sexual activities, and furthermore how relational needs and affects might become sexualized, are central (Coen, 1981; Giugliano, 2003; Goodman, 1998; Sloate, 2010). In sexuality, physical and psychological perceptions and experiences converge, and through human development, sexuality becomes a part of the self that is connected to both physical and symbolic processes and experiences (Dimen, 2005; Weinryb, 1992). Moreover, perceptions of sexuality are shaped by contextual factors. Therefore the individual is influenced by current beliefs and norms about sexuality thus influence the individual. Therefore, even though the psychodynamic tradition is not specifically focused on investigating contextual factors and beliefs about sexuality, the contextual impact on the sexual life of the individual, and how psychological difficulties might be connected to current beliefs about sexuality is an area of significance (Zamanian, 2011; Zizek, 1994).

The relational perspective has been criticized for the increasing attention towards relational needs and the simultaneously decreasing attention towards experiences and perceptions connected to sexuality (Mills, 2005; Zamanian, 2011). There are however researchers who focus on questions of gender and sexuality from the relational perspective, and accordingly integrate questions of both relational needs and sexual experiences and perceptions in their theories (Benjamin, 1995; Diamond, 2009; Dimen, 2002; Goldner,

2003; Zamanian, 2011). These researchers are concerned with sexuality as an inherently ambivalent human experience in which delight, excitement, and satisfaction are intermingled with disgust, distress, and uncertainty (Dimen, 2005; McDougall, 1995). Thus, sexuality is seen as both a source of delight, and as a traumatic condition that everyone has to handle in a unique way characterized by individual experiences and perceptions, both of oneself and of one's world (McDougall, 1995).

Sexual activities might serve different affective and relational needs within and between individuals, and excessive sexual activities are multifaceted rather than easily defined (Giugliano, 2008; Hughes, 2010; Reid et al., 2009; Sloate, 2010). Sometimes, sexual activities seem to concern practically anything but sexuality; for example, a striving for acceptance, identity formation, revenge, control, or self-punishment (Adams & Robinson, 2001; Dimen, 2005; Giugliano, 2003; Valenti, 2002). Therefore, excessive sexual activities are not seen as a form of hyper-sexuality, connected to a particularly strong sexual drive, but rather as a form of enactment developed in response to affectively disappointing or even traumatic relational experiences (Giugliano, 2003; Kohut, 1977; Sloate, 2010). Moreover, if a child is raised in a sexually-loaded relational context the child might develop an un-cohesive self and a sexualized mode of relating and being (Coen, 1981). For the child, needs, affects, and bodily sensations become confusing, and overwhelming experiences of non-coherence might arise. Sexual activities and the excitement connected to them have the capacity to momentarily ease both affective suffering and experiences of losing one's boundaries, and might therefore be repeatedly enacted even though they induce shame and increased distress (Beveridge, 2008; Kohut, 1977; Reid et al., 2009). When sexual activities are performed in order to shield from psychological distress, the relational, affective, and potentially satisfying aspects of sexuality are downgraded, while experiences of independence, invulnerability, and self-sufficiency seem to be emphasized (Beveridge, 2008; Coen, 1981; Sloate, 2010).

In the psychodynamic tradition, excessive sexual activities have been described as an addiction (Giugliano, 2003; McDougall, 1995). However, psychodynamic researchers have also suggested that the word addiction should be used with caution, since such a word could become a diagnostic label which hinders acknowledgment of for example sexualization, and the symbolic communication that is embedded in excessive sexual enactment (Essig, 2012; Levine, 2010; Wood, 2007). McDougall (1995) suggests that excessive sexual activities should be defined as behavioral attempts to handle difficulties, or even inability, to integrate sexuality and intimate relationships, since sexuality for the

individual concerned has become connected to overwhelming distress. Sexual activities are repeatedly enacted, in attempts to handle the overwhelming distress, since enactment creates the illusion of being able to control relational and affective difficulties by assuring that the desired object is at one's disposal. McDougall's description seems adequate for a psychodynamic approach towards excessive sexual activities.

Contextual factors

The main focus of attention in this thesis is how the participants perceived their substance misuse, their excessive behaviors, with some priority to excessive sexual behaviors, and themselves. However, individual experiences are associated with, and influenced by contextual factors (Berman, 1997; Reis, 2005). Contextual factors might be explicit and legally or physically mandatory, but they might also be powerful, yet sublime mechanisms that govern both collective and individual self-perceptions, behaviors, and reactions (Howarth, 2000). Discourse is a term that refers to such sublime mechanisms. The term discourse might refer to how individuals use spoken language and other forms of communication in their every day interaction with each other (Magnusson & Marecek, 2012). One example is how individuals in their daily conversation confirm or challenge perceptions about gender. Discourses might also be defined as culturally-based systems of meaning that become collectively accepted and as such come to govern the perception of groups of individuals as well as of unique individuals (Magnusson & Marecek, 2012). It is the latter definition that is referred to in this thesis. In discoursive thinking, the focus is on how contextual factors are incorporated into, and set limits for the experiences, beliefs, and intentions of the individual. Discourses direct and limit how individuals perceive and come to talk about a phenomenon, and also how they perceive and talk about themselves. Furthermore, discourses direct and limit the opinions, reactions, and behaviors that are perceived as available while alternative opinions, reactions, and behaviors become unapproachable (Gavey, 2005; Howarth, 2000).

Discoursive thinking has been integrated with relational theory regarding sexuality and gender. For example Goldner (2003) and Diamond (2009) discuss how the self-perception of the individual is shaped in a context characterized by discourses about gender, which are internalized by individual men and women. Discourses regarding gender are thus absorbed and to varying extents complied with. The view of gender as binary categories that are in opposition to each other has been particularly persuasive, and is incorporated in both

collective and individual experiences (Benjamin, 1995; Diamond, 2009; Goldner, 2003). In relational gender theory, it is however acknowledged that both boys and girls in their individual development identify with both individual men and women, as well as with characteristics that have become regarded as masculine and feminine (Benjamin, 1995; Corbett, 2011; Diamond, 2009). Diamond (2009) further describes how discourses of gender as binary categories might influence the developing child to reject characteristics that are perceived as oppositional to their own gender. The opportunity to identify with and integrate characteristics that are perceived as oppositional to one's own gender is thereby hindered, and the individual might develop difficulties in handling ambiguities, which in turn might hinder a sense of self-coherence. Both men and women are thus caught in discourses that in convergence with individual perceptions and experiences shape the individual perceptions and the behaviors that are enacted (Hollway & Jefferson, 1998). In psychodynamic terminology, discourses become part of the unconscious (Zizek, 1994). Thus, individuals do not consciously choose to view neither themselves, nor their gender, according to, or in opposition to, certain gender positions. Rather, the view of oneself, and the behaviors that are enacted, are shaped by discourses that influence our strivings as well as our perceptions of ourselves, both on a conscious and an unconscious level (Hollway & Jefferson, 1998; Howarth, 2000; Zizek, 1994).

Knowledge about discourses of misuse supports the understanding of how individuals who have difficulties with misuse view these difficulties and themselves. A current discourse regarding both substance misuse and excessive behaviors is that such difficulties should be seen as an identity - an addictive personality - and hence as an inherent part of the individual (Bailey, 2005; Kellog & Tatarsky, 2012; Vrecko, 2010). Moreover, discourses regarding misuse become intermingled with discourses regarding gender. For example, the view of gender as binary categories is reflected in the representation of women who drink alcohol as problematic and victimized, while men who drink alcohol are represented as active and responsible for their actions (Bogren, 2011). Moreover, men's drinking is implicitly viewed as normative, and perhaps even desirable, as a sign of masculinity (Abrahamson & Heimdahl, 2010; Bogren, 2011; Ramos, 2004). Simultaneously, men who use illicit substances are represented as threatening and anti-social, and as performing a form of hyper-masculinity that is seen as destructive and out-of-control (Keane, 2005). Such insight points to the importance of acknowledging that both men and women might enact perceptions about gender and identity through substance

misuse and excessive behaviors, and in this process masculinity as well as femininity can be seen as a masquerade that has become internalized (Bogren 2011; Keane, 2005; Zizek, 1994).

Aims

General aims

The overall aim of this thesis was twofold. The first aim was to investigate whether clients in substance abuse treatment considered themselves as having experienced excessive behaviors and if so, whether these behaviors had been considered during treatment. The second aim was to investigate how clients in substance abuse treatment perceived their difficulties with substance misuse and excessive behaviors, and how they perceived themselves.

Therefore, the work began with an investigation of self-reported co-occurrence of substance misuse and excessive behaviors. This was followed by investigating how clients with a history of substance misuse, with or without excessive behaviors, perceived their substance misuse, their excessive behaviors (where relevant), and themselves. Moreover it was investigated how they came to misuse substances, and in relevant cases enact excessive behaviors, despite awareness of the negative consequences and despite a conscious wish to refrain.

Specific aims of the studies

The aim of *Study 1* was to investigate whether clients in substance abuse treatment considered themselves as having experienced difficulties with excessive behaviors (food intake, sexual activities, exercise, and/or gambling), and if excessive behaviors had been considered during treatment.

The aim of *Study 2* was to investigate how clients in substance abuse treatment, who had also experienced excessive behaviors, perceived their substance misuse, their excessive behaviors, and themselves.

The aim of *Study 3* was to investigate how male clients in substance abuse treatment who had also experienced excessive sexual activities perceived their excessive sexual activities, how they came to enact sexual activities they themselves found inappropriate, and how they perceived themselves with respect to sexuality.

The aim of *Study 4* was to investigate how clients in substance abuse treatment who had misused alcohol but did not report excessive behaviors understood their alcohol

consumption, and how they against their better judgment they had increased their alcohol consumption beyond what was experienced as tolerable and desirable.

Methods

The first step in the work of this thesis was to investigate the occurrence of self-reported excessive behaviors among clients in treatment for substance misuse, including illegal substances. A study-specific questionnaire was constructed for this purpose (*Study 1*). In order to further investigate co-occurring substance misuse and excessive behaviors, clients in substance abuse treatment were asked to participate in an interview study regarding how they perceived their excessive behaviors and themselves (*Study 2*). Based on the findings from *Study 2*, in which the male participants described excessive sexual activities as their most distressing and shameful difficulty, a further investigation of the excessive sexual activities among the male participants was conducted (*Study 3*). In order to broaden the knowledge regarding how clients concerned perceived substance misuse, interviews were conducted among clients with a history of alcohol misuse who did not report excessive behaviors (*Study 4*). An overview of the methodology of the studies is presented in Figure 1.

The data that constitutes the basis for this thesis were gathered from different treatment units. The participants in *Studies 1, 2,* and *3* were clients in treatment units in the Swedish public health and social care system. The units were aimed at clients with poly substance misuse, including illegal substances, and co-occurring psychiatric symptoms and/or social problems such as unemployment, and/or homelessness. The treatment they participated in included indoor or outdoor detoxification, medication prescribed by psychiatrist, and supportive contact with a social worker and/or a psychiatric nurse. The participants in *Studies 1, 2*, and *3* thus represent a population with severe poly substance misuse, considerable psychological distress, psychiatric symptoms, and probable social problems. The participants in *Study 4* had been to a 12-step residential care unit aimed at employed clients with a history of alcohol misuse and without pronounced psychiatric symptoms or social problems. The participants in *study 4* thus represent a population with a distinct alcohol misuse, and without considerable psychiatric symptoms or social problems.

In this thesis, the term participants is used with reference to the individuals who contributed to the studies. Clinical psychological studies might use data from individuals who are asked to participate in the investigation, and actively chose to do so, and/or client data from registers or medical records. The term participants emphasizes that the individuals actively chose to answer the questionnaire and/or participate in interviews.

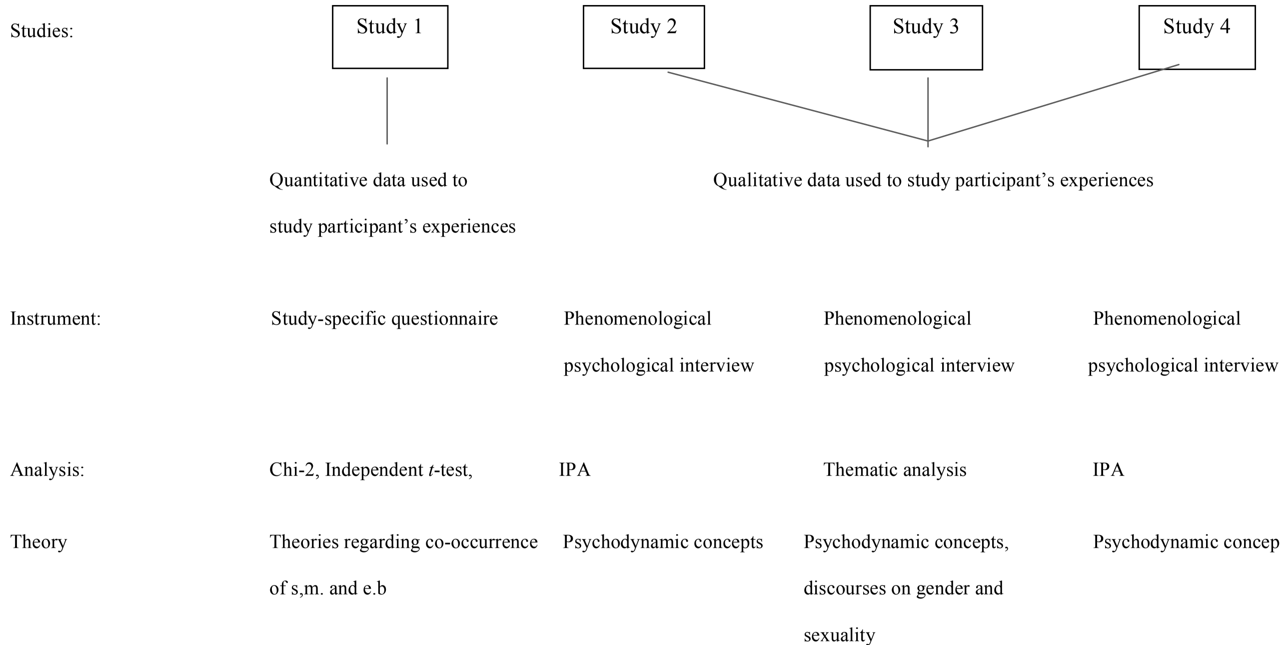

Fig. 1. Overview over the design of the thesis

Methodological considerations

Different research perspectives and methods rely on different assumptions of knowledge, and thereby contribute different pieces of information to the investigation and the understanding of the studied phenomenon (Parker, 2004). The usage of both quantitative and qualitative data in this thesis is based on the suggestion that researchers should choose the data source that is appropriate for understanding the investigated phenomenon with respect to the aim of the study (Biesta, 2010). Moreover, it is suggested that results from studies based on different methods should be integrated and interpreted together.

In the present thesis, the four studies were conducted separately and then their findings were integrated and interpreted together in order to increase the knowledge about substance misuse and excessive behaviors. The methodological design was sequential, and some priority was given to qualitative methods.

Findings from previous research have shown that in substance abuse treatment, as well as in treatment for excessive behaviors, interventions should be based on the individual needs of the client concerned rather than being based on a specific diagnosis (Kellog & Tatarsky, 2010; Parker & Guest, 2003; Valenti, 2002). Therefore it was regarded as appropriate to focus on whether the participants considered themselves as having experienced excessive behaviors, and to make their considerations central for knowledge regarding co-occurrence of substance misuse and excessive behaviors. Thus, the study-specific questionnaire that was used in *Study 1* focused on whether the participants considered themselves to have experienced excessive behaviors.

The focus of *Studies 2, 3* and *4* was to investigate how the participants perceived their substance misuse, their excessive behaviors, and themselves. Therefore the interviews concerning substance misuse and excessive behaviors were conducted according to the psychological phenomenological method, in which the experiences and perceptions of the individuals concerned are the main focus of attention (Giorgi, 1985; Giorgi & Giorgi, 2008; Smith & Osborn, 2008). The interviewer strives to encourage the participant to describe situations that have occurred in their everyday lives, and to give concrete examples of the studied phenomenon. The interview starts with an open question about the studied phenomenon. Follow-up questions are formulated in order to encourage the participants to expand on their descriptions. During the interview, the interviewer strives to bracket own pre-perceptions about the studied phenomenon, and adopts a not-knowing mode of inquiry. This not-knowing mode is adopted in order to focus on the experiences and perceptions of

the participant as far as possible, both in the interview and in the analysis. Since this approach supports the researcher to focus on the perceptions and experiences of the participants, aspects of the studied phenomenon that could not be achieved through pre-articulated questions, hypotheses, and/or specified definitions or concepts might be illuminated (Giorgi & Giorgi, 2008; Smith & Osborn, 2008).

The interviews were analyzed according to Interpretative phenomenological analysis (IPA), or thematic analysis. Both these methods allow a bottom-up approach in which the experience of the participants is the focus of attention (Braun & Clarke, 2006; Larkin, Watts & Clifton, 2006). IPA was used in *Studies 2* and *4*, and thematic analysis was used in *Study 3*. The aim of thematic analysis is to identify common themes in the interviews. The themes might be identified in accordance with specific theoretical constructs, and/or according to a bottom-up approach (Braun & Clarke, 2006). Moreover, the themes might be presented and discussed without being interpreted, or they might be interpreted according to specific theories and/or constructs. In *Study 3,* the interviews were analyzed with the aim of identifying themes from a bottom up approach. The identified themes where then subject to interpretation from the perspective of contemporary psychodynamic relational theory, with respect to the importance of contextual factors.

IPA was chosen as the method of analysis in *Studies 2* and *4*, because it is specifically suited for studying how the individuals concerned understand the studied phenomenon, as well as how they understand themselves. The themes that are identified are closely connected to the statements made by the participants. Thereafter the themes are interpreted from the perspective of theoretical understanding. The analysis thus stays close to the interview data, while still enabling interpretation. The difference between thematic analysis and IPA is that when conducting IPA, the focus is necessarily on how the participants understand the phenomenon that is being studied and how they make sense of their world (Smith & Osborn, 2008). In thematic analysis, the common themes do not necessarily concern how the participants understand the studied phenomenon. The themes might concern aspects of the phenomenon that for example are perceived as important or incomprehensible by the participants without being directly connected to how they understand the studied phenomenon (Braun & Clarke, 2006). IPA is thus more specific in scope compared to thematic analysis. Another difference is that IPA necessarily includes interpretation, while thematic analysis might be conducted with or without interpretation of the identified themes.

In psychological interview studies, the interactional nature of interviews tends to be somewhat neglected (Potter & Hepburn, 2005). For example, quotations from the participants are often presented without addressing the circumstances in which the words were articulated. Hence, it is not made clear whether the statement was a response to a specific question or whether it was articulated with reference to a specific topic in the interview. Such methodological problems are connected to a view of psychology as a value-free science, implying that the interviewer becomes invisible in the final report (Keen, 2012). The article thus becomes seemingly objective, and the data are discussed as neutral findings (Brinkmann & Kvale, 2005; Keen, 2012). In addition, the position of the interviewer and potential effects of the interviewer's personal characteristics might also be neglected (Potter & Hepburn, 2005). The position of the interviewer, the interview reports and/or the interaction cannot be fully represented in the final report, and it is the responsibility of the researcher to reflect on their own position (Smith, Hollway & Mishler, 2005). The position of the interviewer is here briefly presented and reflected on.

As a clinical psychologist in psychodynamic practice, the author has training and experience in interviewing individuals in order to identify and understand themes that might be sensitive and potentially anxiety and shame provoking, and therefore might not be explicitly articulated by the individual. One advantage of this professional background is that the interviewer is trained to focus on topics that are sensitive and/or insinuated by the participants. Moreover, the interviewer is trained to use broad follow-up questions in order to encourage the participants to expand, even on sensitive topics, and to describe their individual experiences. On the other hand, a potential disadvantage is that the interviewer might become preoccupied with psychological processes, implicit themes, sensitive topics, and individual experiences, to the extent that there is a risk of neglecting concrete aspects and descriptions such as how often something happens, how much of the object that is used, and the consequences. In order to counteract such neglect, concrete topics were discussed with the participants, including amount, occurrence, durability, the psychological, physical, financial and social consequences, and the chronology of the substance misuse and the excessive behaviors.

Participants

Study 1 included 69 clients in indoor or outdoor substance abuse treatment units in the Swedish public health and social care system. The mean age was 34 years, and the group

consisted of 50 (72 %) men and 19 (28 %) women. The mean age at onset of experimentation with substances was 14 years. A majority of the participants (97 %) reported daily substance misuse, and 94 % reported having misused at least two illegal substances. The most consumed substances were: non-prescribed medication, opiates, cannabis, amphetamine, and alcohol. Table 1 presents the pattern of substance use reported by participants with and without self-reported excessive behaviors.

Table 1. Reported pattern of substance use among participants in *Study 1* without and with reported behavioral problems. Data presented in frequency (percentage), or as mean ± standard deviation

	Participants without behavioral problems *n* = 23 (33 %)	Participants with behavioral problems *n* = 46 (67 %)
Age (years) of onset for experimentation with substances	14 ± 2	14 ± 5
Age (years) of onset for regular substance use	18 ± 6	18 ± 5
Years of regular substance use	14 ± 10	16 ± 10
Daily substance use (yes)	22 (96 %)	43 (93 %)
Experience of poly substance use (yes)	22 (96 %)	45 (98 %)
Intravenous substance administration (yes)	16 (70 %)	24 (52 %)

The participants in *Studies 2* and *3* were clients in the outdoor substance abuse treatment unit in which *Study 1* was conducted. Five men and one woman (see table 2), participated in *Study 2*. In order to present a comprehensive picture of what was communicated in the interviews, a brief presentation of the participants in *Study 2* is given here.

Two of the male participants grew up with fathers with severe alcoholism, who also abused them physically. Their mothers were described as unable to protect them from abuse. During childhood they had been exposed to a sexual climate in their families, such as witnessing adults' sexual activities and adults' use of pornography. These two participants

were currently working part time and had satisfactory social lives. However, they still experienced intense psychological suffering and self-criticism.

The other three male participants grew up with parents who abused drugs, were involved in criminal activities, and/or had severe psychological and social difficulties. All three had been emotionally, physically, and sexually abused during childhood, and had been subject to social interventions, such as being placed in foster care. They were currently retired, or worked in adjusted settings arranged by social services. They still experienced intense psychological suffering and self-criticism. Even though they had social and intimate relationships, these relations were described as distressing, and they had a tendency to isolation.

The female participant's father had abused drugs and was involved in criminal activities. Her mother was described as anxious and depressed, but a caring person. During childhood she was repeatedly sexually abused by a friend of the family. She was currently studying and living with her fiancée. She described self-doubt and a sense that it was her duty to please others.

Table 2. Background characteristics, participants *study 2*

Participant	Age and gender	Time of abstinence	Age of onset, alcohol	Age of onset, illegal drugs	Misused substances	Behaviours
Participant 1	35, Male	2 years	14	16	Alcohol, amphetamine, benzodiazepine	Exercise, food, Internet, sexuality
Participant 2	39, Male	1 years	13	17	Alcohol, amphetamine, benzodiazepine, cannabis	Exercise, food, sexuality
Participant 3	30, Male	2 years	14	16	Alcohol, amphetamine, benzodiazepine, cannabis	Food, gambling, Internet, sexuality, shopping
Participant 4	44, Male	2 years	13	15	Alcohol, amphetamine, benzodiazepine, cannabis	Exercise, food, sexuality
Participant 5	42, Male	3 years	13	14	Alcohol, amphetamine, benzodiazepine, cannabis, cocaine	Food, gambling, sexuality
Participant 6	25, Female	1 years	19	19	Alcohol, amphetamine, benzodiazepine,	Exercise, food, sexuality

Excessive sexual activities and food intake were the predominant behaviors described by the six participants. The sexual activities described by the male participants concerned excessive masturbation, consumption of pornography, and excessive sexual activities in relationships. One man also described sexual activities with multiple partners. The female participant described how she had repeatedly participated in sexual activities on the condition of others. She had been working as a stripper and as a prostitute, and she sensed that these experiences had increased her doubts in herself.

Regarding food intake, all participants described binge eating. During binge eating episodes they had consumed considerable amounts of so-called junk food, sweets, and soda. The excessive behaviors described by the participants had started during childhood and preadolescence, while the substance misuse started during adolescence. The participants described that they had used substances and behaviors periodically and that their excessive behaviors had increased during periods in life when they had been abstinent from substances.

The participants were characterized by: (1) previous substance misuse; (2) experiences of excessive behaviors; (3) stabile abstinence from substances; (4) established treatment contact in order to ensure support was available if sensitive topics needed to be discussed after the interviews. A senior psychiatrist conducted a Structured Clinical Interview for DSM-IV Axis I Disorders (SCID) (First, Gibbon, Spitzer & Williams, 1997). It was found that the participants earlier in life had misused a range of substances and earlier in life had met DSM-IV criteria for poly substance dependence (American Psychiatric Association, 1995). The disorders that were diagnosed are presented in Table 3.

Table 3. Diagnosis according to DMS, participants *study 2*

Participant	Current DSM-IV Axis-I diagnosis	Global assessment of functioning	History of DSM-IV Axis-I diagnosis
Participant 1	Bulimia, Depression, OCD	50	Depression, OCD, Specific phobia
Participant 2	PTSD	50	PTSD
Participant 3	PTSD, Specific phobia	60	PTSD, Specific phobia
Participant 4	None	75	Specific phobia
Participant 5	OCD	50	OCD
Participant 6	None	65	None

The men who participated in *Study 2* also participated in *Study 3*.

The participants in *Study 4* had been to a 12-step residential alcohol care unit for treatment lasting four weeks. At the time of the interview they were in after care-meetings and had refrained from alcohol for periods ranging from eight months up to several years. Inclusion criteria were: (1) previous alcohol misuse; (2) stable abstinence; (3) established after care. Four men and one woman (see Table 4) participated. They were in employment, had not used illegal drugs, and reported no social problems or psychiatric symptoms.

Table 4. Background characteristics, participants *study 4*

Participant	Age and gender	Education	Relational status	Age of onset alcoholism	Time of abstinence	History of detoxification in hospital
Participant 1	53, Male	College degree	Stable relationship	In his forties	1 year	Yes
Participant 2	55, Male	College degree	Married	In his twenties	8 months	Yes
Participant 3	58, Male	Skilled worker	Stable relationship	In his thirties	5 years	Yes
Participant 4	55, Female	College degree	Married	In her thirties	8 months	Yes
Participant 5	50, Male	Skilled worker	Stable relationship	In his forties	1 year	No

Ethical considerations

The studies were approved by the Regional Ethics Review Board, Sahlgrenska Academy.

The participants in *Studies 2, 3* and *4* were informed that the study concerned their experiences of substance misuse and excessive behaviors, and how they perceived their difficulties and themselves. They were also informed that the interviews would be recorded, that participation was voluntary, and that they were free to discontinue their participation at any time without having to give a reason. The participants were given written information about the study; thereafter they could sign a form to signify their choice to participate, or they could decline. Before the interviews started, the participants were once again informed that they could withdraw their participation, and that they were free to refrain from answering any question they considered too difficult or too distressing.

Sensitive topics were discussed during the interviews, such as shamefulness, shortcomings, childhood abuse, and anxiety-provoking sexual desires. There were

occasions when shame and shortcomings connected to sexuality became so anxiety-provoking that the participants stated that they were unable to talk about it. It would have been unethical to insist on discussing these topics and they were accordingly not further investigated. Therefore the nature of the sexual activities the participants had enacted is to some extent unknown. This is of concern to *Study 3*, and thus to this thesis. Nevertheless, priority was given to the ethical considerations.

Ethical questions also need to be considered with respect to the researcher's position of power (Barron, 1999). Being in the position of power carries the advantage of being the one who defines the area of interest, frames the interview, poses the questions, and judges how the collected data should be analyzed and reported (Brinkmann & Kvale, 2005; Hunter, 2005). This position goes beyond the immediate interview situation and the immediate research study, since the researcher holds the capacity to govern at a distance (Martin & Stenner, 2004). Since research has become viewed as a form of knowledge superior to others, such as practical skills or wisdom, researchers are in a position to influence both how a phenomenon is generally perceived, and how individual clients are encountered in clinical practice (Martin & Stenner, 2004; Schön, 1983; Vrecko, 2010). This position needs to be applied with discretion. It does not seem easy to avid the construction of hierarchal positions between researchers and participants, and the researcher cannot achieve a state of neutrality in which prior knowledge and perspective can be ignored; the position therefore needs to be reflected on (Hunter, 2005). One attempt to handle the hierarchal position might be to strive to achieve an accepting and empathic interview context. It should however be considered that loyalty towards the participants, and the striving towards a caring context, might neglect the power positions that are inherent in the research situation, while these positions rather should be reflected on and approached ethically (Barron, 1999; Brinkmann & Kvale, 2005). In an attempt to balance the positions of the researcher and the participants, the experiences and perceptions of the participants and the difficulties they have struggled with have been the starting points for the work of this thesis. Hence the participants in a sense had some possibility to define how the area of interest should be approached.

Instruments

Study 1 was based on a study-specific questionnaire including questions about pattern of substance use (i.e. age of onset, number of years with substance misuse, which substances that were consumed, whether substance misuse was daily, and whether substances had been

injected intravenously), experiences of excessive behaviors (food intake, sexual activities, gambling, exercise), and whether excessive behaviors had been acknowledged in treatment. The questions regarding substance misuse were formulated in accordance with guidelines for identifying patterns of substance use among clients in substance abuse treatment, developed by the Swedish National Board of Health (Socialstyrelsen, 2006). The questionnaire consisted of 22 questions, both dichotomous and continuous.

Study 2 was based on interviews conducted according to the psychological phenomenological method, in which the participants are encouraged to describe situations in everyday life, and how they perceive and understand the studied phenomenon (Giorgi, 1985; Giorgi & Giorgi, 2008; Smith & Osborn, 2008). Interviews according to this method are initiated with an open question. In *Study 2* the initiating question was "*Could you please tell me about the difficulties with behaviors you described that you have experienced*". The interviews focused on how the participants perceived their excessive behaviors, how they came to enact behaviors despite a conscious wish to refrain, and how they perceived themselves. The participants were also asked to give concrete descriptions of their substance misuse and their excessive behaviors, for example regarding onset, duration, similarities and differences between substance misuse and excessive behaviors, and their consequences.

During the first 15 minutes of the interviews, the interviewer mainly listened and formulated short questions in order to encourage the participants to develop their descriptions. Thereafter, follow-up questions used to encourage the participants to deepen topics that had been presented. Towards the end of the interview, the interviewer also communicated to the participants how the descriptions were perceived, and asked the participants to correct any misunderstandings. Two interviews were conducted with each participant. The interviews lasted for 90 – 150 minutes for each participant, were audio-recorded and transcribed verbatim, including pauses and non-verbal material.

In *Study 3*, the interviews from Study 2 were further analyzed with a specific focus on the participants' descriptions of excessive sexual activities, and how sexual activities had been enacted against a conscious wish to refrain. An additional interview was conducted with each participant, covering sexual functioning, sexual satisfaction, perceptions about sexuality, and relational aspects of sexuality.

Study 4 was based on interviews conducted according to the method (Giorgi, 1985; Giorgi & Giorgi, 2008; Smith & Osborn, 2008) described for *Study 2*. The opening question was "*Could you please tell me about your difficulties with alcohol, and if there are other experiences you find important, feel free to describe them as well*." The interviews focused on how the participants understood their excessive drinking, and how they perceived themselves. The participants were asked to give examples of their alcohol misuse, for example regarding onset, duration, and consequences. They were also asked to describe their thoughts regarding how they came to increase their alcohol use against their better judgment and thereby came to drink more than was tolerable or desirable. Each interviews lasted for 80-90 minutes, and was transcribed verbatim, including pauses and nonverbal material.

Procedure

In *Study 1*, staff members asked clients with no overt psychotic symptoms or other severe psychiatric symptoms if they wanted to participate in the present study by anonymously answering a questionnaire about substance misuse and excessive behaviors. Staff members also administrated written information about the study, and the clients could then chose to decline or to sign an informed consent. Of the 73 questionnaires distributed, 69 were answered, giving a response rate of 95 %. The participants returned the questionnaires and the informed consent anonymously, and in separate envelopes, via a "letter-box" placed at the reception of the unit.

In *Study 2,* information sheets were placed in the waiting room of the treatment unit. Clients with a history of excessive behaviors were asked to participate in an interview study regarding their experiences of these behaviors. Interested clients were informed that they could either contact the author directly, or leave a note at the reception at the treatment unit, and thereafter be contacted by the author in order to arrange the interview.

Study 3 can be viewed as an extension of *Study 2*. The male participants in *Study 2* described their difficulties with excessive sexual activities as their most distressing and shameful difficulty, and therefore they were asked to participate in an additional interview concerning sexuality. Simultaneously they were informed that they were free to decline from participation in this additional interview. No one declined further participation. During

the first contact, the clients were asked to describe what types of excessive behavior they had experienced, and it was also aensured that they had established treatment contact. Experiences of substance abuse and stable abstinence were investigated during the first interview.

Study 4 was presented at after-care group meetings with clients who earlier had been to the residential care unit and who were stably abstinent at the time of the presentation. The clients were informed that the planned study concerned individual experiences of excessive drinking, with a focus on how individuals come to repeatedly drink against their own better judgment. They were asked to contact the author to arrange an interview if they wanted to participate.

Analysis

The results from *Study 1* were analyzed in order to investigate self-reported co-occurrence of substance misuse and excessive behaviors, and in order to compare excessive behaviors reported by men and women. Moreover, it was investigated whether the participants perceived that excessive behaviors had been acknowledged during treatment. Between group differences in frequency, were tested using chi-square goodness-of-fit and chi-square test for independence.

The data from *Study 2* were analyzed according to IPA in which experiences and meaning making are analyzed, remaining close to the participant's narrative, yet enabling interpretation (Larkin, Watts & Clifton, 2006). In IPA, the analysis focuses on understanding how the participants make sense of the studied phenomenon (Smith & Osborn, 2008). IPA admits multiple understandings of the studied phenomenon to become visible. This means that if the participants understand the phenomenon as contradictive and ambiguous, then the contradictions, ambiguity and the multiplicity become visible, and are interpreted and presented in the final work. The themes identified in *Study 2* were interpreted according to the psychodynamic concepts of dissociation and concretization.

In *Study 3*, the data from the interviews in *Study 2*, and the additional interviews, were analyzed according to thematic analysis (Braun & Clarke, 2006). Concepts from psychodynamic relational theory, with specific focus on shame, as well as discoursive

thinking regarding gender and sexuality, as formulated by Hollway (1984), were essential in the interpretation of the themes that were identified. The discourses formulated by Hollway will be presented when the results from *Study 3* are discussed.

The data from *Study 4* were analyzed according to IPA as described for *Study 2.* The themes that were identified were interpreted according to the psychodynamic concept of dissociation and with respect to theories on the multiplicity of the self.

Results and Discussion

Study 1

Pattern of excessive behaviors

In the studied population (*n* = 69), 67 % of the participants reported at least one excessive behavior. Among the participants who reported excessive behaviors, a majority (67 %) reported two or more types of excessive behaviors. Excessive food intake (72 %) and sexual activities (72 %) were most frequently reported, followed by exercise (39 %) and gambling (22 %). There were no significant differences regarding gender and type of behavior, with the single exception that significantly more women reported excessive food intake, compared to men (93 % and 62 % respectively, $\chi^2 = 7{,}03$; $p < 0.01$).

The findings in *Study 1* indicate that a substantial group of clients in substance abuse treatment consider themselves to have experienced difficulties with excessive behaviors. The participants in this study had the opportunity to report their own experience of excessive behaviors. Prior studies have relied on self-ratings according to specified criteria, which have shown that excessive food intake (Cowan & Devine, 2008; Harrop & Marlatt, 2010) gambling (Petry, 2000; Toneatto & Brennan, 2002), and excessive sexual activities (Goodman, 2008; Hartman et al., 2012; Roller, 2007) tend to co-occur with substance misuse. However, the rate of occurrence of substance misuse and excessive behaviors is uncertain (Karim & Chaudhri, 2012; Sussman et al., 2011). One reason for this uncertainty might be that researchers have used different thresholds for defining excessive behaviors as problematic, and another might be that different subgroups have been examined (Ledgerwood & Downey, 2002; Petry, 2000; Sussman et al., 2011; Walther et al., 2012). Another reason for the uncertainty regarding the co-occurrence of substance misuse and excessive behaviors is that studies have primarily examined one specific behavior, not seldom in a population consisting of individuals who misuse one specific substance (Christo et al., 2003; Karim & Chaudhri, 2012; Orford, 2001; Shaffer et al., 2004; Sussman et al., 2011). Hence, the focuses of the studies become so narrow that they do not admit identification of a range of substances and behaviors. S*tudy 1* contributes findings indicating that when a range of excessive behaviors are studied, it becomes visible that a substantial proportion of clients in substance abuse treatment consider themselves having experienced difficulties; not only with one, but perhaps with two or more excessive behaviors.

Clients with co-occurring substance misuse and excessive behaviors might be excluded from research studies and/or treatment programs that have a narrow focus on one of these conditions (Hartman et al., 2012). If treatment is focused exclusively on substance misuse or on certain excessive behaviors, there is a risk that clients will be transferred from one treatment unit to the other since they have difficulties that do not match the narrow treatment focus of the units concerned. Hence, and somewhat ironically, those clients who have considerable treatment needs also might have considerable difficulties in obtaining treatment. Based on the findings in *Study 1* it seems reasonable to suggest that treatment should be adapted to the needs of clients with co-occurring substance misuse and excessive behaviors, and the capacity to offer integrated treatment should be developed.

The two most reported excessive behaviors in *Study 1* were food intake and sexual activities. Previous studies have pointed out that eating disorders among men might pass unnoticed, and that questionnaires regarding eating disorders mainly reflect female concerns and are validated on women, and therefore lack the capacity to acknowledge eating disorders among men (Cowan & Devine, 2008; Nökleby, 2013; Spillane, Boerner, Anderson & Smith, 2004). A tentative understanding of the findings in *Study 1* is that the opportunity the participants had to report excessive behaviors without any specified definitions and thresholds, contributed to the relatively high reporting of excessive food intake among the male participants. Prior studies have also indicated that excessive sexual activities seem to be more common among men than among women (Roller, 2007; Wood, 2007). These studies however tend to rely on criteria that reflect male concern and therefore lack the capacity to identify excessive sexual activities among women (McKeague, 2014). Perhaps the opportunity the participants had to report if they considered themselves as having experienced excessive sexual activities contributed to the relatively high reporting of excessive sexual activities among the female participants.

Moreover, it is possible that the generally high reporting of excessive behaviors in *Study 1* might have emerged because of the opportunity the participants had to report whether they considered themselves having difficulties with excessive behaviors, without further defining criteria for excessive behaviors. It is therefor possible that excessive behaviors therefore were over-reported, since no definitions or thresholds were specified. On the other hand it might be argued that if clients consider themselves having experienced excessive behaviors, this should be taken seriously. This indicates the need to routinely strive to identify and acknowledge a range of excessive behaviors in an integrative treatment.

Excessive behaviors in substance abuse treatment

Among the participants who reported excessive behaviors, 40 % reported that their excessive behaviors had been considered during treatment, whereas 60 % did not report that their excessive behaviors had been considered during treatment. This finding perhaps illustrates that a sub-group of clients in substance abuse treatment experience excessive behaviors that are unknown to the practitioners. When clients have difficulties that are unknown to the practitioners, the treatment the clients receive might be insufficient with respect to their individual needs (Ledgerwood & Downey, 2002; Roller, 2007). Since excessive behaviors might complicate substance abuse treatment, it is important to raise awareness and acknowledge that it is relatively common for clients in poly substance abuse treatment to consider themselves as having experienced excessive behaviors.

Practitioners in the treatment units in which the questionnaire was administrated had no guidelines for identifying excessive behaviors. Despite this, 40 % of the participants reported that excessive behaviors had been acknowledged during assessment and/or during treatment. A tentative thought is that practitioners have awareness about the probability of excessive behaviors, and might try to identify such difficulties among their clients, but perhaps lack adequate procedures for identification. Since 60 % of the participants did not report that excessive behaviors had been acknowledged, it is important to raise awareness about the need to identify excessive behaviors and integrate them in substance abuse treatment. The findings in *Study 1* illustrate the importance of empowering practitioners to develop their capacity to acknowledge excessive behaviors, and, when needed, to provide a treatment that accounts for both substance misuse and excessive behaviors.

Comprehensive understanding

Taken together the findings in *Study 1* indicate that experiences of one or more excessive behaviors should not be viewed as a marginal phenomenon among clients in substance abuse treatment. Excessive behaviors seem to be rather common among clients in substance abuse treatment addressed at clients with poly substance misuse, psychiatric suffering, and potential social problems. Nevertheless, excessive behaviors might pass unnoticed in substance abuse treatment. Considering the treatment needs among clients with such co-occurring difficulties, it is suggested that excessive behaviors should be acknowledged in substance abuse treatment. Therefore procedures for identifying such difficulties need to be

developed, and practitioners should be encouraged to pay attention to both single and multiple excessive behaviors so that such difficulties might be properly addressed and integrated in the individual treatment.

Study 2

When the participants in *Study 2* described their experiences of excessive behaviors, and how they perceived their difficulties and themselves, the following three themes were identified: (1) Avoiding distressing self-experiences, (2) Feelings and relations transformed to enactment, and (3) Comprehension.

Avoiding distressing self-experiences

During the interviews, the participants described how their behaviors had created a momentarily sense of coherence, that they otherwise were lacking. Moreover, they described that through enacting behaviors they could momentarily avoid parts of themselves that were perceived as unaccepted. Excessive behaviors thus seemed to serve two functions, namely to counteract non-coherence, and simultaneously to avoid unaccepted self-parts such as those connected to relational needs and vulnerability. The participants described that substances and behaviors served similar functions. Since both behaviors and substances, served two functions it became difficult for the participants to formulate a straightforward description of their experiences. However, through the interviews, it was possible to glimpse how excessive behaviors had momentarily created a shield from overwhelming self-experiences. Simultaneously, a sense of being self-sufficient, and free of need, was created. This was described by one of the participants in the following words:

> *I tried to disappear in a way. Not feel and be reminded of the circumstances. Not to give a damn. You're totally freed from all your needs. To belong, love. I started masturbating when I was six… got inside myself and there was this core inside of me. Nothing existed outside, it was only me. I can see it was disturbed, but by doing this I could "close around myself."*

In the analysis of the participants' attempts to achieve a sense of self-coherence, and a shield from unaccepted self-parts, the concept of dissociation became useful. It should be noted that it is hard for the individuals concerned to describe dissociation, since dissociation

occurs outside of consciousness (Burton, 2005; Director, 2005). However, they can perceive and describe the effects of dissociation. Hence the processes of dissociation might be perceived and analyzed by a researcher or a practitioner who enters a dialogue with the individual (Billig, 1997).

The selves of the participants seemed organized so that unaccepted self-parts connected to vulnerability were dissociated, and thus a state of self-sufficiency and control was achieved. This organization had an adaptive function, since experiences of non-coherence as well as distress connected to unaccepted self-parts, became mitigated, whereby a fragile sense of coherence was momentarily achieved. However, simultaneously such a self-organization precludes persistent self-coherence, and the individual, on an unconscious level, gives up durable coherence in order to momentarily protect themself from non-coherence and overwhelming distress (Bromberg, 2001, Holmes et al., 2005).

Prior studies show that dissociation has to be acknowledged during treatment so that unaccepted self-parts are not excluded from the dialogue but might be identified and accepted by the client (Bromberg, 2001, Burton, 2005). Thereby, the development of self-coherence is enabled, and simultaneously the risk of enactment of unaccepted self-parts is limited (Kellog & Tatarsky, 2012). Based on these findings from *Study 2* it is proposed that dissociation might be seen as a process that serves two functions. The first function is to disintegrate unaccepted self-parts. Simultaneously, desired self-parts, for example parts that support self-sufficiency and needlessness, are enhanced. The other function is to defend against overwhelming non-coherence. Thereby, misuse creates a fragile and momentary perception of coherence, but simultaneously distressing processes of disintegration are preserved. Thus, dissociation is preferably seen, not as a single process, but as multiple on-going processes that shields the individual from overwhelming suffering.

Feelings and relations transformed to enactment

During the interviews, it came forth that excessive behaviors were not primarily perceived as pleasurable, but rather served to mask suffering connected to unfulfilled affective and relational needs. In addition, substance misuse and excessive behaviors created a sense of control over oneself and one's experiences, by transforming suffering to concrete behaviors. Needs and feelings became transformed into excesses, centered on sensations of eagerness.

> *Feelings were so confusing… sexuality is disturbed… everything was about sex. A very negative use of sex. A lot of cruising, find someone, fuck like hell … I wasn't able to have a real relationship, couldn't unite sexuality with relations. They weren't interesting as human beings. Sometimes I had sexual relations with lots of persons. Called someone, and it was just… then it was time to leave. And sometimes I got eager. I couldn't wait until it was time to meet the other person, so I called someone else and had sex with that person before I went on to the one I called first.*

Throughout the interviews, sexual activities were not described as satisfying or joyful, nor did the participants describe a strong sexual drive. On the contrary, sexuality was described as a distressing part of their lives, their relationships, and themselves. They sensed that a troubled sexuality was their fundamental difficulty. Even though, or just because, sexuality was so bothersome for them, sexuality had become a preoccupation. In connection to questions about quantity, the participants described that they did not only regard the quantity as troublesome, but also their attitude toward themselves, their bodies, and others. Excessive sexual activities as well as other behaviors became a temporary answer to overwhelming feelings, relational needs, vulnerability, self-criticism, and even self-hate. The tendency for enactment was described as being rooted in a constant sense of dissatisfaction, connected to a deeper sense of disappointment, with oneself and with the possibility of fulfilled affective and relational needs. Instead, the participants turned to acts that were connected to the illusion that concrete activities and objects could ease the affective and relational suffering that they considered incomprehensible. One of the participants described this in the following words;

> *It's deficiency of love in your childhood. And that's what I try to satisfy, the emptiness inside"… " A desire, which I satisfy. Or don't… because it's the same frustration. It doesn't work.*

Concretization has been described as a process in which overwhelming affective experiences and relational needs are materialized in concrete perceptual and sensorimotor activities (Stolorow et al., 1987). Concretization arises in response to insufficient or distorted relational interaction that has created both a sense of not comprehending one's own affects and needs, and a sense of non-coherence (Schore 2002; Stolorow et al., 1987).

When the incomprehensible needs and affects are transformed to concrete activities that involve perceptual stimuli, these needs and affects become perceived as controllable, and comprehensible. Concretization might thus be understood as a mode of acting that develops because distress cannot be symbolized (Director, 2002; Fischer, 1988). Instead of symbolizing distress through language, nonverbal communication, or imagination, distress is enacted in concrete activities. In other words, sexual activities, food intake, and other activities are enacted in order to avoid distress, without connection to a sense of satisfaction (Giugliano, 2003; Wood, 2007). This is in line with the participant's descriptions of excessive behaviors as powerful ways to avoid distress which were simultaneously highly distressing in themselves, rather than satisfying activities.

Comprehension

Throughout the interviews the participants described the efforts they had made to comprehend themselves, their substance misuse, and their excessive behaviors. Comprehension was perceived as fundamental for change, and was described as an ongoing process rather than a result of cognitive evaluation or consciously made decisions. Insight into one's shortcomings was described as a prerequisite for the ability to comprehend and change one's life-course. One participant gave the following description of how comprehension and acceptance of shortcomings was fundamental for the ability to counteract non-coherence and change the course of life:

> *One tries to… see a pattern throughout life. I think very much is about how you look at yourself. One tries to change that. But I don't know how it can be done. It was a sense of emptiness. I felt insufficient. Bad. Empty inside. Had a great hunger for something. Was insecure, and things became obsessions. It eases for a while in a way … It was hopelessness. I never saw any possibility to manage anything... When things got serious everything became overwhelming. Everything was black. I had a very negative view of myself.*

The participants gave convincing examples of willpower and capabilities. For example, one participant, who had started to masturbate and use pornography to "*get away from himself*", "*relieve anxiety*" and "*calm down*" when he was 11 years old, explained:

I've learned this. I've refrained from pornography for more than one and a half years. I don't use it. But… it's there… And it's very hard to withstand.

He was now confronted with his suffering, without having developed other ways to "*relieve anxiety*". When talking about pornography as being there, he referred to advertisements for pornography and other sexual activities on the Internet. He described the Internet as a part of everyday and in order to withstand, he limited his time on the Internet, never used the computer in the evenings, and turned the computer off when sexually loaded advertisements occurred. So, he presented ability to resist, but at the same time, he described himself as *"deficient"* and of *"no value",* and with an inclination for destructive behaviors and self-punishment.

This is one example of how the participants described their capabilities during the interviews. Consequently, in one sense they were aware of their capabilities; but at the same time it seemed difficult for them to acknowledge capable parts when they described their perceptions of themselves.

To comprehend oneself, unaccepted self-parts need to be integrated, so that self-coherence might slowly develop (Director, 2005; Kellog & Tatarsky, 2012). Moreover, clients with a history of excessive behaviors and/or substance misuse who are supported to comprehend themselves seem to achieve capacity to refrain from substances and behaviors, and change their life-course (Costorphine et al., 2007; Levine, 2010; Valenti, 2002). When the participants in this study understood their misuse in retrospect they described a lifelong struggle for comprehension. The findings from *study 2* thus contribute with understanding of how struggle for comprehension seem to exist alongside misuse, rather than being a phase that is initiated when abstinence is achieved.

Comprehensive understanding

Study 2 concerned the participants' perceptions of themselves and their difficulties. It should however be noticed that self-perception is a seemingly ambiguous concept. Self-perception is related not only to one's own personal history but also to social structures that shape the behaviors and perceptions of individual men and women (McNay, 2000). Social structures and categories, such as gender and class, are not straightforwardly imposed on individuals, but might rather be seen as sets of norms that are both reproduced and transformed in the lives of individual men and women (McNay, 2000). Social

structures imply positions of dominance and/or subordination, but cannot be seen as deterministic, since individual men and women are capable of autonomous action and change (McCall, 2005; McNay, 2000). Nevertheless it must be acknowledged that autonomous action and change are not mere questions of voluntarism, but rather are driven by both social structural change and unconscious individual processes (McNay, 2000). In order to investigate how social categories shape the individual, and how self-perceptions and behaviors might change and develop, theory and methodology need to account for the inherent reciprocity of the psyche and the social context, and the methodology should have the capacity to investigate the complexity of social life (Magnusson, 2011; McCall, 2005). With the awareness that *Study 2* has a one-dimensional emphasis on personal history and psychodynamic processes concerning the participants' perceptions of themselves, their difficulties, and their capacity for change, the comprehensive understanding of the participants' experiences will now be presented.

Based on what was communicated in the interviews, excessive behaviors seem connected to experiences of disappointment, dissatisfaction, unfulfilled relational needs, and overwhelming affects. The relational needs and affects paradoxically became both dissociated and concretized in excessive behaviors, as well as in substance misuse. Through dissociation and concretization the relational needs were repeatedly avoided and thus became impossible to satisfy, as well as to comprehend.

A tentative thought is that excessive behaviors can be seen as a compromise between two contradictory tendencies; first the longing for fulfillment, and second, the simultaneous belief that fulfillment of needs is impossible, and that one is not worthy of fulfillment. Through the preoccupation with substances, food, sexual activities, and other objects and behaviors, the individual can partially meet the longing for fulfillment. However, by acting in a way and/or to a degree that makes satisfaction impossible, the individual confirms the belief that fulfillment is impossible. Hence, an inner conflict between longing and resignation is acted out. Through this enactment the disappointment and the self-criticism grow, and fulfillment becomes even more out of reach, and a spiral of frustration and dissatisfaction is created and maintained.

Based on the findings in *Study 2*, it is suggested that clients in substance abuse treatment need support to comprehend how their needs and affects have been dissociated, and concretized in substance misuse and excessive behaviors.

Study 3

Two themes were identified when male excessive sexual activities were specifically analyzed. The themes have been labeled after quotes from the participants. The first theme, "*I couldn't even think about it. It was too shameful*," reflects descriptions of sexuality and shame. The second theme, "*I used to think it was normal—hey, I'm a man*," reflects descriptions of how perceptions and expectations about masculinity had influenced the participants and their excessive sexual activities.

"*I couldn't even think about it. It was too shameful*"

The participants described how the quantity of the sexual excessiveness, had been troublesome in itself; for example they described how they had masturbated to such an extent that the penis was sore, and that they had persuaded their girlfriends to engage in sexual activities up to ten times a day. However, they emphasized the qualitative aspects of sexuality and sexual activities and expressed concern about how they had behaved towards prior partners. One participant described this concern with the following words:

> *It's not about how many times I have sex with a girlfriend. It's about how I relate to her. And why I want to have sex. If we just have sex, then it's fine. But if I am using her to feed me with sensations or to feel on top of things… Then I'm way out...*

The participants described that it was hard to understand at which point sexual activities went wrong, and expressed uncertainty regarding their own and others' boundaries, and of who was the "owner" of desire and the sexual initiative. Therefore they could feel like perpetrators, even when they engaged in mutual relationships, and even though the sexual excessiveness was in the past, it was still hard to achieve satisfying relationships, as one participant explained:

> *I become so uncertain…. thinking, "She is also a part of the sex." But who's really? Who has the initiative? I have to comprehend my part of it…. It is hard to talk about this. There's so much shame.*

The participants related how they during childhood had been exposed to a sexual climate in their families. Some of the participants had been sexually abused, in some cases repeatedly. Moreover, they found it painful to think about how they had coerced or persuaded girlfriends to participate in sexual activities that they deep inside did not even want to act out themselves. When asked by the interviewer to explain what kind of activities they referred to, the participants explained how they could brood over whether their former girlfriends really wanted to watch porn, have sex in public places, engage in sexual activities up to ten times a day - or if they wanted to have sex at all, considering the difficulties in the relationship. Furthermore, the participants described that they had tried to avoid thinking of their prior behaviors, and earlier in life had tried to reinterpret behaviors they considered inappropriate, in order to avoid overwhelming shame. They expressed that it was hard to bring the topic up in treatment, even though they wanted to, and they proposed that practitioners should "*be better at reading between the lines".* They sensed a need to have a dialogue about sexual activities that were perceived as shameful, as articulated in the following way by one of the participants:

> *It's unbelievable how much shame there is. Hell, this is heavy stuff. I regret I said it… But I think it's good… It's exactly those things I have to express. To shine a light on… those ghosts… inside.*

Moreover, the excessive sexual activities were described as being connected to relational and affective suffering, and self-criticism, rather than connected to sexual desire or sexual satisfaction. This finding is in line with prior studies showing that excessive sexual activities seem to be connected to underlying affective difficulties, as well as difficulties in establishing relationships (Giugliano, 2003; Levine, 2010; Reid et al., 2009; Roller, 2007; Valenti, 2002; Wood, 2007).

Taken together, the participants sensed that it had been hard to raise the topic of troubled sexuality during treatment. They underlined that practitioners must be attentive to insinuations since it is hard to acknowledge behaviors that one is ashamed of, especially when these behaviors are connected to having violated the boundaries of others. Moreover, the participants suggested that it is important to read between the lines throughout treatment since it might take some time before one dares to mention troubled sexuality. It cannot be presumed that clients express everything that is important to them, and the capacity to listen to what is not being said, has to be developed (Billig, 1997; Gavey, 2005; Hollway &

Jefferson, 2008). This capacity seems especially important with reference to shame, since shame is connected to intense fear of exposure and therefore to avoidance (Kaufman, 1974). While guilt might invoke a striving to make up for what has been done, shame is the experience of being inherently bad as an individual (Kaufman, 1974). It should however be acknowledged that shame and guilt are not mutually exclusive (Schore, 1994). This seems important with respect to the findings in *study 3*. The participants seemed to experience guilt connected to their prior behaviors. In their descriptions of themselves and their difficulties, there was also a fundamental sense of being an unworthy individual and the sexual violation of the boundaries of others were connected to this shameful unworthiness. Therefore, practitioners need to take the first step by asking questions about sexuality, thereby communicating that sexuality and sexual shortcomings are speakable (Shalev & Yerushalmi, 2009). The questions of sexuality, shame, and self-criticism, should be taken seriously, so that clients might be supported to overcome some of their suffering and shame.

"*I used to think it was normal—hey, I'm a man*"

During the interviews the participants described how their excessive sexual activities had been fueled by their perceptions and expectations about masculinity. When asked by the interviewer to expand on such statements, they for example related that they perceived themselves as properly male, in control, self-sufficient, and/or desirable, when they engaged in sexual activities. These perceptions were in sharp contrast to their critical perceptions of themselves as unworthy, insufficient, and unwanted. Moreover, during sexual activities they sensed an assurance of being properly male, and thereby achieved a momentary sense of coherence which otherwise was lacking. They had also perceived that the essence of being male was to be sexually aroused, and ready to engage in sexual activities. This is illustrated in the following quotation:

> "*If I had sex I knew… I was a man, and I knew that I was alive. Like… well… fucking—that is what men do, isn't it?*"

The participants expressed that their views of themselves and of sexuality had been guided by such expectations, which they felt had been destructive for them, as expressed in the following quotation:

For me, it's impossible to be intimate. It is impossible to stay in bed after intercourse, because there's so much shame… I wish I could… I never had real relationships. Either I had a sexual relationship or a more… intellectual relationship. I took the role of the super-sexual man. I just fuck and fuck.

The participants wished they had questioned these expectations earlier in life. They also described how ideas about masculinity had fueled their difficulties in integrating sexuality with mutual relationships, even though they had a longing for intimacy and mutuality. Instead, sexuality became a disintegrated part that came to live its own life.

During the interviews, a wish to escape the restrictive parts of masculinity was articulated. When asked to expand on such statements, the participants for example expressed wishes to be female, or described fantasies of being passive and penetrated, and they could be uncertain regarding whether they perceived themselves as masculine or feminine. One of the participants expressed this in the following way:

I'm so tired of being male, to be constantly occupied with sex ... and I don't know.... This wish to be a woman.... Is it really a wish to be a woman, or is it just that I wish that I didn't have to be a man? Or… the grass is always greener, you know. I have been thinking that maybe I should ask for… sex change. But I don't dare… 'cause I'm not sure if that would be a solution…. Is this wish just a part of this constant dissatisfaction with myself and… everything?

Paradoxically, the dissatisfaction and the shame had fueled a preoccupation with sexuality, and thus sexual activities were repeatedly sought out, despite negative consequences and increasing shame, not only towards sexuality, but also towards themselves and their bodies. The implication for the preoccupation was a sense of being coherent, desired, and in control, when sexual activities were enacted.

Hollway (1989) has presented three discourses about sexuality: (i) the *male sexual drive* discourse, which implies that men are always sexually active and prepared; (ii) the *have/hold* discourse, which implies sexuality as an arena for trading and exchanging "favors" and possibilities; and (iii) the *permissive* discourse, which implies that for both men and women, sexuality is an activity that is performed "for fun," without consequences,

and furthermore is a prototype for pleasure. These discourses seemed to have influenced the participant's views both of themselves and of their excessive sexual activities. For example, the *male sex drive* discourse was reflected in their perception of sexual activities as an assurance of being male. Excessiveness was, in other words, not a goal per se, but a sexualized concretization that created perceptions of self-coherence, control, needlessness, and invulnerability. A bit provocatively, based on the findings in *Study 3*, it can be proposed that some men in an attempt to shield from suffering, vulnerability, and a sense of non-coherence, develop an "I fuck, therefore I am" principle that have a temporary calming effect, but in the long run such an attempt rather increases suffering.

Discourses regarding permissiveness and negotiability have paradoxical demanding aspects since they imply that sexual activities should be enacted without bothering about negative consequences, and since there is an implicit demand to enjoy sexuality (Gavey, 2005; Hollway, 1989; Zizek, 1994). However, the participants knew the suffering that was connected to thoughtless repeated sexual activities without boundaries. They perceived the view of sexual activities as permitted, enjoyable, and negotiable as threatening and demanding rather than liberating and/or comforting as illustrated in the following quotation;

> *People say that everything is normal, that there's nothing to feel ashamed about. But I feel ashamed. So I become ashamed of being ashamed… because I start to think… maybe there's something wrong with me, since I feel ashamed. You can't imagine how confusing it might be.*

Comprehensive understanding

Sexual activities have the capacity to transforms relational needs, vulnerability, overwhelming affect, and non-coherence, into a seemingly controllable question about physical excitement (Coen, 1981; Giugliano, 2003; Reid et al., 2009; Wood, 2007). It also has to be acknowledged that sexual activities are shaped in processes where individual experiences and contextual factors converge, and both men and women are caught up in discourses that limit and complicate sexuality and mutual relationships (Diamond, 2009; Gavey, 2005; Hollway & Jefferson, 1998).

The findings in *Study 3* suggest that the enactment of excessive sexual activities despite a conscious wish to refrain, might be understood as a behavior that is fueled both by intra psychological processes and by contextual factors (Gavey, 2005; Hollway, 1989).

Hence men with a troubled sexuality, should be given the opportunity to discuss their view of masculinity, sexuality, and themselves during treatment. Vulnerability and shame might be highly distressing topics, partly due to discourses regarding masculinity and sexuality, partly due to the nature of shame as a "not wanting to be seen" affect, especially if shame is connected to having violated the boundaries of others. It should however be noticed that in *study 3,* the interviewer was female, and in the same age as the participants. It cannot be excluded that the gender and age of the interviewer influenced the participant's descriptions of themselves and their excessive sexual activities. The gender and age of the interviewer might for example have influenced the participants to reflect on the consequences their excessive sexual activities had on their former girlfriends. With a male interviewer, the participants might have emphasized other aspects of sexuality.

Study 4

Four themes were identified in the analysis of the participant's understanding of their alcohol misuse, and themselves. These themes were: (1) Inherent alcoholism; (2) Personal experiences; (3) Proper me and not-me; (4) Overwhelming demands. In other words, no single description, or understanding, could capture the experience of excessive drinking, or of the participants' perceptions of themselves. Rather, there were several understandings, which existed simultaneously, and these understandings could sometimes seem to be contradictory.

Inherent alcoholism

The participants described themselves as inherently addicted. They sensed that they had a genetic predisposition for alcoholism, and an addictive personality, and that alcoholism was a disease that was out of their control. In other words, they understood their excessive drinking as a consequence of inherent alcoholism, as illustrated in the following quotation;

> *"It's a disease. Just like heart failure or diabetes… I do not feel ashamed for what I have done. It was not me, it was the disease".*

Through viewing alcoholism as a disease, the participant grasped an understanding of themselves and their excessive drinking, and at the same time overwhelming experiences of shortcomings and shame was avoided. Since the disease made them drink excessively, it

became unnecessary to try to understand oneself, as well as to understand the excessive drinking. Through the view of themselves as inherently addicted, the participants sensed that it became possible to focus on the destructive drinking behavior, and refrain from alcohol.

The participants seemed influenced by the view of alcoholism as an identity, an essential part of oneself (Bailey, 2005). Their description of alcoholism as a disease, and an inherent part of themselves, however has to be viewed in light of the 12-step treatment they were involved in. 12-step treatment is a culture with its own terminology and values, and a substantial part of treatment is that each client should admit being powerless to alcohol (Holleran & MacMaster, 2005; Sachs, 2009). Admitting powerlessness does not necessarily mean that substance misuse is viewed as a disease. However, in 12-step treatment, education regarding substance misuse as a disease has become a substantial element (Kellog & Tatarsky, 2012), that might have influenced the participant's view of themselves as inherent alcoholics. It also has to be acknowledged that the view of themsleves as inherently addicted, was calming and supported the participants to concentrate on remaining abstinent.

Personal experiences

The participants also described that their excessive drinking could not be understood unless attention was paid to their life history, and they underlined the importance of relationships, social context, and painful experiences. There were no descriptions of traumatic events. Instead the participants described that certain areas in life became increasingly difficult to handle, until life was perceived as overwhelming and alcohol became a momentary solution. The difficulties could concern a perceived inability to speak out and say no to others, with an accompanying sense of not being true to oneself. Painful experiences concerning difficulties in interpersonal relations, and adverse circumstances both at work and at home, were also connected to the excessive drinking. The importance of personal experiences that were described by the participants, is visible in the following quote:

> *I was really badly treated at work, but I have always been "too nice". I should have said, "don't go further, here's my limit." But that is how I am… I spoke to my boss and the labor union, but I never talked to anyone, for real. I should have raised my voice… Instead, things got worse and I hid everything inside, as I've always done. Then one day, I couldn't cope with it anymore. I just felt*

> *panic when I went to work, and the panic grew. And a friend of mine told me to have a glass of wine to relax. And I tried, and I thought… just for a while…*

Holleran and Macmaster (2005) suggest that even though the 12-step culture influences the client's self-perception, this influence does not mean that clients replace the prior identity with the identity of an addict. The clients rather adopt the identity as an addict, while maintaining their identity as a unique individual with a personal history and a personal set of beliefs, and thus a sense of "biculturalism" develops. The participant's descriptions of themselves as both inherently addicted, as well as unique individuals with personal experiences that could not be neglected, seem to illustrate this biculturalism. Moreover, their descriptions of themselves also illustrate that the self-perception is multiple rather than unitary, and that individuals understand themselves as multifaceted rather than unambiguous (Bromberg, 2001; Burton, 2005; McAdams, 2001).

Proper me and not me

When the participants described their excessive drinking, it came forth that they understood their excessive drinking as an alien part of themselves. They underlined that excessive drinking was not a part of their proper me, neither was excessive drinking accepted by the proper me. The participants further described that they had been raised to behave well, and to be competent, and throughout life they had tried to live up to this ideal. The not me part that acted out excessive drinking was however the opposite of this ideal. Therefore, the excessive drinking was distressing for the competent part that was perceived as the proper me. The self thus consisted of conflicting parts. An alien part had acted out the excessive drinking, and that part regarded excessive drinking as ego-syntonic. Simultaneously, the proper me regarded excessive drinking as ego-dystonic, as described in the following quote:

> *It was like an inner force, which I couldn't control. I went from work… I was going home. But suddenly I was outside the liquor store. The car went by itself… I cannot explain it. I was going home, that was what I was thinking, but there was this force that wanted to have alcohol. I knew… this destructive lifestyle… It wasn't me.*

In both 12-step treatment and popular culture, the self of an addicted individual tends to be described as divided (Holleran & Macmaster, 2005; Kellog & Tatarsky, 2012), and through

this description, the addict is viewed as an unaccepted part of the self. The participants descriptions of their proper me and their "not me" were however not limited to such general formulations. The participants not only termed their drinking as "not me" but also gave concrete examples of their excessive drinking and in these descriptions it became visible how they perceived the drinking as enacted by a "not me" part.

The not-me experiences that were described by the participants were analyzed and understood as processes of dissociation, since the different self-states were perceived and enacted without connection to each other (Bromberg; 2001; Holmes et al., 2005). Dissociation served to separate unaccepted self-states from desired self-states, and thereby the distress that was connected to excessive drinking was mitigated.

Overwhelming demands

The participants also understood their excessive drinking as a response to overwhelming demands. These demands could be connected to both their own expectations on themselves, or to distressing experiences and circumstances such as unreasonable expectations at work, or at home. The demands were connected to a perception that they were not allowed to fail. The participants described that it had been hard for them to admit that they did not have the strength to handle certain situations and they sensed that they could be overly concerned with being competent or complying to expectations from others. Simultaneously, the strife for competence had become a personal characteristic that they appreciated. One participant described this in the following words:

> *I've always been the one that should be very competent. I was raised to be competent. "Look! He's so competent." And I liked it in a way. Deficiencies were not allowed in my family.*

Since the participants had sensed that they were not allowed to fail, they pushed themselves a little more, even though the demands were overwhelming. It was as if giving up, or admitting that their strength was a finite resource, was not an option.

Individuals who misuse alcohol struggle with their self-perception as well as with interpersonal relations, and these struggles imply a paradoxical sense of both specialness and inferiority (Sachs, 2003, 2009). The striving for competence that was described by the participants in *Study 4*, might thus be understood both as striving against inferiority, and as

a striving for a positive self-perception, and recognition by others. However, through such strivings, both self-perception and recognition by others become dependent on achieved competence, and lack of deficiencies, and therefore doubt and insecurity will be constant followers. Thereby, the individual can never be competent enough and the striving for competence, that has a productive and positive element since it creates a sense of ability, in the long run might become a burden for the individual (Kohut, 1977).

Comprehensive understanding

The participants' various understanding of their excessive drinking reflects that understanding and self-perception is a dynamic process that involves different, and sometimes opposing, experiences (McAdams, 2001; Reis 2005). Various understandings of oneself are in other words not inherently troublesome. However, difficulties arise when certain parts, or experiences cannot exist simultaneously, and be brought into a coherent story (Bromberg, 2001; Kellog & Tatarsky, 2012; McAdams, 2001).

When the participants described themselves and their alcohol consumption, it was as if one day they were suddenly alcoholics, and reflections regarding the process of increasing drinking were absent in their descriptions. Interestingly, this absence concerned the aim of the study; namely to understand how individuals against better judgment come to increase their drinking beyond what is perceived as tolerable and desirable. The participants' understanding of their increasing alcohol consumption seemed to be a disintegrated part. In this sense, the story became somewhat incoherent. Therefore the absence was regarded as interesting and was accordingly analyzed and interpreted. One interpretation of the absent understanding of the increased alcohol consumption is that the thought of oneself as an individual who could have hindered the process towards alcohol misuse, but instead gave in to excessive drinking, was overwhelming and therefore became dissociated. Through experiencing drinking as "not me", it was possible to shield from reminders of shortcomings and dissatisfaction with oneself. At the heart of the dissociation and the excessive drinking was a perception that one had to be competent, and live up to demands, both from oneself and from others. This perception had become ego-syntonic, and equated with the proper me. The not me, the addict, consumed increasing amounts of alcohol while the proper me held the judgment towards the addict. In light of these dissociative processes, the enactment of drinking against better judgment becomes understandable.

The connection between dissociation and misuse is established knowledge (Bromberg, 2001; Burton, 2005). However, dissociation among clients with substance misuse who have a history of childhood trauma, and severe psychological difficulties such as overt self-destructive behaviors or personality disorder has been emphasized (Bromberg, 2001; Burton, 2005; Waska, 1998). The findings from *Study 4* indicate that dissociative processes also are important for understanding excessive drinking and self-perception among socially stable clients. Dissociation is hard to identify, since it occurs outside awareness and hence cannot be described by the client (Burton, 2005; Chapman, 1992; Director, 2005). Mild forms of dissociation among clients with alcohol misuse, but no psychiatric symptoms or social problems, might be particularly hard to identify, partly since they are less dramatic, partly since they might pass unnoticed because of unawareness. The findings from *Study 4* contribute with insights in the importance of acknowledging dissociative processes among socially stable clients. The findings also contribute with insight into how hard it might be to admit one's own shortcomings and limited capacity.

It has been suggested that in treatment, integration of the "not me" part should be supported, so that personal deficiencies and shortcomings might be accepted instead of overwhelming and avoided (Burton, 2005; Chapman, 1992; Director, 2002). If shortcomings are accepted they do not necessarily trigger dissatisfaction, and thus shortcomings do not have to be avoided. It might be beneficial to view alcohol misuse among socially stable individuals as a syndrome of shortcomings that have been dissociated. For an individual who lives under the demand to be competent, it is unacceptable to admit deficiencies, and shortcomings. When a "not me" part hold the dissociated experiences, the distance between the ego-syntonic, competent self-part, and the ego-dystonic deficient self-part increases. If such dissociative processes continue they might be a risk of relapse (Burton, 2005; Kellog & Tatarsky, 2012). So, the view of oneself as inherently addicted, and the view of the alcoholic as not the proper me, might be supportive in the early phase of abstinence. However, it seems important that the client is supported to move beyond this view of themself, and to slowly integrate shortcomings and dissociated parts in the self.

Integrative discussion

The main findings from *Study 1-4* will now be integrated and discussed in relation to each other.

The participants who had experienced both substance misuse and excessive behaviors described these conditions as similar to each other, and used the word misuse with respect to both substances and behaviors. Their descriptions of substance misuse and excessive behaviors as similar to each other are in line with research and theories that describe substance misuse and excessive behaviors as different expressions of an underlying tendency to misuse rather than as different phenomena (Costorphine et al., 2007; Fischer & Smith, 2008; Goodman, 2008; Karim & Chaudhri, 2012; Orford, 2001; Shaffer et al., 2004; Volkow et al., 2013). Moreover, the findings from *Study 1* indicated that a substantial group of clients in substance use treatment have experienced difficulties with excessive behaviors. This finding is in line with research that indicates that substances and behaviors might be misused simultaneously and/or interchangeably (Costorphine et al., 2007; Goodman, 2008; Karim & Chaudhri, 2012; Shaffer et al., 2004; Sussman et al., 2011). Therefore, the term misuse will further on be used, with respect to substances as well as to behaviors.

Needs, affects, and dissatisfaction

Based on the findings from *Studies 2, 3*, and *4*, a tentative thought is that misuse might be characterized as a state of need that is enacted in ways that makes fulfillment impossible, and thus implies a spiraling state of deficiency and dissatisfaction. The dissatisfaction concerns the concrete enactment, one's life experiences, and perhaps most importantly, oneself.

This general description of misuse should however not obscure that individuals who misuse substance and/or behaviors have unique experiences and unique perceptions of their misuse and of themselves. In other words, the underlying needs and affects, the ways in which they are enacted, and what the dissatisfaction concerns, might vary between individuals and groups of individuals. The present thesis concerned individuals who had a sense of being unworthy of fulfillment, who had experienced abuse, and were overwhelmed by relational needs, affects, and experiences of non-coherence, as well as individuals who sensed that it was necessary to be competent in order to be worthy of fulfillment and satisfaction. Their varying experiences illustrate that the individual aspects of misuse need to be acknowledged, since individuals with misuse preferably are seen as a heterogeneous

group, even though they share similarities. Based on the findings in this thesis, it is suggested that misuse should be seen as a misguided attempt to handle relational needs and affects, rather than as a disorder. Thereby misuse is understood as a process rather than as a stable characteristic.

When the relational needs of an individual have been insufficiently fulfilled, or even connected to abuse, the desperate need and the dissatisfaction that arise are accompanied by overwhelming affect, non-coherence, and self-criticism (Bromberg, 2001; Fischer, 1988; Schore, 2002). Simultaneously, studies show that experiences of trauma and abuse, as well as unfulfilled relational needs and difficulties in handling affects, are seen among individuals with a range of difficulties and symptoms other than misuse (Costorphine et al., 2007; Stolorow et al., 1987). The replacement of relational needs with concrete use of objects and activities, in an attempt to satisfy unfulfilled relational needs and overwhelming affects, is however specific to misuse. A tentative thought is that concrete use of objects and activities somehow might have been presented, and perceived, as a compensation for relational needs and thereby the individual has developed a preoccupation with consumption, concrete objects, and activities as an imagined solution to suffering.

It has been described that misuse arises when an individual has experienced rewards and powerful sensations to such an extent that the brain becomes "hi-jacked" (Elam, in press; Karim & Chaudhri, 2012). According to this perspective, an individual with a hi-jacked brain cannot appreciate the satisfactions of everyday life, since these are too weak compared to the effects of the substance. Accordingly, it has been said that an individual who has misused pornography and/or has engaged in deviant sexual activities cannot appreciate everyday life sex, since everyday sex is not comparable to the effects of pornography or deviant sexual activities (Goodman, 1998).

The view of misuse as a result of a hi-jacked brain is connected to the presumption that sensations and excitement, are equivalent to satisfaction of needs, and that satisfaction is a question of quantity; the more sensations, the more satisfaction. However, sensations and excitement are not equivalent to satisfaction of affective and relational needs, but qualitatively different (Solms & Turnbull, 2002). One participant described the qualitative difference between sensations on one hand, and satisfaction of affective and relational needs on the other hand, with the following words; *"It* [misuse of substances and behaviors] *doesn't help. The dissatisfaction is constant, because the love system is not connected".* This quotation illustrates how relational needs cannot be satisfied through substances, sexual activities, or any other sensation or excitement, no matter how many or how

powerful they are. Increasing amounts of sensations rather increases the frustration, and thereby the dissatisfaction becomes even more pronounced. It has been argued that clients with misuse need support in identifying, acknowledging, and accepting the relational needs and affects that have been avoided and distorted in the process of misuse (Director, 2005; Fischer, 1988; Kellog & Tatarsky, 2012). It should however be noticed that the participants in *Studies 2, 3*, and *4*, sensed that the misuse has to be terminated, in order to understand the affective suffering and/or make comprehension and change possible. Since *study 1* showed that a substantial proportion of the participants reported excessive behaviors, it seems important to also acknowledge behaviors in substance abuse treatment. Otherwise substances might be substituted with behaviors in repetitive circles of enactment.

In order to understand the avoidance and the distortion of needs and affects, as well as the process of misuse, defense mechanisms should be acknowledged (Burton, 2005; Director, 2005; Kernberg et al., 1989). In *Study 4,* the participant's rejection of thoughts about how they had increased their alcohol consumption was understood as processes of dissociation. A tentative thought is that defense mechanisms were intensified during the interviews with these participants, since they had something to lose if they dived deep into their suffering and shortcomings; namely their view of themselves as competent individuals whose "proper me" rejected drinking. This is understandable since the insight that one is prone to misuse, is a deep wound to one's self-perception (Ramos, 2004). The participants in *Studies 2* and *3,* on the other hand, perceived themselves as full of shortcomings, and their defense mechanisms might have been milder when they during the interview were asked to describe their experiences of misuse and themselves. Thereby, the interview was perhaps not that threatening for them. This interpretation is in line with the relational perspective, which emphasizes that defense mechanisms mitigate distress connected to a suffering self (Director, 2005; Rothschild & Gellman, 2009). From a clinical perspective, it should be noted that defense mechanisms are potential obstacles to the treatment process (Kernberg et al., 1989; Weinryb, 1992; Yeomans & Delany, 2008). Through examining the defense mechanisms that are characteristic of the individual client, potential obstacles to the treatment are identified and thus might be handled in the treatment process.

Troubled sexuality

In *Study 1*, it came forth that 72 % of the participants who considered themselves having experienced excessive behaviors, reported excessive sexual activities. In *study 2* the male

participants described their excessive sexual activities as their most distressing difficulty. The results from *Study 3* illuminated the suffering and shame connected to the male participants misuse of sexual activities. Moreover, the results from *Study 3* indicate that the capacity to meet the needs of clients with a troubled sexuality could be improved. The suffering described by the male participants was connected to an aversion towards sexuality, as well as towards oneself and one's body. Paradoxically, this aversion had fueled a preoccupation with sexual activities and in this process the boundaries of others had been violated. It should be noted that troubled sexuality was not described as an effect of substance misuse, but as a difficulty on its own.

The participants in *Studies 2* and *3* had a history of emotional and physical abuse. They had also been victims of sexual abuse and/or had been exposed to a sexual climate, such as being witness to parent's sexual activities and use of pornography. This finding is in line with prior studies that show that a history of trauma and abuse, should be acknowledged in treatment with clients who misuse sexual activities as well as substances and other behaviors (Bernstein, 2000; Costorphine et al., 2007; Giugliano, 2003). Understanding the influence of traumatic events was beyond the specific aim of this thesis. The participants however underlined that childhood abuse had influenced their excessive sexual activities and their perception of themselves.

The male participants in *Study 3* were also afflicted by their sexual behaviors towards others. They expressed a need to talk about these experiences, but sexuality had been a neglected subject during their treatment and the participants also described that practitioners had not raised questions about troubled sexuality. This is somewhat remarkable since difficulties with excessive sexual activities have gained increased interest both among researchers and practitioners, during the last decades (Goodman, 2008; Hartman et al., 2012; Levine, 2010; Reid et al., 2009; Wood, 2007). It has also been suggested that diagnostic criteria regarding misuse of sexual activities should be defined, in order to achieve knowledge regarding the occurrence, and in order to facilitate identification of sexual misuse (Giugliano, 2003; Goodman, 2008; Hartman et al., 2012).

Sexual misuse is however not a mere question of diagnostic criteria, but a behavior that is connected to affective distress and relational difficulties (Giugliano, 2003; Hartman et al., 2012; Levine, 2010; Reid et al., 2009). Moreover, diagnostic criteria might be counterproductive, since individuals who enact sexual activities excessively might react with resistance towards labeling their behaviors as a disorder (Levine, 2010). The findings from *Studies 2* and *3*, point to a need both to identify, and to acknowledge the meaning of

excessive sexual activities. Moreover, the results point to the importance of acknowledging affective suffering and relational needs, as well as potential aversion towards oneself.

Discourses regarding permissiveness, negotiability, and men as constantly sexually aroused (Gavey, 2005; Hollway, 1989: Lorentzen, 2007), seemed to have influenced the excessive sexual activities described by the male participants. This finding does not imply neglect of individual responsibility. The result from *Study 3* on the contrary shows that the participants were aware of their responsibility, and they expressed a need to address their prior behaviors and experiences in treatment. It is therefore suggested that male clients with excessive sexual activities should be given opportunities to discuss how perceptions about masculinity and sexuality had influenced their view of themselves and their sexuality.

Only one woman participated in *Study 2*. She had been a victim of sexual abuse during childhood, and described that the abuse had influenced her self-perception and her sexual behaviors. She did not describe shame and suffering connected to having behaved inappropriately towards others, but rather described a tendency to participate in sexual activities on the condition of others. This tendency needs to be understood with respect both to her personal experiences and to discourses on sexuality. Gavey (2005) describes how the male sex drive discourse has become so pervasive that women might sense that they have no alternative other than to comply with sexual activities. The influence of discourses on women and female sexuality has not been focused in this study. Nevertheless, it is reasonable to presume that the previously described discourses regarding sexuality and gender, also influence troubled sexuality and excessive sexual activities among female clients (Gavey, 2005; Hollway, 1989). Research on sexual misuse has to a great extent concerned men, and male experiences, even though women are estimated to make up a substantial part of the individuals who have difficulties with sexual misuse (McKeague, 2014). It should be considered that etiology, as well as the meaning of excessive sexual activities, might be different for men and women. (McKeague, 2014). Moreover, it should be considered that women who enact excessive sexual activities might do so in a social context that is controlled by men, and thereby women might encounter considerable risks (Giddens, 1995; Roller, 2007). It seems as if women who misuse sexuality are more concerned with interpersonal aspects of sexuality, and their sexual activities tend to be influenced by the idea that women obtain a worthy identity through male partners and through being desired by men. However it should be considered that both men and women who enact excessive sexual activities tend to experience overwhelming shame, and

paradoxically may seek out sexual activities and encounters in which they reproduce shameful situations (McKeague, 2014).

Excessive masturbation and use of pornography tend to be in focus when sexual misuse is discussed. While such difficulties might be characteristic for male clients, they are not necessarily characteristic for women who enact excessive sexual activities (Levine, 2010; Roller, 2007; Wood, 2007). The focus on activities such as excessive masturbation and use of pornography in research regarding excessive sexual activities might have contributed to the view that excessive sexual activities occur more frequently among men than among women. The male participants in *Study 3* indeed reported excessive masturbation and use of pornography. It should however be noted that the findings from *Study 1* did not show significant differences between men and women regarding reported excessive sexual activities. In *Study 1*, the men and women had the opportunity to report their own experiences rather than answering specific questions regarding excessive sexual activities. This permitted both men and women to report excessive behaviors that were troublesome to them, even though the nature of their excessive behaviors perhaps was not in accordance with behaviors that tend to be in focus in research concerning excessive sexual activities.

Sexual misuse might be accompanied by difficulties with food intake (Corstorphine et al., 2007; McCeague, 2014; Power, 2005). Difficulties with food intake in turn might be connected to body-shaping behaviors such as excessive exercise and restrictive dieting (Gudnadóttir & Gardarsdóttir, 2014; Sussman et al., 2011). Sexual activities, food intake, and exercise concern physical sensations, the body, and bodily appearance. It should be noted that media images concerning the ideal appearance of the body, together with materialistic values, might influence both men and women to perceive that their bodies have a certain value on a market centered on consumption (Gudnadóttir & Gardarsdóttir, 2014). However, media images and materialistic values concerning the body as an object with a certain value however seem to influence young women more than young men (Kacen, 2000: Gudnadóttir & Gardarsdóttir, 2014). A tentative thought is that the view of the body as an object with a trade value, together with the have/hold discourse, which implies sexuality as an arena for exchanging favors, influence sexual behaviors among men and women in both similar and different ways. It thus seems important to pay attention to how men and women perceive their bodies when trying to understand both sexual misuse and other excessive behaviors. Female experiences, and women, have been neglected in studies of sexual misuse (McKeague, 2014). Consequently the experiences of women with sexual

misuse, and how they perceive their bodies, should be investigated. In order to understand the complexity of self-perception and behavioral misuse, such investigations should also acknowledge other excessive behaviors that concern the body.

Clients with excessive sexual activities seem to benefit from a treatment that aims not only at terminating the behavior, but also at understanding the meaning of sexual activities (Levine, 2010; Parke & Guest, 2003; Reid et al., 2009). In line with such findings, the results from *Studies 1, 2,* and *3*, indicate that the individual experiences and perceptions of sexuality should be acknowledged. The women and men in *Study 1* reported excessive sexual activities to the same extent, and prior studies have shown that identification and treatment needs among women with sexual misuse need increased attention (McKeague, 2014; Roller, 2007). Therefore it is suggested that both men and women during treatment should be encouraged to express their views of themselves, of sexuality and of sexual enactment, so that the individual meaning of sexuality is revealed. In this process both potential gender similarities, such as the impact of childhood abuse and shame, as well as gender difference, such as contextual factors and how perceptions of sexuality influence the perspction of oneself, should be acknowledged. When the individual meaning of the client concerned is revealed, the treatment becomes possible to plan according to the needs of the client concerned.

Shame

It has been suggested that shame needs to be acknowledged when understanding troubled sexuality, excessive sexual activities, and treatment needs among male and female clients with such difficulties (Dimen, 2005; McKeague, 2014; Reid et al., 2009; Sachs, 2009; Scheff & Retzinger, 1997; Shalev & Yerushalmi, 2009). In clinical practice, shame must be worked through in order to make it possible for the client to approach questions of responsibility and achieve the capacity to change their life-course (Fischer, 1988; Grosch, 1994; Shalev & Yerushalmi, 2009). The participants in *Study 3* underlined that it is hard to admit sexual shortcomings, since the topic is loaded with shame, especially when the shame concerns enactment with negative consequences for others.

Shame is relevant to acknowledge, not only for understanding excessive sexual activities, but also for understanding and treating substance misuse (Fischer, 1988; Kellog & Tatarsky, 2012; Luoma et al., 2012; Sachs, 2009). Dearing, Stuewig and Tangney (2005) show that shame-proneness is connected to substance misuse and they suggest that since

shame is hard to admit, shame tends to be avoided, and thus might be neglected in substance abuse treatment. Avoided shame cannot be reflected on, and thus cannot constitute a basis for changing one's behaviors (Cook, 1998; Dearing et al., 2005). Studies however indicate that if shame is acknowledged in substance abuse treatment, and clients are supported to accept shame, the treatment outcome is increased (Luoma et al., 2012).

In *Study 4* it came forth that the participants felt ashamed of their drinking patterns, and of having behaved in ways that were the opposite of their ideals. Paradoxically, the participants also related that they did not feel ashamed of what they had done since it was the addict inside them that had enacted the drinking. In 12-step treatment, the striving to bring secrets to awareness, and share them with others might alleviate shame, and this striving is regarded as beneficial for the process towards abstinence (Sachs, 2009). Shame however has to be acknowledged slowly, otherwise shame might be overwhelming and imply a wish to escape from the situation (Cook, 1988; Luoma et al., 2012). The findings from *study 4* indicate that the participants held the addict in them responsible for the shameful behaviors. If clients in substance abuse treatment however are supported to comprehend that it was they themselves who enacted the shameful behaviors, the treatment outcome is enhanced (Sachs, 2009). A tentative thought is that during early abstinence, it might be supportive to place the shamefulness in the addict, thereby hindering shame from becoming overwhelming. However, clients who have achieved stable abstinence need to deal with shame in their treatment, since the acknowledgment of shame supports comprehension and ability to regulate affects, thereby lowering the risk of relapse (Luoma et al., 2012). In line with these findings, and based on the findings from *study 4, i*t is suggested that clients with prior alcohol misuse need support to integrate the disintegrated parts of them self, and accept shameful behaviors as a parts of themselves that might be overcome.

Identification and assessment of excessive behaviors

Clients in substance abuse treatment often struggle with a range of difficulties, all of which are important to identify and integrate in treatment. The needs of the clients are extensive, and so is the waiting time for assessment and treatment. These circumstances are demanding not only for the clients but also for the treatment units, and for the individual practitioners.

Frequently, researchers and policy makers recommend that self-rating instruments covering various difficulties, symptoms, and diagnoses, should be administered to clients before, during, and after substance abuse treatment (Christo et al., 2003; Harrop & Marlatt, 2010; Keaney, 2006; Socialstyrelsen, 2014). However, it might be questioned whether it is possible for practitioners to administer self-rating instruments covering the many difficulties that occur among clients in substance abuse treatment. Nevertheless, it must be acknowledged that excessive behaviors seem relatively common among clients in substance abuse treatment, and might pass unnoticed, be risk factors for relapse, and furthermore are connected to considerable negative consequences (Costorphine et al., 2007; Harrop & Marlatt, 2010; Ledgerwood & Downey, 2002; Petry, 2000; Shaffer et al., 2004; Toneatto & Brennan, 2002). Moreover, identification is a necessary first step towards integration in treatment. Therefore, treatment units should be supported to develop a clinical practice for identifying excessive behaviors.

Based on the findings in *Study 1*, it seems like a possible way to identify difficulties with excessive behaviors, is to ask the client a few specific questions regarding excessive behaviors. It is possible to use a short questionnaire, as in *Study 1*. It is likely also possible to formulate specific questions about excessive behaviors in clinical interviews, since both written and verbal questions are appropriate to use during assessment (Keaney, 2006). If questions about excessive behaviors become routine in substance abuse treatment, there is a decreased risk that such difficulties will pass unnoticed. Moreover, if questions about excessive behaviors become a natural part of substance abuse treatment, the clients are offered an opportunity to acknowledge excessive behaviors without having to bring up sensitive topics themselves. This is beneficial, since excessive behaviors might be shame provoking, as in the case of sexual activities (Dimen, 2005; Reid et al., 2009; Scheff & Retzinger, 1997; Shalev & Yerushalmi, 2009).

The participants in *Study 2* had been exposed to maltreatment and abuse during childhood, described intense self-criticism, had enacted self-destructive activities and had also been in contact with both health care and social services. Yet, during SCID-1 interviewing (First et al., 1997), these overwhelming experiences and life circumstances were not identified. During the open-ended research interviews these experiences and life circumstances could however be identified. Therefore it is suggested that careful clinical interviews, focused on understanding the experiences and difficulties of the client, should be part of the assessment process in substance abuse treatment.

If an excessive behavior is identified, further assessment should aim at understanding the nature of the enacted behavior, the self-perception of the client concerned, and moreover to investigate whether additional excessive behaviors are present, since excessive behaviors might accompany each other. Furthermore, it seems important that practitioners are capable of reading between the lines and perceiving hints from the clients about excessive behaviors, not only during assessment but also throughout treatment.

Clinical practice and research

Research and clinical practice are sometimes viewed as separate domains (Falkum, 2008; Keen, 2012). However, it has been suggested that the division between research and clinical practice is arbitrary, and that integration of theory, research, and clinical practice increases the possibility to achieve knowledge of natural validity (Frie, 2010, Keen, 2012; Schön, 1983). Research tends to concern topics that are clearly defined, whereas clinical practice concerns ambiguous situations that escape methods aimed at handling well-defined difficulties (Sharpless & Barber, 2009). Moreover, clinical practice seldom concerns the solving of isolated difficulties, but the main task is rather to understand what the difficulties are all about (Schön, 1983). Therefore, theory, research, and clinical practice might be seen as domains that represent different forms of knowledge that should be integrated with and enrich each other. From such a perspective, the moving front and back between theory, research, and clinical practice is perpetual, and through this moving front and back, insights, knowledge, and development become facilitated. From such a perspective methods are not the main focus of attention (Keen, 2012). The methodologies, whether they are questionnaires, semistructured interviews or openended dialogues, are rather ways to investigate the studied phenomenon, and/or understand the individuals concerned (Keaney, 2006). *Study 1* is an example of how quantitative data from a questionnaire might be used to investigate the experience of clients concerned.

Clinical research and practice also requires a moving back and forth between the unique experience of the client concerned, and knowledge concerning the general phenomenon of interest (Keen, 2012; McAdams, 2001; Schön, 1983; Sharpless & Barber, 2009). Generalized recommendations based on results from studies that have investigated the outcome of certain treatment modalities might be beneficial for providing treatment that likely is appropriate for a considerable part of the clients concerned. General knowledge or recommendations are however not sufficient in the planning of treatment for an individual

client, with unique needs, personal characteristics, relations, and social circumstances, and consequently, the practitioner has to evaluate the unique situation, and what should, or should not, be done (Falkum, 2008; Keaney, 2006; Schön, 1983). It should be noticed that clinicians both an explicit and an implicit power position in relation to their clients, and need to avoid presenting themselves as authorities and thereby fall into the expert trap and referring to principles or what "research says" (Edwards, 2013). To counteract this risk, the clinician needs to be able to identify with others and their varying experiences, and perceive the dilemmas of the individual client rather than relying on principles. It is thus of clinical importance to focus on the individual perceptions and unique experiences of the individual client (Hunter, 2005).

One intriguing question is whether it is possible to understand the perceptions, experiences, and lived situations, or the needs and affects of another individual. After all we cannot know what the other needs, feels, perceives, or haa been through. Still, there are researchers who view the understanding of individual perceptions and experiences as fundamental for psychology both as an academic and as a clinical discipline (Frie, 2010; Friedman, 2002; Keen, 2012). The dialogic philosophy has considerable significance for researchers working in this tradition (Friedman, 2002). According to dialogic philosophy, dialogue is the core of human existence, and through engagement in dialogues, and ongoing reflection, the capacity to understand unique situations, is developed (Berman, 1997; Falkum, 2008; Friedman, 2002; Schön, 1983).

When dialogue and reflection are at the center of attention, in research and/or in clinical practice, there is increased possibility to understand the other. Without doubt, there is an inherent unknowable element in the dialogic relation, as well as in treatment, which has to be acknowledged, handled, and perhaps most importantly, accepted. It is not possible to precisely define and/or measure the experience of the other. However, it is possible to communicate perceptions, experiences, and situations that are lived through in everyday life. Such phenomena are not easily defined or measured. Yet, they are of significance both for the individuals concerned and for theoretical understanding, and therefore need to be acknowledged in research, theory, and clinical practice.

Limitations

There certainly are limitations to the present thesis. The relatively low number of participants limited *Study 1*, which therefore should be regarded as a pilot study. Moreover,

the questions on whether excessive behaviors had been acknowledged during assessment and treatment should be further elaborated in order to understand how identification could be further supported. Another limitation was that the questions regarding excessive behaviors did not concern age of onset, number of years with excessive behaviors, any quantification of excessive behaviors, or their consequences. If the questions had been elaborated with respect to such characteristics, the study could have deepened the knowledge about excessive behaviors among clients in substance abuse treatment. On the other hand, the main aim of *Study 1* was to investigate the co-occurrence of substance misuse and excessive behaviors from the perspective of the participants, and the findings indicated that a majority of the participants had experienced excessive behaviors.

Another limitation is that the data from *Studies 2, 3*, and *4* reflect only the experiences of those who were interested in participating. It is therefore uncertain whether the themes that were identified as important for the participants also apply to other clients in substance abuse treatment. In addition, the low number of participants facilitated in-depth analysis at the cost of generalizability. Moreover, the results might have been influenced by the treatment that the participants engaged in, namely supportive contact regarding *Studies 2,* and *3*, and 12-step treatment in *Study* 4. The experiences described by the participants did however seem important for them. Thus, the results contribute with insight in experiences that might be important to consider when encountering clients in substance abuse treatment. It should be noticed that even though the participants in *Studies 2* and *3* perceived that misuse of substance and behaviors were similar to each other, other subgroups of clients might perceive excessive behaviors from other perspectives.

In this thesis, excessive sexual activities and shame among men was specifically investigated. Excessive sexual activities and shame among women was however not investigated. This is a limitation, especially since there were no significant difference between men and women concerning the self-reported occurrence of excessive sexual activities, as reported in *Study 1*.

The methodological design concerning *Study 3* might also be seen as a limitation. Analyzing interviews a second time might imply that the second analysis becomes biased. Also the additional interview that was conducted in *Study 3* might have been biased by the findings in *Study 2*. On the other hand, the methodological design illustrates the aim of understanding the experiences of the participants. It might be seen as beneficial to start with a general perspective on the occurrence of the studied phenomenon, as in *Study 1*, followed by an investigation of how the individuals concerned experience the studied phenomenon,

and from their descriptions investigate specific areas that the participants expressed concern about.

The studies are also limited by the inability to live up to the full experiences of the participants. For example, some experiences and personal characteristics had to be excluded in order to safeguard the privacy of the participants. Moreover, it was impossible to pay proper attention to the variety of concerns that were emphasized by individual participants since a thesis necessarily has to be somewhat narrow in its scope.

The contextual perspective in *Study 3* could have also been emphasized also in the other studies, as well as in the thesis as a whole. Contextual factors does not only influence sexual activities and perceptions about gender, they also influence for example individual's perceptions of themselves as clients and social beings. An area that was not acknowledged was the potential impact of societal status. The relative social marginalization of the participants in *Studies 2* and *3,* and the social stability of the participants in *Study 4* might have influenced their perceptions of themselves and their difficulties.

To frame a thesis in a perspective that prioritizes relational needs, affects, and self-perceptions might also be limiting. The relational perspective has been criticized for not paying attention to sexual and aggressive drives, inner conflicts, and the symbolic content of symptoms and behaviors, thereby pursuing a conciliatory form of psychoanalytic theory. Taking an alternative psychoanalytic perspective could have admitted for an examination of for example sexual and aggressive drives and the symbolic content of misuse. Furthermore, the focus on relational needs and affects might be perceived as empathic and thoughtful. Needs and affects should however be approached with discretion, since the striving to understand otherwise might be sentimental or even invasive.

In this thesis, the co-occurrence of substance misuse and excessive behaviors, and the perceptions and experiences of misuse of substances as well as behaviors, was investigated. There is no established terminology regarding excessive behaviors, and during the work of the studies, different terms have been used. This gives a somewhat scattered impression that the author hopes that the reader might tolerate. Moreover, the focus on a range of substances and behaviors implies difficulties in studying the impact and the meaning of specific substances and behaviors; this has to be regarded as a limitation, since the knowledge might become somewhat superficial. On the other hand, acknowledging a range of substances and behaviors gives the opportunity to study misuse as a phenomenon with varying expressions and interchangeable objects.

Final clinical reflections and future studies

Some reflections on how misuse of substances and behaviors might be approached in clinical practice will now be presented. Hopefully, these suggestions will support practitioners to avoid clinical failures such as those described in the clinical vignette, and they may also have value for researchers interested in individual experiences of misuse.

In order to identify excessive behaviors, it is suggested that one has to be comfortable with a respectful "not-knowing" approach towards the client. Since excessive behaviors seem hard to describe, practitioners should be prepared to maintain this approach during treatment. In other words, identification might be viewed as an approach, rather than as an initial phase that is conducted and terminated and followed by treatment.

It also seems important to listen to what is not being said, and to develop the capacity to expand on subjects that the client initiates or insinuates. As researchers and practitioners we need to read between the lines, to quote one of the participants, and perceive processes that are unconscious, partly conscious, or straigtforward avoided, even among ourselves. Dissociation should be specifically addressed so that dissociated parts of the self might be identified and made possible to integrate in the treatment dialogue.

It seems specifically important to be receptive about troubled sexuality, and prepared to respectfully discuss the less appealing sides of sexuality, including potential violations of the boundaries of others. When doing this, it is important to acknowledge the influence of contextual aspects of sexuality, shame, and gender.

Misuse seems to be a state of deficiency and dissatisfaction. Relational needs and affects, and how they have become dissociated and concretized in misuse, should therefore be examined. In clinical practice, it seems important to support the client to de-concretize relational needs and affects. Practitioners in substance abuse treatment should be aware of processes that might fuel concretization and enactment and rather develop an element of thoughtfulness that hinders impulsive enactment.

The findings from *Study 1* show that a substantial group of clients in substance abuse treatment have experiences of one or more excessive behaviors. The practitioner should acknowledge that a terminated substance misuse might reappear in a behavioral misuse that in turn needs treatment. Of course, this has to be done without losing focus on the substance misuse. In this process, the clients should be supported to comprehend themselves and integrate unaccepted self-parts. Thereby, they might slowly move towards

an experience of self-coherence which seems to protect against misuse of both substances and behaviors.

These clinical reflections point to areas that seem important to develop in future research. It is therefore suggested that future studies should specifically address questions of troubled sexuality and excessive sexual activities and misuse, both from a gender perspective specifically focusing on women, and with respect to shame. Such knowledge about troubled sexuality could support the capacity to integrate questions of troubled sexuality among male and female clients in substance abuse treatment. Moreover, the study concerning the self-reported co-occurrence of substance misuse and excessive behaviors should be repeated with a larger sample and more detailed questions. Dissociation among socially stable clients should also be further examined. More specific, studies concerning how 12-step treatment could be combined with interventions aiming at supporting integration of dissociated parts of the self would contribute to clinical practice. Studies also need to acknowledge treatment needs among clients with a range of excessive behaviors.

* * *

One important question remains as the work of this thesis is about to be concluded. How would I, as a clinical psychologist, approach the clients that were described in the clinical vignette, after having had the opportunity to investigate misuse as a broad phenomenon?

I think I would have approached the clients with a more attentive attitude. I would have asked them whether they sensed that they had a tendency to consume "too much" of other substances, objects, or behaviors than the ones that were known. I would have maintained this attentive attitude, and hopefully also listened more to what was not being said.

Moreover, I am now more aware of the importance of listening to how the clients perceive themselves, and the importance of acknowledging how a demanding, criticizing, or even self-hating view of oneself, can move an individual to enact behaviors beyond what is perceived as desirable or tolerable. In this process I would acknowledge the influence of contextual factors and perceptions about gender. I would also acknowledge that a seemingly positive development might scaffold both excessive behaviors and profound self-doubt. I would have tried to support the clients to understand their destructive tendencies, shortcomings, and negative life-experiences. Simultaneously, I would have tried to support them to integrate their capabilities into their comprehension of themselves. I would not

neglect the impact of aggressive and sexual drives and unconscious motives, and I would have asked for adequate supervision in order to reflect on, and handle, my own reactions towards the clients.

However, to be honest, I am unsure what I would and should have done. Perhaps, being unsure is a good start. It makes you ask.

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I

Co-occurring self-reported behavioral problems in a Substance use disorder (SUDS) treatment population: Treatment perspective

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Abstract

Both research and clinical experience indicate that individuals with substance use disorders (SUD) may also experience problems with excessive food intake, sexual activity, exercise and gambling. Such behavioral problems cause individual suffering and might also complicate substance abuse treatment. In clinical practice, behavioral problems however seem to escape identification. Through the use of a questionnaire, this study investigated whether patients in substance abuse treatment considered themselves having experienced behavioral problems, and whether behavioral problems had been acknowledged during treatment. 69 individuals in substance abuse treatment answered the questionnaire. 67 % of the participants reported behavioral problems, predominantly two or more behaviors. 40 € of the participants reported that their behavioral problems had been acknowledged in treatment. Based on these findings, it is suggested that treatment units should be prepared to identify behavioral problems, and meet the treatment needs of patients who experience one or several behavioral problems.

Keywords; SUD, treatment, behavioral problems, excessive behaviors, assessment

It is well known that individuals with Substance use disorders (SUD) might suffer from psychiatric symptoms such as anxiety and depression (Keaney, 2006; Petry, 2000). In clinical practice, the co-occurrence of SUD and psychiatric symptoms seem to be acknowledged and identified through both clinical interviews and questionnaires (Keaney, 2006). It has also been observed that individuals with SUD may experience problems with excessive food intake, sexual activities, exercise, and gambling (Christo et al., 2003; Goodman, 2008; Holden, 2010; Plant, Miller & Plant, 2005; Potenza, 2006). Studies have shown that such behavioral problems tend to complicate treatment and impair the treatment outcome regarding substance use. For example, Ledgerwood and Downey (2002) have shown that patients in methadone treatment, who also engaged in pathological gambling, were more likely to relapse in substance abuse, and more likely to drop out from the program, compared to patients without pathological gambling. In line with these results, Toneatto and Brennan (2002) found that pathological gambling was a risk factor for relapse in substance abuse, and therefore gambling should be identified and acknowledged during substance abuse treatment. It is important to identify patients with behavioral problems, since these patients likely benefit from a treatment that focuses on the SUD and the behavioral problems simultaneously (Christo et al, 2003; Ledgerwood & Downey, 2002; Plant et al., 2005).

Studies have however found that behavioral problems might pass unnoticed in clinical practice (Cowan & Devine, 2008; Harrop & Marlatt, 2010; Petry, 2000). Also clinical experience indicate that it is hard to identify behavioral problems and that behavioral problems might occur among patients in substance abuse treatment without staff members being aware of the co-occurrence. One difficulty with studying occurrence of behavioral problems is the lack of consensus regarding how such problems should be defined (Giugliano, 2006; Orford, 2001; Schuckit, 2013). The most widely used term is addiction, and proponents

for this term argue that behavioral problems share characteristics such as craving, withdrawal symptoms, and increasing tolerance with substance addiction (Mudry et al, 2011; Potenza, 2006). Moreover, in DSM-5, excessive gambling is included in the chapter "Substance-Related and Addictive Disorders". It should however be noted that excessive exercise, food intake, and sexual activities are not included in the DSM-5, and the term addiction is not established for such conditions (American Psychiatric Association, 2013; Schuckit, 2013). There are also researchers who argue that the term addiction should be used cautiously since it might imply a medicalization of human behavior (Vrecko, 2010). With awareness about the discussions concerning definitions, the term behavioral problems is used in this work.

Co-occurrence of substance use disorders and behavioral problems

Studies that investigate behavioral problems among patients with SUD have come to diverse results regarding the rate of co-occurrence. For example, Ledgerwood and Downey (2002) investigated probable pathological gambling in a methadone maintenance population, and found that 17.7 % met criteria for probable pathological gambling. Petry (2000), on the other hand, investigated problematic gambling among patients with SUD, who used a range of substances, and found that 24 % met criteria for probable problematic gambling. One reason for the diverse results regarding occurrence of behavioral problems, might be that researchers have investigated different subgroups, and behavioral problems might be more frequently occurring in some populations than in others. For example, men report higher occurrence of excessive gambling (Svensson, 2011) and sexual activities (Goodman, 2008) compared to women. In an overview article concerning behavioral problems, Sussman et al. (2010) estimated a coexistence of 40 % for SUD and sexual addiction. They did not locate any studies that investigated SUD and exercise addiction. Concerning food intake, it has been reported that up to 46 % of women in substance abuse treatment have concurrent eating

disorders (Cohen et al., 2010; Harrop & Marlatt, 2010), while eating disorders among men with SUD is more uncertain.

Substance abuse treatment and behavioral problems

It has been proposed that substance abuse treatment needs to be adapted to the individual patient and his/hers self-perception and difficulties (Larkin & Griffiths, 2002; Sachs, 2009). In order to provide an accurate treatment, practitioners therefore need to balance general knowledge concerning SUD and behavioural problems, with an understanding of the unique patient (Kellog & Tatarsky, 2012; Levine, 2010). The present study is conducted from the perspective that in clinical practice, patients own perceptions of their problems should be taken seriously, and treatment should be planned in accordance with their perceptions.

The purpose of the study thus was to investigate whether patients in substance abuse treatment perceived that they experienced co-occurring behavioral problems and whether these problems had been addressed during treatment. Patients in substance abuse treatment were therefore asked to report if they considered themselves having experienced behavioral problems regarding food intake, sexual activities, exercise, and/or gambling, by answering a study-specific questionnaire. The reason for focusing on these behaviors was that they are, according to Orford (2001), the “core addictions”. Where applicable the participants were also asked whether their behavioral problems had been acknowledged during treatment.

Aim

The aim of the present study was to investigate whether patients in substance abuse treatment considered themselves having experienced co-occurring behavioral problems (food intake,

sexual activities, exercise and/or gambling), and if behavioral problems had been acknowledged during treatment.

It was hypothesized that significantly more participants would report behavioral problems compared to not reporting behavioral problems. It was also hypothesized that among participants reporting behavioral problems, significantly more participants would report two or more behaviors compared to reporting one behavior.

Furthermore, it was hypothesized that behavioral problems would pass unnoticed in clinical practice, so that significantly more participants would report that behavioral problems had not been acknowledged during treatment, compared to reporting that behavioral problems had been acknowledged during treatment.

Method

Participants and procedure

The participants were in substance abuse treatment when the questionnaire was answered. The treatment units belong to the Swedish health care and social system and are specialized in treating patients who meet criteria for SUD (American Psychiatric Association, 2013), and use a variety of substances (i.e. alcohol and illicit drugs). The participants were either in inpatient or outpatient settings. Since the treatment units belonged to the same organization, the participants who were in inpatient setting could have been/could be transferred to the outpatient setting, and vice versa.

The study was approved by the Regional Ethics Review Board, Sahlgrenska Academy. Staff members asked patients if they wanted to participate in the present study, by answering a questionnaire about substance use and behavioral problems. Staff members also

administrated written information about the study. The patients could thereafter choose to participate or to decline, and were informed that if they wanted to participate, they were free to discontinue their participation without giving reasons for this. Patients with severe psychiatric problems, such as acute psychosis, were excluded. Out of 73 distributed questionnaires, 69 were answered. The response rate was accordingly 95 %, consisting of 50 men (72 %) and 19 women (28 %). The mean age in the population (n = 69) was 34 ± 8 years.

Questionnaire

The study-specific questionnaire consisted of 22 questions. The first part of the questionnaire focused on substance use and was developed according to guidelines for identifying pattern of substance use among patients in substance abuse treatment (Socialstyrelsen, 2006), developed by the Swedish National board of Health. The questions were formulated in the following manner: *How old were you when you started experimenting with substances?*; *How many years have you had a problematic substance use?* The participant also reported the frequency of the substance use, by reporting if he/she typically used substances every day or 1-6 days a week. Participants could also report up to three primary substances he/she had used. In the second part of the questionnaire, the participants could answer whether they considered themselves having experienced excessive food intake, sexual activities, exercise and gambling. The variables were dichotomous (yes/no) and the question was formulated in the following manner: *Have you experienced some of the following excessive behavioral problems? You may select more than one behavior.* Participants who reported behavioral problems also answered the third part of the questionnaire. It consisted of questions regarding whether staff members had paid attention to behavioral problems, and/or whether the participants considered themselves having received treatment regarding behavioral problems.

Statistics

Between-group comparisons concerning reported behavioral problems were performed by using chi-square (χ^2) for goodness-of-fit. Differences between male and female participants with reported behavioral problems were analyzed using χ^2 test for independence.

Results

For the total sample (n = 69), age of onset regarding experimentation with substances was 14 ± 4 years. Age of onset concerning regular substance use was 17 ± 5. Mean number of years with regular substance use was 14 ± 9. A majority of the participants (97 %) reported daily substance use, and 94 % reported having used at least two illegal substances. The most reported substances were: non-prescribed medicaments (71 %), opiates (52 %), cannabis (48 %), amphetamine (35 %) and alcohol (33 %). More than half of the participants (58 %) had administered substances intravenously. At the time of the study, the reported mean number of months with abstinence was 3.

Descriptive data regarding pattern of substance use for participants with, and without, reported behavioral problems is shown in Table 1.

Self-reported behavioral problems

Out of the total sample (n = 69), 67 % (n = 46) reported at least one behavioral problem. Among participants who reported behavioral problems, 67 % considered themselves having experienced two or more behavioral problems. There thus was support for the hypothesis that significantly more participants would report behavioral problems. Analysis showed a significant difference in the current sample, χ^2 (n = 69) = 7.67, $p < .01$. There was also support for the hypothesis that among those who reported behavioral problems, significantly more

participants would report two or more behaviors. Analysis showed a significant difference in the current sample, χ^2 (n = 46) = 5.57, $p < .05$.

Behavioral problems were reported by 62 % (31/50) of the men, and 79 % (15/19) of the women (*ns).* The reported type of behaviors, and the distribution among men and women, is shown in Table 2. Among participants who reported behavioral problem, food intake (72 %) and sexual activities (72 %) were predominant, followed by exercise (39 %) and gambling (22 %). Significantly more women reported food intake, compared to men (93 % and 62 % respectively, χ^2 = 7,03; $p < 0.01$).

Behavioral problems in substance abuse treatment

Among the participants who reported behavioral problems 91% (n = 42) also answered the questions regarding whether their behavioral problems had been acknowledged during treatment. Out of those 42 participants, 17 (40 %) reported that behavioral problems had been acknowledged, whereas 25 participants (60 %) did not report that staff members had paid attention to behavioral problems or that they had received treatment for behavioral problems (*ns*). The hypothesis that significantly more participants would report that behavioral problems had not been acknowledged during treatment was thus not supported.

Discussion

In the present study, 67 % of the participants considered themselves having experienced behavioral problems. The majority of those participants reported two or more behavioral problems. This is a rather high co-occurrence, compared to previous studies regarding SUD and behavioral problems (Harrop & Marlatt, 2010; Petry, 2000; Sussman et al., 2010). The opportunity the participants had to report if they had experienced behavioral problems,

without taking suggested diagnostic criteria into account, might lead to an overestimation. On the other hand, it could be argued that if patients in substance abuse treatment experience behavioral problems, this should be taken seriously.

One important question is whether the participants are representative for patients in substance abuse treatment. Characteristics of patients in substance abuse treatment in Sweden are relatively well known through the National Board of health (Socialstyrelsen, 2006). The participants in the present study are compatible with national data concerning for example age, age of onset, proportion of men and women and daily substance use. Considering the relatively high proportion of opiate use, daily substance use, and poly substance use, it should be observed that the participants represent a subpopulation with severe substance use.

Multiple behavioral problems

The results indicate that experiences of behavioral problems among patients in treatment due to severe substance use are no deviation. Furthermore, a significant part of the participants who reported behavioral problems, reported two or more behaviors. While bearing in mind that a substantial proportion of the participants in this study reported a range of behavioral problems, each behavior that was investigated will now be briefly discussed.

Food intake

In the present study almost all women who reported behavioral problems (93 %) reported excessive food intake. Furthermore, 62 % of the men who reported behavioral problems, reported excessive food intake. It has been highlighted that problems with food intake among men might pass unnoticed (Cowan & Devine, 2008; Nökleby, 2012; Spillane, Boerner, Anderson & Smith, 2004). The result from the present study is interesting since it shows that

excessive food intake seems to be frequently experienced by women as well as men in substance abuse treatment. So, although the result shows a significant difference between men and women regarding food intake, such problems should not only be viewed as a female condition.

Sexual activities

In the present study, 72 % of those who reported behavioral problems, reported excessive sexual activities. Such problems thus plausibly concern a substantial part of patients with SUD and therefore needs to be acknowledged. However, it is a delicate task to identify and assess a troubled sexuality and it should be noticed that sexuality is a complex phenomenon, which serves different emotional and relational needs both within and between individuals, and a troubled sexuality tend to be multifaceted, rather than easily defined (Bancroft & Vukadinovic, 2004; Dell'Osso et al., 2006; Giugliano, 2006). It is therefore suggested that clinicians are encouraged to empathetically raise questions of sexuality, and if problems are revealed, to acknowledge them in treatment.

Exercise

There is a lack of studies concerning problematic exercise among patients with SUD (Sussman et al., 2010), even though exercise is mentioned when co-occurrence of SUD and behavioral problems are discussed (Christo et al., 2003; Plant et al., 2005; Shaffer et al., 2004. It should be noticed that exercise have both positive and negative effects on personal health, and it might be hard to know the difference between commitment and excessiveness (Allegre, Souville, Therme & Griffiths, 2006). Furthermore, exercise might be performed for different reasons, for example in order to compensate for excessive food intake, or in order to refrain from substances (Plant et al., 2005). Nevertheless, in the present study a substantial proportion

of the participants reported problematic exercise, so this relatively unexplored area needs to be addressed in future studies, as well as in clinical practice.

Gambling

In the present study 22 % of the participants reported problems with gambling. Those who reported problematic gambling were predominantly male. The reported rate is somewhat low compared to the reported food intake, sexual activities and exercise, but in line with previous research (Ledgerwood &Downey, 2002; Petry, 2000). The fact that gambling was the least reported behavior does not mean that gambling problems among patients with SUD, or the suffering connected to gambling, should be overlooked. The importance of identifying excessive gambling, on the contrary, seems important since problematic gambling tend to complicate substance abuse treatment (Grant & Potenza, 2005; Toneatto & Brennan, 2002).

Acknowledging behavioral problems in substance abuse treatment

Results from this study could not confirm the hypothesis that behavioral problems tend to pass unnoticed in clinical practice. This is somewhat surprising since previous studies have indicated that behavioral problems tend to escape identification. Even though there certainly were participants who reported that their behavioral problems had not been acknowledged during treatment, it seemed as if staff members had capacity to consider behavioral problems. Interestingly, staff members in the treatment units in which the questionnaire was administrated have no guidelines regarding how to handle behavioral problems. A tentative thought is that staff members in substance abuse treatment are aware that behavioral problems might occur among their patients, but might lack routines for identifying and treating such problems. Perhaps even more importantly, they might lack support from policy makers and superiors in their striving to acknowledge the many varying problems among their patients.

Their awareness might be seen as a resource, and perhaps staff members could be empowered to develop the capacity to identify behavioral problems among their patients. In order to do this, decision-makers and superiors need to appreciate that neither SUD, nor behavioral problems, are conditions that can be treated isolated from other problems, or from the life circumstances of the individual. On the contrary, substance abuse seems to be a malice that seldom comes alone. It is therefore suggested that staff members are supported to ask a few direct questions about behavioral problems to each patient, or perhaps use a short screening instrument. Such a procedure might help in identifying patients who experience behavioral problems, since the method of asking a few direct questions has been showed to be successful for identifying substance misuse and behavioral problems (Nelson & Oehlert, 2008; Socialstyrelsen, 2014). It seems important that identification becomes a routine, so that the identification process will not be limited by preconceptions about for example gender and behavioral problems. Moreover, if staff members are provided with education and supervision that pay attention to behavioral problems they might be empowered to identify such behaviors and in relevant cases plan for integrated treatment. Hopefully, superiors and policy makers acknowledge that both substance abuse and behavioral problems are complex phenomena, and support treatments units in their strivings to develop a treatment that accounts for problems with both substances and behaviors.

It is however important to notice that substance abuse might increase the risk for developing behavioral problems (Cowan & Devine, 2008; Peles et al., 2009; Shaffer et al., 2004). It thus seems reasonable to view identification of behavioral problems as an on-going process rather than as a question of initial screening. During treatment, it thus should be considered that behavioral problems might develop, and simultaneously, the SUD should not be overlooked (Burton, 2005). Therefore, it seems necessary to adapt treatment to the needs of

the individual client, and create a treatment context characterized by acceptance in which it becomes possible for clients to approach their problems and the varying forms they may take (Keaney, 2006; Levine, 2010; Luoma, Kohlenberg, Hayes & Fletcher, 2012). Thereby, clients might be supported to avoid relapse to substance abuse as well as to behaviors.

Limitations

The present study has some limitations that need to be mentioned. One limitation is that the behavioral problems cannot be described in detail. For example, there is no information about age of onset, duration, or severity. Another limitation is that the study includes relatively few participants, especially few women. In a larger sample, differences regarding pattern of substance use, behavioral problems and gender could be investigated. The present study should be regarded as a pilot study, which preferably is repeated with a larger sample, and elaborated questions regarding the characteristics of behavioral problems.

An important notice is that shopping, Internet use, and online role-playing games also are said to have addictive potential (Plant et al., 2005; Sussman et al., 2010). Those behaviors were not focused in the present study and it is therefore possible that behavioral problems are underestimated. Despite these limitations, the results indicate that a substantial group of patients in substance abuse treatment have one or several behavioral problems, a finding that should be taken seriously.

Conclusions

This study indicates that a substantial group of patients in substance abuse treatment also experience behavioral problems, and individuals who report behavioral problems tend to have problems with two or more behaviors. In other words, behavioral problems should not be

viewed as a deviation among individuals with severe SUD. The behaviors that are predominantly reported, both by men and women, are food intake and sexual activities. This clarifies the importance of paying attention to a range of behavioral problems among men and women in substance abuse treatment. It also clarifies the importance of supporting staff members to identify behavioral problems, and, when needed and viable, to develop a treatment that accounts for problems with both substances and behaviors.

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Table 1. Reported pattern of substance use among participants without and with reported behavioral problems. Data presented in frequency (percentage), or as mean ± standard deviation

	Participants without behavioral problems *n* = 23 (33 %)	Participants with behavioral problems *n* = 46 (67 %)
Age (years) of onset for experimentation with substances	14 ± 2	14 ± 5
Age (years) of onset for regular substance use	18 ± 6	18 ± 5
Years of regular substance use	14 ± 10	16 ± 10
Daily substance use (yes)	22 (96 %)	43 (93 %)
Experience of poly substance use (yes)	22 (96 %)	45 (98 %)
Intravenous substance administration (yes)	16 (70 %)	24 (52 %)

Table 2. Reported problems with food intake, sexual activities, exercise and/or gambling, and reported number of behavioral problems (one behavior, or two or more behaviors). Data presented in frequency (percentage) with multiple answers possible.

	All participants reporting behavioral addiction $n = 46$	Men reporting behavioral addiction $n = 31$	Women reporting behavioral addiction $n = 15$
Type of behavior			
Food intake	33 (72 %)	19 (62 %)	14 (93 %) *
Sexual activities	33 (72 %)	25 (81 %)	8 (43 %)
Exercise	18 (39 %)	12 (39 %)	6 (40 %)
Gambling	10 (22 %)	9 (29 %)	7 (%)
Number of behaviors			
One behavior	15 (33 %)	10 (32 %)	5 (33 %)
Two or more behaviors	31 (67 %)	21 (68 %)	10 (67 %)

II

Behavioral misuse among clients in substance abuse treatment. An interview study.

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Abstract

Background: The co-occurrence of substance misuse and behavioral misuse, such as excessive food intake, sexual activities, gambling, and exercise, has been increasingly acknowledged in both research and treatment practice during recent decades. It has also been shown that behavioral misuse complicates substance abuse treatment, and that clients with such co-occurring difficulties have considerable treatment needs.

Methodology: This study was based on interviews with six clients in substance abuse treatment who also had a history of behavioral misuse. The interviews concerned the participants' perception of their behavioral misuse and of themselves, and were analyzed using interpretative phenomenological analysis.

Findings and clinical implications: The participants perceived behavioral misuse as an avoidance of self-criticism and experiences of non-coherence. They also perceived

relations and affects as overwhelming. Through behavioral misuse, relational and affective needs, as well as distressing self-experiences were mitigated. The participants also described the efforts they had made to comprehend themselves. Their experiences were interpreted with respect to dissociation and concretization. It is suggested that during treatment, practitioners need to support the client's comprehension, and their capacity to approach affective and relational needs, and in this process dissociation and concretization need to be handled.

Keywords: Sexual behaviors; Substance abuse; Qualitative

Over the past decades, the co-occurrence of substance misuse (SM) and behavioral misuse (BM) concerning food intake, sexual activities, gambling, exercise, and/or Internet have been emphasized in both research and treatment practice (Goodman, 1998; Karim & Chaudhri, 2012; West, 2006). Studies have shown that both SM and BM are characterized by loss of control, tolerance, and experiences of withdrawal (Goodman, 1998; Shaffer et al., 2004; Sussman, Lisha & Griffiths, 2011).

Criteria for diagnosing SM and gambling are established, whereas diagnostic criteria concerning other BM are not (American Psychiatric Association, 2013; Schuckit, 2013). In this paper, the term BM refers to behaviors being repeatedly enacted despite awareness of negative physical, social, and psychological consequences, and despite a wish to refrain (Larkin & Griffiths, 2002).

BM seems to complicate and impair the outcome of substance abuse treatment (Costorphine, Waller, Lawson & Ganis, 2007; Harrop & Marlatt, 2010). Moreover, clients might replace substances with behaviors, and vice versa, so that when they recover from one form of misuse, they might develop another (Karim & Chaudhri, 2012; Shaffer et al., 2004).

Since clients with co-occurring SM and BM benefit from treatment that acknowledges the complexity of their difficulties, researchers emphasize the importance of investigating a range of behaviors among clients in substance abuse treatment (Ledgerwood & Downey, 2002; Sussman et al, 2011).

Perceptions of misuse, and of oneself

Treatment should be adapted to the client's subjective perception of misuse, otherwise significant difficulties might pass unnoticed and thus hinder successful treatment (Larkin & Griffiths, 2002, Rothschild, 2007; Sachs, 2009). Clients in substance abuse treatment tend to experience self-criticism, self-hatred, and non-coherence (Kellog & Tatarsky, 2012; Rothschild & Gellman, 2009). Non-coherence refers to a sense that one consists of disintegrated self-parts, and moreover to experiences of losing oneself and one's boundaries; experiences that are so terrifying that one might do anything to avoid them (Bromberg, 2001; Rothschild, 2007; Weegman, 2005).

It has consequently been suggested that subjective experiences and self-perception should be acknowledged in research concerning SM and BM (Larkin & Griffiths, 2002; Parker & Guest, 2003; Sachs, 2003). Moreover, before concluding how BM should be defined and treated, there is a need for further understanding of how BM is perceived by the clients concerned (Levine, 2010; Sussman et al., 2011). Nevertheless, few studies have investigated experiences of BM among clients in substance abuse treatment. The aim of this study was therefore to investigate how clients in substance abuse treatment, who also had a history of BM, perceived their BM and themselves.

Methods

Participants and procedure

Five male and one female client in an outpatient clinic in Swedish public health and social care, specialized in treatment of poly substance abuse and co-occurring social and psychiatric

problems, participated. Treatment included weekly supportive contact with a social worker/nurse, and contact with psychiatrist. Clients with experiences of BM were asked to participate via information sheets. Those who were interested were given written and oral information about the study and were informed that they could discontinue their participation at any time. They then signed a form of participation. The Regional Ethics Review Board, Gothenburg, Sweden approved the study.

An experienced psychiatrist conducted the Structured Clinical Interview for DSM-IV Axis I Disorders (First, Gibbon, Spitzer & Williams, 1997) and found that the participants earlier in life had met criteria for poly substance abuse but were now stably abstinent. The participants had also terminated their BM but remained in treatment due to social and/or psychiatric problems. Table 1 presents the participants' prior SM and BM.

The participants had been exposed to childhood maltreatment. Table 2 briefly presents their childhood experiences and current life situation.

Interview

The interviews were conducted according to a psychological phenomenological approach in which the participants were encouraged to develop their descriptions about their experiences (Giorgi, 1985; Giorgi & Giorgi, 2008). The initial question was "*Could you please tell me about the difficulties with behaviors you described that you have experienced"*. During the first 10-15 minutes the interviewer was mainly listening, and sometimes formulating short questions to encourage the participant to continue. Thereafter ambiguities and/or contradictions were discussed, and broad follow up questions were used. The interviewer also described her perception of what the participant was communicating, and asked the participant to reflect on this perception, in order to avoid misunderstandings. The first author conducted the interviews, on two occasions with each participant. Duration was 90 – 150 minutes for each participant. The interviews were audio recorded and transcribed verbatim.

Analysis

The interviews were analyzed with interpretative phenomenological analysis (IPA) (Larkin, Watts & Clifton, 2006). In research concerning subjective experiences, IPA has been suggested as an appropriate method, since it focuses on how individuals make sense of themselves and their experiences, while allowing researchers to make use of their expert knowledge in the process of gathering and analyzing data (Larkin & Griffiths, 2002; Smith & Osborn, 2008). IPA studies are focused on lived situations, and in order to support understanding of the psychological world of the participant, a limited number of participants is recommended (Larkin et al., 2006). This approach permits topics that the researchers have been unaware of to emerge (Larkin et al., 2006). Furthermore, since participants are free to develop the topics they find important, the approach allows ambiguities and contradictions to be articulated, and thereby analyzed and interpreted.

In the first step of the analysis, the first and second author read and reread the interviews, highlighting statements concerning experiences of BM and self-perception. In the second step, both authors grouped the statements into subthemes, reaching a first level of abstraction. These subthemes were then grouped together, to reach a higher level of abstraction and create the themes that are to be presented, These themes were compared to the interviews to ensure that the analysis was grounded in the interviews with all participants. Finally, the three authors connected the themes to each other, in order to present the participants' understanding of themselves and their BM. The presentation was compared to the interviews, to ensure that the statements had not been distorted during the analysis.

Findings

Three themes were identified. These were; (1) Avoiding distressing self-experiences, (2) Feelings and relations transformed to enactment, (3) Comprehension. The themes are not

definite, nor mutually excluding, but hopefully support the conceptualization of a complex phenomenon.

The participants perceived sexual activities as their most distressing difficulty. The male participants described excessive masturbation, consumption of pornography, and excessive sexual activities in relationships. Benjamin also described multiple partners. Felicia had repeatedly participated in sexual activities on the condition of others, and had been working as a stripper and as a prostitute. Since the participants emphasized sexuality, the presented quotations mostly concern sexual activities. However, the themes were also relevant to other behaviors described by the participants.

Avoiding distressing self-experiences

Throughout life, the participants had experienced self-criticism, a sense of being a stranger to themself, and a sense of losing themself and their boundaries, and BM had mitigated these self-experiences. Benjamin, described lifelong experiences of not belonging, of being unable to protect himself, and of falling apart, and attempted to avoid such experiences through behaviors:

> *I tried to disappear in a way. Not feel and be reminded of the circumstances. Not to give a damn. You're totally freed from all your needs. To belong, love. I started masturbating when I was six… got inside myself and there was this core inside of me. Nothing existed outside, it was only me. I can see it was disturbed, but by doing this I could "close around myself."*

This quotation illustrates how the participants reached something at least reminiscent of self-coherence and a simultaneous calming state of self-sufficiency through behaviors, both during childhood and during their adult life. Behaviors thus paradoxically served both to counteract experiences of non-coherence, and simultaneously to disintegrate the unaccepted self-parts connected to relational needs and vulnerability.

Benjamin's attempt to avoid distressing self-experiences through masturbation was based on the possibilities he perceived as available. Since he and the other participants perceived that their difficulties were rooted in themselves as individuals, they saw no possible solution to their suffering. The BM however only led to increased suffering that in turn intensified non-coherence and self-criticism, and repetitive circles were developed, as described by Eric:

> *You relax, don't constantly feel the tension. You don't brood so much when you use substances. But then, as soon as it leaves the body… Rumination gets ten times worse ... And other things work the same way. How can I get rid of the drugs? I have to get something else that serves the same purpose. Because it's this purpose that is the problem ... Sexuality… after two minutes anxiety comes, and shame and guilt. It's like detox … and constantly you want to replace everything with something else.*

Feelings and relations transformed to enactment

The participants described how enactment of behaviors transformed overwhelming feelings and relational needs into concrete activities. The behaviors induced a perception of being able to control themselves and their feelings, and a sense of being detached from relational needs. The behaviors involved elements of perseverations; they had to be done in the same, predictable way to be calming. This could for example concern stereotypical enactment of sexual activities. Simultaneously, the activities had to involve new elements to be appealing, and the participants described increasing excessiveness. As Benjamin expressed it:

> *Feelings were confusing… sexuality is disturbed… everything was about sex. A very negative use of sex. A lot of cruising, find someone, fuck like hell … I wasn't able to have a real relationship, couldn't unite sexuality with relations. They weren't interesting as human beings. Sometimes I had sexual relations*

with lots of persons. Called someone, and just… then it was time to leave. And sometimes I got eager. I couldn't wait until it was time to meet the other person, so I called someone else and had sex with that person before I went on to the one I called first.

Benjamin illustrates the participants' perceptions of being unable to tolerate feelings and relations, and of moderating behaviors. Feelings were reminders of relational needs, and excessiveness supported detachment from feelings. Adam explained this with the following words; "*I haven't allowed any feelings to exist, couldn't stand it. Instead I turned to excesses*".

Moreover, descriptions of positive feelings and satisfaction were absent in the interviews. For example, the participants did not express that they enjoyed sexuality, but felt incapable of enjoying sex, and regarded sexuality as a distressing part of their life and themselves. The excessive sexual activities had fuelled self-criticism and the sense of being unable to handle feelings and relations, which in turn had fuelled tendencies for enactment. Thus a vicious circle was created and maintained. Enactment and excessiveness were also connected to experiences of disappointment and dissatisfaction. As David explained:

It's deficiency of love in your childhood. And that's what I try to satisfy, the emptiness inside… A desire, which I satisfy. Or don't… because it's the same frustration. It doesn't work.

The participants had acted according to the illusion that behaviors could ease affective suffering and substitute for relational needs. David described how this illusion rather increased disappointment and dissatisfaction:

I can't get satisfaction. I feel an urge, got to have, take, feel the emptiness, dissatisfaction… I've used lots of different things, something new all the time… replaced things. But it's this emptiness inside… that grows.

Comprehension

Throughout life, the participants had found it hard to understand their own enactment and themselves. Simultaneously, they described the efforts they had made to comprehend themselves. Through the efforts to comprehend, a storyline in their lives was slowly grasped, and such comprehension was perceived as fundamental for the ability to change. For example, Charles described his efforts to comprehend and change his life-course, with the following words:

One tries to… see a pattern throughout life. I think very much is about how you look at yourself. One tries to change that. But I don't know how. It was a sense of emptiness. I felt insufficient. Bad. Empty inside. Had a great hunger for something. Was insecure, and things became obsessions. It eases for a while in a way … It was hopelessness. I never saw any possibility to manage anything...

Although Charles described a negative self-perception, his capacity to approach his shortcomings made it possible for him to see new sides of himself, other than the negative.

I've forced myself to take risks and cross boundaries I've had, and create boundaries when I didn't have any… And the change has been brutal. It's been a year of pain straight up. But also a reward in the pain. I have felt free in a way. And I've never felt so good, either.

Felicia gave another example of the efforts to comprehend, and simultaneously described how comprehension is no straightforward solution:

I got something out of being a stripper and a prostitute. Basically it's the same… This paedophile who abused me… I attached to him. At least he saw me, appreciated me for something. No one else did. So I used my body to get something in return. Though I've been aware of this for long, it was so hard to change the pattern. In a way, it was the only thing I knew. I have to relearn, but it's so hard …

Her description illustrates the participants' ability to fight for comprehension, and for change. Adam, who started to masturbate and use pornography to "*get away from himself*" and "*relieve anxiety*" during preadolescence, explained:

> *I've learned this. I've refrained from pornography for more than one and a half years. I don't use it. But… it's there… And it's very hard to withstand.*

The phrase *"it's there"* refers to advertisements for pornography and other sexual activities on the Internet. Adam described the Internet as a part of life that cannot be avoided. To withstand, he limited his time on the Internet, never used the computer in the evenings, and turned the computer off when sexually loaded advertisements appeared. He thus presented an ability to resist, but at the same time described himself with the following words:

> I *cannot stand myself… self-destructive in everything… deficiency, bad self-esteem, no value. I used to cut myself a lot. I understood that it wasn't good for me, and because it isn't good for me, I do it again.*

It was difficult for Adam to perceive that, despite his shortcomings and his negative self-perception, he also had capabilities. These capabilities were described so that they became visible in the interview. Consequently, in one sense he was aware of his capabilities; but simultaneously he seemed unaware of them. Thus, it was as if he could not integrate competent self-parts and comprehend himself as a capable person.

Discussion

Dissociation was a useful concept for understanding the participants' avoidance of distressing self-experiences. Furthermore, the transformation of relations and feelings into enactment was understood as a process of concretization. Dissociation and concretization have both been described as responses to unfulfilled relational and affective needs (Stolorow, Brandchaft & Atwood, 1987). However, for the sake of clarity, dissociation and concretization will however be presented separately.

Dissociation

In dissociation, distressing experiences are avoided through the disintegration of affect-awareness, cognitive insights, and unaccepted self-parts, whereby ego-dystonic self-parts come to hold the distressing experience (Holmes et al., 2005). Since these self-parts become estranged and disintegrated, the individual is shielded from the distressing experience as well as from painful affective and/or cognitive insights into themself (Holmes et al., 2005; van der Hart, Nijenhuis, & Steele, 2006). It is difficult for these clients to describe dissociation, since dissociation occurs outside of consciousness (Bromberg, 2001; Rothschild, 2007). However, the effects of dissociation are perceived and can be described. Hence the processes of dissociation might be perceived and analyzed by a researcher or a practitioner who enters a dialogue with the individual (Weegman, 2005).

When the participants described their BM, they related that they perceived the self-parts that longed for relational fulfillment as unacceptable since these parts became reminders of unfulfilled needs. During BM such unaccepted self-parts were dissociated, as Benjamin explained when he said that he was freed from the needs to belong and to love. Dissociation thus became momentarily calming.

The findings provide insight into how BM seems to have two dissociative functions that accordingly need to be acknowledged in treatment. One function is to dissociate self-parts that are reminders of relational needs, and are therefore unaccepted. The other function is to avoid distressing experiences of non-coherence. Thus, dissociation might preferably be seen, not as a single process, but as multiple on-going processes that shields the individual from overwhelming distress connected to their own self-perception.

Concretization

Concrete behaviors might function as an escape from overwhelming affect, and might therefore repeatedly be sought out (Levine, 2010; Reid, Harper & Anderson, 2009). The term concretization refers to a process in which affects and experiences that threaten the self become expressed in sensory-motor behaviors, and thereby become perceived as comprehensible and controllable (Stolorow et al., 1987). The participant's descriptions of BM as attempts to control affects and relational needs might thus be understood as concretization.

A tentative interpretation is that BM is rooted in an experience of unfulfilled affective and relational needs. Unfulfilled needs become connected to a sense of deficiency, which in turn implies a state of dissatisfaction and disappointment that the individual strives to mitigate. Through concretization, the affective and relational longing become perceived as a concrete behavioral need, and the individual acts according to this perception. However, since the relational and affective needs are concretized, they cannot be identified, and thus cannot be satisfied. The perception of deficiency thus becomes constant, and the dissatisfaction and disappointment increase the tendency towards repeated concretization.

Comprehension and integration

Throughout their lives, the participants had struggled to comprehend both their BM, and themselves. Comprehension was perceived as fundamental for their capacity to change.

Previous research has shown that acceptance of shortcomings and integration of unaccepted self-parts should be supported during treatment, since acceptance and integration counteracts dissociation (Kellog & Tatarsky, 2012; Luoma, Kohlenberg, Hayes & Fletcher, 2012; Weegman, 2005). Based on the findings in this study, comprehension, dissociation, and concretization, all seem to be intertwined. It is therefore suggested that clients should be supported to comprehend and integrate their dissociated self-parts, and to empathically approach their affective and relational needs. Positive self-parts must also be acknowledged so that self-criticism might be overcome.

Limitations and future studies

This study has several limitations. Firstly, the participants had considerable treatment needs, and a history of childhood maltreatment. It cannot be assumed that their experiences apply to all clients in substance abuse treatment. It should also be noticed that self-perception is a seemingly ambiguous concept related to one's own personal history and simultaneously related to social structures that shape the behaviors and perceptions of individual men and women (McNay, 2000). Moreover, even though an IPA study is ideally based on comparatively few individuals (Larkin et al., 2006), it should be noticed that this study included only six participants, and only one woman. It is possible that the experience of behavioural misuse differ between men and women, a possibility that was not investigated in this study.

This study investigated a range of behaviors. This approach might contribute knowledge that seems overly general, and the study might seem somewhat scattered. However, the inclusive approach enables understanding of BM as a broad phenomenon, which contributes to understanding the treatment needs of these clients.

Future studies should further investigate dissociative symptoms among clients with BM, and specifically address BM among women. Studies could also investigate BM among clients who are active in SM and/or BM, and thereby contribute insights into various phases of misuse and consequently lead to improved treatment.

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Table 1. Prior substance and behavioral misuse.

Assumed name	Age	Time of substance abstinence	Age of onset, alcohol	Age of onset, illegal drugs	Substance misuse	Behavioral misuse
Adam	35	2 years	14	16	Alcohol, amphetamine, benzodiazepine	Binge eating, sexuality, Internet, sexuality
Benjamin	39	1 years	13	17	Alcohol, amphetamine, benzodiazepine, cannabis	Binge eating, exercise, sexuality
Charles	30	2 years	14	16	Alcohol, amphetamine, benzodiazepine, cannabis	Binge eating, gambling, Internet, sexuality, shopping
David	44	2 years	13	15	Alcohol, amphetamine, benzodiazepine, cannabis	Binge eating, exercise, sexuality
Eric	42	3 years	13	14	Alcohol, amphetamine, benzodiazepine, cannabis, cocaine	Binge eating, gambling, sexuality
Felicia	25	1 years	19	19	Alcohol, amphetamine, benzodiazepine,	Binge eating, exercise, sexuality

Table 2. Childhood experiences and current life situation.

Assumed name	Father's personal difficulties	Mother's personal difficulties	Emotional abuse and neglect	Physical abuse	Sexual abuse	Relationship status	Employment status
Adam	Severe alcoholism	Emotionally detached	Yes	Yes	No	Stable relationship	Working part-time
Benjamin	Substance abuse, criminality	Substance abuse, severe psychiatric problems	Yes	Yes	Yes	Single	Retired early
Charles	Substance abuse, criminality	Substance abuse, severe psychiatric problems	Yes	Yes	Yes	Stable relationship	Working part-time
David	Severe alcoholism	Emotionally detached	Yes	Yes	No	Single	Working full-time
Eric	Substance abuse, criminality	Emotionally detached	Yes	Yes	Yes	Married	Retired early
Felicia	Substance abuse, criminality	Emotionally detached	Yes	No	Yes	Stable relationship	Student

III

Excessive sexual activities among male clients in substance abuse treatment. An interview study.

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Abstract

Purpose: The co-occurrence of substance abuse and excessive sexual activities is acknowledged in research and treatment practice. Men seem particularly at risk for developing excessive sexual activities. Excessive sexual activities complicate substance abuse treatment, and clients with such co-occurring difficulties have considerable treatment needs. It is therefore important to investigate how male clients who have enacted excessive sexual activities perceive their excessive sexual activities and themselves.

Design: Interviews were performed with five male clients in substance abuse treatment, who had enacted excessive sexual activities. The interviews concerned the participants' perception of themselves and how they came to enact excessive sexual activities. The interviews were analyzed using thematic analysis.

Results: Two major themes were identified. One theme concerned overwhelming shame and difficulty discussing sexuality in treatment. The second theme concerned how perceptions about masculinity had influenced sexual activities. Although the participants described a need to discuss sexuality, they also noted that this topic was absent from their previous and ongoing treatment.

Implications: Future studies should investigate how excessive sexual activities might be identified and handled in treatment. It also seems important to investigate how gender-perceptions might influence excessive sexual activities. We suggest that practitioners should address sexuality, shame and perceptions about gender during treatment.

Value: This study provides insight into the lived experiences of male clients with a history of excessive sexual activities. Such insight seems important for researchers and practitioners seeking to understand excessive sexual behaviors, and provide adequate treatment.

Keywords: Excessive sexual activities; Interview study; Masculinity; Shame; Substance abuse; Treatment

In recent decades decades, co-occurring substance abuse and excessive sexual activities have been acknowledged in both research and treatment practice (Goodman, 1998; Karim & Chaudhri, 2012; Levine, 2010; Hartman, Ho, Arbour, Hambley & Lawson, 2012). It has ben estimated that about 40% of individuals with substance abuse also enact excessive sexual activities, and vice versa (Sussman, Lisha & Griffiths, 2011). It has also been suggested that men seem to be particularly at risk for developing difficulties with excessive sexual activities (Goodman, 1998; Karim & Chaudhri, 2012).

Varying terms, such as sexual addiction, compulsion, misuse, or excessiveness, are used with respect to a preoccupation with sexual activities, (Mudry et al., 2011). This study used the term excessive sexual activities to refer to sexual activities which are repeatedly enacted despite knowledge of negative psychological, social, or physical consequences, and

despite a conscious wish to refrain (Giugliano, 2003; Levine, 2010; Plant & Plant, 2003). The term troubled sexuality is also used, with reference to persistent worries about sexuality, and a perceived aversion towards sexuality and towards oneself as a sexual being.

Individuals with co-occurring substance abuse and excessive sexual activities have considerable treatment needs, and unidentified excessive sexual activities might complicate substance abuse treatment (Goodman, 1998; Hartman et al., 2012). Moreover, it seems that excessive sexual activities might accompany psychiatric conditions such as anxiety, depression, and dissociative syndromes (Karim & Chaudhri, 2012; Plant & Plant, 2003). In addition, individuals who enact excessive sexual activities tend to have a negative self-perception, and researchers have emphasized the connection between excessive sexual activities and difficulties with relationships and affect-regulation (Giugliano, 2003; Parker & Guest, 2003; Valenti, 2002). Accordingly, clients with excessive sexual activities need support to develop their capacity for affect-regulation and to nuance their perception of themselves, so that their excessive activities might be terminated (Goodman, 1998; Hughes, 2010; Levine, 2010). Treatment therefore needs to be adapted to the client's personal experience of their own difficulties and self-perception (Larkin & Griffiths, 2002).

Self-perception, affects, and excessive sexual activities

The self has been described as the center of the experiencing individual, and in the self-perception, various experiences, thoughts, and affects are integrated, to achieve a coherent sense of oneself and one's activities (Schore, 1994). The term coherence reflects an ability to integrate multiple experiences and perceptions without loosing a sense of continuity (Corbett, 2011; Diamond, 2004; Sloate, 2010).

Self-perception is preferably understood with respect to developmental processes (Parker & Guest, 2003; Valenti, 2002). When individual development takes place in relation to empathetic others who have the capacity to attune to the child's affective states and

relational needs, the child develops the ability to identify, accept, and regulate affects such as joy, sadness, and shame (Schore, 1994). However, if attunement is insufficient, the child experiences a sense of isolation and a perception that their affects and needs are unacceptable; experiences that will enter the emerging self (Schore, 2002). Consequently, a self that cannot regulate relational needs and affects develops. Needs and affects become incomprehensible, and the individual will lack a sense of cohesiveness (Parker & Guest, 2003; Sloate, 2010). The lack of cohesiveness might be counteracted with concrete activities that are perceived as comprehensible and controllable. Through enactment, overwhelming affective experiences become expressed in sensory and motoric behaviors, and thereby become perceived as comprehensible and controllable (Stolorow, Brandchaft & Atwood, 1987).

The child also has a wish to integrate both masculinity and femininity into the developing self (Benjamin 1988; Corbett, 2011; Diamond, 2009). Sometimes, caregivers are unable to create a relational context in which the child perceives themselves and others as cohesive. Under such circumstances, relations become associated with disappointment, and femininity and masculinity might become perceived as binary contradictions (Benjamin, 1988). The boy might reject femininity, and perceive it as connected to passivity, and thus an inclination to activity might be fundamental for his self-perception since such as rejection creates a sense of being a coherent male (Benjamin, 1988; Corbett, 2011; Diamond 2009).

Both men and women are influenced by discourses about gender and sexuality throughout their lives (Hollway & Jefferson, 1998). Discourses are here defined as culturally based systems of meaning that become collectively accepted and as such come to govern the perception of groups of individuals as well as of unique individuals (Magnusson & Marecek, 2012). Hollway (1989) has discussed three discourses about gender and sexuality: (i) the *male sexual drive* discourse, which implies that men are always sexually active and prepared, while women are objects of this drive; (ii) the *have/hold* discourse, which implies that sexuality is

an arena for trading and exchanging “favors”; (iii) the *permissive* discourse, which implies that for both men and women, sexuality is a prototype for pleasure, a desirable activity that is performed without consequences.

In sexuality, individual boundaries become physically and symbolically intermingled, which is a desirable aspect of sexuality, since it is appealing to lose one’s boundaries (Benjamin, 1988). However, the intermingled boundaries are simultaneously a potential worrisome part of sexuality, in the sense that some boundaries, one’s own and others cannot be crossed without risk, and without undesired consequences arising (Kulish, 2010).

It has been shown that excessive sexual activities seem to pass unnoticed in treatment, and practitioners in substance abuse treatment should therefore ask their clients about excessive sexual activities (Goodman, 1998; Karim & Chaudhri, 2012; Plant & Plant, 2003). It has also been shown that treatment of excessive sexual activities should be planned according to the needs and perceptions of the individual client (Hughes, 2010; Parker & Guest, 2003; Valenti, 2002). It is therefore important to investigate how clients in substance abuse treatment, who also have enacted excessive sexual activities, perceive their excessive sexual activities and themselves since such investigations might enhance the possibility to acknowledge such difficulties in treatment. Since men seem particularly at risk for developing excessive sexual activities it is considered specifically important to investigate excessive sexual activities among male clients.

The aim of this study was to investigate how men in substance abuse treatment, who had enacted excessive sexual activities, understood their repeated sexual activities, and how they perceived themselves.

Methods

Participants and procedure

The five participants were clients at a treatment unit in public health and social care, directed at individuals with poly substance abuse and mental health difficulties. Treatment at this unit continued for several years after abstinence had been achieved, and included supportive contact with a social worker or a nurse, and meetings with a psychiatrist and psychiatric nurse.

Clients with experiences of excessive sexual activities were recruited via information sheets. Five men, 31- 44 years old, who all identified as heterosexuals, participated. They had earlier in life met criteria for poly substance abuse according to DSM-IV (American Psychiatric Association, 2013).

The participants were characterized by: (1) previous substance abuse; (2) experience of excessive sexual activities; (3) stabile abstinence from substances; (4) established contact with public health and social care service. The participants received written and oral information about the study and were informed that participation was voluntary, and that they could discontinue their participation at any time without having to give any reason. Thereafter they signed a form to indicate their choice to participate. The Regional Ethics Review Board, Sahlgrenska Academy, approved the study.

Two of the participants grew up with fathers with severe alcoholism, who also abused them physically. Their mothers were described as unable to protect them from abuse. These two participants had no formal education, but were currently working part time and had a satisfactory social lives. However, they still experienced psychological suffering, and described difficulties in intimate relationships, as well as a tendency to self-criticism.

The other three participants grew up with parents who abused various substances, were involved in criminal activities, and/or had severe psychiatric symptoms. These participants had been emotionally, physically and sexually abused, and had been subject to social interventions, such as being placed in foster care. They had no formal education and had either retired, or worked in settings arranged by social services. Even though they were

abstinent and their excessive sexual activities were terminated, they still experienced intense psychological suffering. They sensed that relationships were potentially threatening, and described a tendency to isolation.

All participants described a history of excessive masturbation, consumption of pornography, and sexual activities in relationships, as well as multiple partners and potentially provoking activities such as exhibitionism. They sensed that their troubled sexuality emerged during childhood and preadolescence, while their substance misuse started during adolescence.

Interviews

The interviews concerned experiences of excessive sexual activities and self-perception, and were conducted according to a psychological phenomenological approach described by Giorgi (1985) in which the experiences and perceptions of the individuals concerned are the main focus of attention . The initial question was *”Could you please tell me about the difficulties with behaviors you described that you have experienced*”. Throughout the interviews, the participants were encouraged to reflect on issues they perceived as important. During the first 10-15 minutes the interviewer was mainly listening, sometimes formulating short questions to encourage the participant to develop the narrative. Thereafter ambiguities were discussed with the participants. In order to prevent misunderstandings in the later analysis the interviewer also described how she perceived what the participant was communicating, and asked the participant to reflect on this perception. When the participants described experiences of treatment, further questions were asked about how they perceived that their troubled sexuality had been handled in treatment. All the interviews were audio recorded and transcribed verbatim.

Analysis

The interviews were analyzed using thematic analysis, in which the aim is to present common themes that are identified in data (Braun & Clarke, 2006). With this approach, the individuals

disappear in a sense, and instead the themes become the focus of attention. In this way, the privacy of the participants is safeguarded. Moreover, this method allows exploration of the participants' subjective experiences of the participants while simultaneously admitting the use of the researcher's theoretical and professional knowledge (Braun & Clarke 2006).

In the first step of the analysis, the first author read and reread the interviews in their entirety, highlighting all statements concerning the purpose of the study. These statements constituted the dataset that was analyzed. In the second step the three authors grouped the statements into subthemes, reaching a first level of abstraction of the data. In the third step the subthemes were grouped together, to create the themes that are to be presented. At this stage a higher level of abstraction was reached. The themes were repeatedly compared to the original dataset to ensure that the analysis was grounded in the actual narratives. The final step was to connect the themes to each other in order to articulate a narrative about the narratives. This narrative was compared with the interviews to ensure that the actual statements had not been distorted during the analysis.

Results

Two major themes emerged and were labeled with quotations from the participants. In the first theme, "*I couldn't even think about it. It was too shameful*," the focus is on experiences of sexuality and shame. In the second theme, "*I used to think it was normal—hey, I'm a man*," the focus is on how perceptions about masculinity had influenced the participants and their sexual activities. Those themes are not separate entities; nor are they mutually exclusive. Rather, they illustrate two storylines in the narratives, and as such, they should be seen as a conceptualization of a complex phenomenon.

I couldn't even think about it. It was too shameful.

The sexual activities that the participants described were characterized by excessiveness, such as excessive masturbation, consumption of pornography on the Internet, and sexual activities

with a partner and/or multiple partners. Interestingly however, when the participants deepened their narratives, they described relational aspects of sexuality as equally or even more bothersome than the excessiveness. As one man expressed it:

> *It's not about how many times I have sex with a girlfriend. It's about how I relate to her. And why I want to have sex. If we just have sex, it's fine. But if I am using her to feed me with sensations or to feel on top of things… Then I'm way out...*

As this quotation illustrates, the participants were concerned about the relational meaning of sexuality, and how they had behaved towards prior partners. Earlier in life they had perceived sexuality as an arena of control and struggle of power, rather than as a possibility for mutuality. They described how overwhelming shame arose when they thought about how they had persuaded and/or coerced former girlfriends to engage in sexual activities that they themselves regarded as inappropriate; either because of the nature of the activities, or because of excessiveness, or both. As one participant said: *"Did my girlfriend really want to do all this? I didn't even want to do it myself."*

The participants expressed that the coercion and persuasion had not primarily been physical, but rather emotional. They were concerned with how sexuality was treated in popular media and worried about what they perceived as a sexualization of human beings, including what one participant described as the "*anything goes*" attitude. When the participants perceived that sexuality was presented as an "*anything goes"* activity, they could become uncertain about themselves and their shame:

> *People say that everything is normal, that there's nothing to feel ashamed about. But I feel ashamed. So I become ashamed of being ashamed… because I start to think… maybe there's something wrong with me, since I feel ashamed. You can't imagine how confusing it might be.*

The participants also expressed difficulties in understanding at which point sexual activities went wrong. They were uncertain of their own and other people's boundaries, and of who was the owner of the desire. Therefore they could feel like perpetrators, even though they were in mutual relationships. One participant described sexuality as an almost constant worry, even when he made efforts to live in a mutual relationship:

> *I become so uncertain…. thinking, "She is also a part of the sex." But who's really? Who has the initiative? I have to comprehend my part of… It is hard to talk about this. There's so much shame.*

This uncertainty fueled shamefulness, and even though the excessiveness was in the past, it was still difficult to achieve satisfying relationships. The participants expressed a need to have a dialogue about these difficulties, instead of continuing to avoid them, but it seemed as if the topic had passed unnoticed in treatment; *"No one ever asked".* Moreover, the participants described that that it was hard to bring the topic up themselves.

> *I feel that it's impossible to tell [the practitioner] about my sexual problems… and how painful everything is. I feel that I have to make her happy… when we talk about… that I'm not using substances anymore… she is so pleased… And we both feel fine, and I go home… and have no one to talk to.*

It seemed like a growing circle of silence had evolved in the treatment context. Interestingly, it seemed that when during the interviews the participants were supported in verbalizing their shame and difficulties during the interviews, they expressed that they felt relieved.

It's unbelievable how much shame there is. Hell, this is heavy stuff. I regret I said it… But I think it's good… It's exactly those things I have to express. To shine a light on… those ghosts… inside.

Adjacent to the feelings of relief, the participants described how they had hinted about their difficulties during treatment, but they felt that their intimations had not been acknowledged. One participant said, "*You people who are working with this need to be better at reading between the lines."*

The participants expressed that when they thought about their shortcomings, the shame became overwhelming, and they wanted to escape from memories, thoughts, and themselves. They could brood over whether their girlfriends really wanted to watch porn, have sex in public places, or engage in sexual activities up to ten times a day, or if they even wanted to have sex at all, considering the difficulties in the relationship. The participants expressed that they had tried to avoid thinking of prior behaviors, or they had tried to reinterpret behaviors they considered inappropriate. One participant expressed it in the following way:

It's so shameful. It's been so important for me to create a picture of myself as better than others. I tried to fool myself that I don't have sexual problems, because I don't go to prostitutes. I didn't want to see my shortcomings and admit that I behaved badly.… I always said to myself, "I'm not like ***this*** *or I don't do* ***that****."*

I used to think it was normal—hey, I'm a man.

The participants described how perceptions about masculinity had fueled their sexual activities. For example, they perceived themselves as more powerful and/or desirable than other men, when they enacted sexuality, and competitive aspects of sexuality thus became visible. They also described how throughout their lives they had perceived that the essence of

being male was to be constantly sexually aroused, and ready to enact sexual activities. For example, one participant said:

> *I wanted to have sex all the time. If I had sex I knew… I was a man, and I knew that I was alive. Like… fucking—that is what men do, isn't it?*

The participants described how they had thought that men were expected to be sexually competitive and *"ready*." It also seemed as if their view both of themselves and of sexuality became guided by this expectation. They described how their own perception regarding masculinity had been destructive for them. They now questioned their prior view of masculinity and felt that their perception had fueled their difficulties in integrating sexuality with mutual relationships, despite their longing for physical and emotional intimacy. Instead, sexuality became a disintegrated part of themselves.

> *For me, it's impossible to be intimate. It's impossible to stay in bed after intercourse, because there's so much shame… I wish I could… I never had real relationships. Either I had a sexual relationship or a more… intellectual relationship. I took the role of the super-sexual man…I just fuck and fuck.*

Beyond explicit perceptions of sexuality and masculinity, the narratives also contained descriptions of sexuality that concerned intermixing sexuality and aggression, and wishes to dominate. At some points in the interviews, when the participants were speaking about acts of domination they had performed, they became quiet and changed the subject. For example, one participant started to relate that he felt sorry that his sexuality had always been connected to dominance. Then he became silent, and after a deep sigh, he said, *"It wasn't that my sexuality was brutal… no whips or chains… but…"* Then he shifted focus and started to talk about how he achieved abstinence from substances.

Wishes to escape the restrictive parts of masculinity were articulated. For example, the participants expressed wishes to be sexually passive, to be female, and/or to be penetrated,

and they could sense uncertainty regarding whether they perceived themselves as masculine or feminine. They described how throughout their lives they had struggled with questions about how to regard the role of a man. In this struggle, sexuality became prominent, and a tendency evolved to repeatedly engage in sexual activities, evolved.

> *I'm so tired of being male, to be constantly occupied with sex … I don't know.... This wish to be a woman.... Is it really a wish to be a woman, or is it just that I wish that I didn't have to be a man? Or… the grass is always greener, you know. I've been thinking that maybe I should ask for… sex change. But I don't dare… 'cause I'm not sure if that would be a solution…. Is this wish just a part of this constant dissatisfaction with myself and… everything?*

The participants described how their excessive sexual activities were troublesome and shameful, and therefore, paradoxically were repeatedly sought out despite negative consequences. At the heart of the spiraling excessiveness was dissatisfaction with themselves, and they saw the excessiveness as an attempt to shield from overwhelming affects, relational needs, vulnerability, and non-coherence. They had a shameful attitude, not only towards sexuality, but also towards themselves and their bodies. As one man stated:

> *I masturbated so many times a day... my penis was sore. It had nothing to do with pleasure. It was just… dirty… Many times I've hated my body. I've said it to my therapist, but I don't think she understood. Now… I take care of my body. I can express that I like my body…. I'm sorry. That doesn't sound true [laughs]. It sounds invented… fake. But I'm trying to.*

Discussion

In the analysis it became visible that the participants perceived contextual factors as significant for their enactment of excessive sexual activities. Therefore, the discussion will

concern both the individual experiences described by the participants, and the contextual factors that might have influenced their perceptions of sexuality and of themselves.

For example, the participants described that their perception of themselves as males were significant for their excessive sexual activities. Interestingly, their strivings for masculinity could exist alongside a wish for femininity. Based on the results in this study, it seems that excessive sexual activities could be performed in an attempt to avoid gender ambiguity and lack of coherence. Taking the role of the sexual male allowed them to avoid their overwhelming experiences. Being sexually active meant the perception of being in control, and definitely masculine; and thereby, in at least one sense, coherent. This interpretation is in line with prior findings showing that young men who are disappointed with themselves and their lives, have unfulfilled relational needs, and express stereotypical views of gender, and might prove their masculinity through controlling and even sexually abusing others (Totten, 2003). Simultaneously, young men who push their masculinity also might have serious questions about their sexual orientation (Totten, 2003).

Individual experiences take place in a world loaded with perceptions and expectations that influence both how individuals come to view themselves, and the behaviors that they perform. Individual experience might therefore be seen as a point where personal uniqueness and contextual influence converge (Corbett, 2011; Scheff & Retzinger 1997). The discourses described by Hollway (1989) seemed to have influenced the participants in this study. For example, the *male sex drive* discourse (Hollway, 1989) seemed to have influenced the participants so that they perceived excessive sexual activities as an assurance of being male. The excessiveness was, in other words, not a goal per se; but sexual enactment assured the man that he was a man, and thus created a sense of coherence, at least momentarily. Moreover, the male sex drive discourse fueled the participants' perception of sexual activities as being a feasible way to counteract experiences of vulnerability and non-coherence. The excessive

masturbation described by the participants might have meant that they literally had something to hold on to when overwhelming suffering and non-coherence arose. Maybe a bit provocatively, it is proposed that some men in an attempt to avoid suffering and non-coherence, approach a principle that states, “I fuck, therefore I am.” This approach might have a calming effect in the short term, but in the long term it will only increase their suffering.

The *permissive* discourse (Hollway, 1989) also seemed to have influenced the participants, and was still troublesome for their view of sexuality and themselves. This was, for example, illustrated by the participant who described how confusing it could be to hear people state that there was nothing to be ashamed of. In this quotation, a paradoxical, demanding aspect of the permissive discourse became visible; sexual activities are not only permitted, but also are activities that one should engage in without bothering about negative consequences or the differences between free will and coercion (Gavey, 2005). The participants knew the suffering that was connected to thoughtless sexual activities without boundaries. For them, the view of sexual activities as permitted and negotiable became threatening instead of liberating. The good intentions behind a “permissive” attitude are easily imagined. However, since sexuality is a complex phenomenon, embracing permissiveness might be easier said than done, especially when one’s experience of both sexuality and oneself is loaded with shame.

Treatment implications

Hopefully, the reflections we present here can be helpful for practitioners who are working with men with experiences of excessive sexual activities. Below, we reflect on shamefulness and vulnerability, as well as on the importance of counteracting silence regarding troubled sexuality.

The results of this study it is suggested that practitioners should respectfully address questions of control and vulnerability, so that the potential impact of such questions might be

discussed. It also seems important to support the client to accept potential sexual desires that are perceived as passive and/or feminine so that such desires do not become avoided through excessiveness. Practitioners have to acknowledge that vulnerability and shame might be difficult to talk about, because of the nature of shame as a "not wanting to be seen" affect (Fisher, 1988; Kellog & Tatarsky, 2012). Therefore, an important first step is to counteract silence regarding sexuality and shame.

The advice to "*read between the lines*" should be taken seriously. Since shame is connected to a wish to disappear, it cannot be presumed that clients will express everything that is important to them, if they are not supported in doing so. Thus, the capacity to listen to what is not being said needs to be developed (Billig, 1997; Hollway & Jefferson, 1998). Clients should respectfully be asked questions about sexuality and potential sexual shortcomings, and practitioners have to be prepared to listen and support them. In other words, the evolving silence described by the participants need to be counteracted.

Without support, there is a likelihood of looking at oneself and coming to the conclusion that one has failed as an individual (Schore, 1994). However, supporting a client's struggles to overcome shame and shortcomings is not an easy task for practitioners (Kellog & Tatarsky, 2012; Parker & Guest, 2003; Shalev &Yerushalmi, 2009). When confronted with troubled sexuality, practitioners become affected themselves, and it might be "easier" to view troubled sexuality as something to diagnose. This could explain the considerable interest in how to diagnose so-called sexual addiction (Goodman, 1998; Hartman et al., 2012). Another way for practitioners to avoid being affected is to adopt the permissive attitude toward sexuality (Gavey, 2005). However, in order to support clients to overcome the less appealing aspects of sexuality, their suffering and shame have to be confronted. Consequently, practitioners are encouraged to initiate dialogues about troubled sexuality, shame, and gender with their clients, and be prepared to listen. This study concerned male clients. Research on

sexual misuse have predominantly concerned men, and male experiences, even though women are estimated to make up a substantial part of the individuals who have difficulties with sexual misuse (McKeague, 2014). It should be considered that etiology, as well as the meaning of excessive sexual activities, might be different for men and women (McKeague, 2014).

Limitations and future studies

The participants in this study had been exposed to severe childhood trauma and described painful experiences that could not be acknowledged in detail. Future studies should investigate how excessive sexual activities, vulnerability, shame, and perceptions about masculinity might be understood with respect to childhood abuse. Moreover, this study only concerned male clients. Studies should also examine excessive sexual activities among female clients, in order to clarify how women perceive these activities. Future studies should investigate connections between substance abuse and excessive sexual activities in order to shed light on the co-occurrence of these conditions.

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IV

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"It Wasn't the Proper Me"—Narratives about Alcoholism and View of Oneself: The Impact of Disavowed Shortcomings and Dissociation

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This work is based on interviews with socially stable individuals with a history of alcoholism. The interviews concerned the participants' views of themselves, their alcoholism, and how they came to increase their drinking against better judgment. The participants understood their alcoholism as inevitable, and as connected to life experiences. They expressed difficulties in accepting their own shortcomings, and in understanding their increased drinking. Dissociative processes seemed important for these difficulties. The authors suggest that clinicians should provide a therapeutic context characterized by understanding, in which it is possible to counteract dissociation, and possible for the patient to gradually accept his or her own shortcomings.

KEYWORDS *Alcoholism, dissociation, subjective experience, self, shortcomings*

Alcoholism is a condition that has been explained and understood from varying perspectives (Larkin, Wood, & Griffith, 2006; Orford, 2001; Vohs & Baumeister, 2009). Alcoholism has, for example, been viewed as a brain disease (Vrecko, 2010), as self-medication of emotional distress (Khantzian, 2003), and as a conditioned behavior that has been learned in a social context (Wanigaratne, 2006). There are established diagnostic criteria for assessing and diagnosing alcohol use disorders, such as the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) criteria. According to *DSM-5*,

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alcoholism is measured on a continuum from mild to severe, and criteria for the diagnosis are formulated to match the symptoms that patients display (American Psychiatric Association, 2013). When an alcohol use disorder is established, it becomes manifest as a unitary condition with general characteristics such as tolerance, symptoms of withdrawal, a preoccupation with the substance, and continued drinking despite knowledge of negative physical, social, and psychological consequences. Those general characteristics are important to clarify, to achieve an overall understanding of alcoholism, and to achieve understanding of similarities among individuals with alcoholism. Furthermore, individuals with alcoholism might experience a diagnosis as supportive. For example, the diagnosis might counteract brooding and feelings of shame and guilt and thereby allow the individual to fully engage in the struggle to achieve abstinence (Mendola, 2004).

In diagnostic systems such as the *DSM*, subjective experiences are rarely emphasized. However, in other traditions subjective experiences are regarded as highly important for understanding the development as well as the maintenance of alcoholism (Larkin & Griffiths, 2002; Sachs, 2003). When attention is paid to subjective experiences, it becomes possible to achieve knowledge that contributes to the development of treatment interventions adapted to the needs of the client. For example, Shinebourne and Smith (2010) found in an interview study that participation in treatment in itself does not necessarily provide enough support for individuals who struggle to achieve abstinence. According to their results, recovery from alcoholism cannot be seen as a result of intellectual reasoning articulated in treatment settings. Recovery should rather be seen as a process that has to be incorporated into everyday life. Therefore, Shinebourne and Smith (2010) argued that the circumstances of the client's everyday life, as well as the client's view of himself or herself, have to be acknowledged and integrated into treatment.

It has been proposed that alcoholism, as well as other addictions, should be viewed as a repetitive and paradoxical consummatory behavior that is acted out against one's "better judgment," to an extent beyond what is experienced as tolerable or desirable (Larkin & Griffiths, 2002). This reasoning underlines that alcoholism is an ambiguous and paradoxical condition. One example of ambiguity and paradox is that alcoholism is characterized by simultaneous and contradictory wishes both to resist, and to give in to, drinking (Evans, 1988). In this study, we use the view of alcoholism proposed by Larkin and Griffiths (2002), because it opens up for an understanding of subjective experiences and ambiguity.

Subjective Experience and Self-Perception

Larkin and Griffiths (2002) furthermore underlined that the role of self-perception needs to be addressed in theoretical as well as clinical under-

standing of alcoholism, as well as other addictions. In line with this, Sachs (2003) argued that therapeutic treatment with individuals with a history of alcoholism has to be anchored in an accurate understanding of the self. Sachs further stated that the self of the client might be characterized by, for example, vulnerability, self-attacks, or fear. Thus, treatment interventions have to be adapted to the specific self-perception of the client. Shinebourne and Smith (2009) also showed that the self of an individual with alcoholism is characterized by conflicts between different parts of the self. One self-part might be perceived as chaotic and prone to drinking, whereas another self-part is perceived as controlling, and the inner struggle between those parts is fundamental for the development of alcoholism and the process of achieving abstinence. However, the self is a concept that, just like alcoholism, has been understood and conceptualized from varying perspectives (DeCarvalho, 1991). In this work, the term *self* refers to the center of the experiencing individual. Thus, it is not a technical term but a term that refers to the subjective experience of oneself and one's life history (Frie, 1999; Kohut, 1977). In clinical practice the client's perception of self, and how to come to terms with oneself, are central issues (DeCarvalho, 1991; Parker & Guest, 2001). Clinicians therefore have to provide treatment that meets the needs of the client and acknowledges the specific self-perception, and the distress, that the client experiences (Parker & Guest, 2001; Toneatto, 2008).

In this study, we explore how individuals with a history of alcoholism understand their alcoholism and themselves. Interviews with individuals who earlier in life had met *DSM* criteria for moderate to severe alcohol use disorder, but now were abstinent, were conducted, and analyzed according to interpretative phenomenological analysis (IPA). The participants' understanding of how they had increased their drinking, against better judgment, was particularly addressed. As is presented, it emerged that increased drinking, against better judgment, is preferably understood in light of dissociative processes. Those dissociative processes are connected to overwhelming demands and difficulties accepting shortcomings. Knowledge and insight from this study will hopefully contribute perspectives on self-perception and alcoholism and provide increased understanding of treatment needs among individuals with alcoholism.

Aim

The overall aim of this study was to achieve knowledge about how individuals with a history of alcoholism understand their alcoholism and themselves. Furthermore, there was a specific aim of understanding how individuals, against better judgment, had repeatedly consumed increasing amounts of alcohol that exceeded what was experienced as tolerable and desirable and thereby developed alcoholism.

METHOD

Participants

Four men and one woman who had been to the same 12-Step residential care unit participated in this study. Clients might refer themselves to the treatment unit or might be supported by their employers to participate in treatment. In either case the treatment is voluntarily. Clients stay at the unit for 4 weeks, and thereafter they participate in after-care once a week. At the time of the interviews the participants were in after-care and had been free from alcohol for 8 months up to several years. The participants were so-called socially stable alcoholics who were in their fifties, lived in stable long-term relationships, and had children of various ages. They had a history of moderate to severe alcoholism, according to *DSM-5* criteria.

Procedure and Ethical Issues

After a dialogue with the manager and staff members at the 12-Step residential care unit, the first author was invited to present the study at after-care group meetings. The clients were informed that the study concerned individual experiences of alcoholism, with focus on how individuals increase their drinking against their better judgment. Clients were informed that the interviews would be recorded, that participation was voluntary, and that they were free to discontinue their participation at any time without having to give any reason. The clients were asked to contact the first author if afterwards they wanted to participate and to make an appointment for an interview. Before the interview, the interested clients were given written information about the study; thereafter they could sign a form to signify their choice to participate, or they could decline. As an introduction to the interview, the participants were once again informed that they could withdraw their participation, and that they were free to refrain from answering any question they considered too difficult or distressing. No one discontinued their participation, and no one declined to answer any questions. The interviews were audio-recorded and transcribed verbatim by the interviewer.

Interview

The aim of the interviews was to capture a rich description of the experience of alcoholism, how the participants against their better judgment came to drink more than was tolerable or desirable, and how they perceived themselves. The introductory question was, "Could you please tell me about your difficulties with alcohol, and if there are other experiences that you find important, feel free to describe them as well." Throughout the interviews, the participants were encouraged to express their personal experiences and

to reflect on issues they perceived as important. During the first 10 to 15 minutes the interviewer mainly listened, sometimes formulating short questions to encourage the participant to develop the narrative. Thereafter the interviewer, beyond short questions, also described for the participant how she perceived what the participant had been talking about, asking the participant to reflect on this perception and to correct misunderstandings or incomplete understanding. This was done to avoid misunderstandings during the forthcoming analysis. The interviews lasted for 80 to 90 minutes.

During interviews, there is always a risk of false understanding, especially if questions are at a general level (Smith, Hollway, & Mishler, 2005). For example, individuals with alcoholism tend to report that alcohol is used to relieve anxiety (Khantzian, 2003). If the interviewer comes to a halt with the term *anxiety*, say, in the belief that alcoholism is to be understood as self-medication against anxiety, the possibility of understanding the subjective experience of anxiety, what anxiety is connected to, and how it is understood, is lost. To counteract such risks, the interviewer during the interviews would move beyond established terms and diagnostic labels, in this example, by asking the participant to describe the anxiety and/or the situations in which it arose.

Analysis

The transcripts were analyzed by using IPA. In the field of addiction research, concerned with subjective experience, IPA has been suggested as an appropriate method, because it emphasizes the understanding of how individuals understand themselves and furthermore allows the researchers to make use of their own expert knowledge in the dynamic process of gathering and analyzing data (Besenius, Beirne, Grogan, & Clark-Carter, 2013; Larkin & Griffiths, 2002; Shinebourne & Smith, 2009, 2010). IPA beneficially provides a possibility of analyzing personal experience and understanding in a structured manner that remains close to the participant's narrative, yet enables interpretation. The topic of the study is explored in detail, and the understanding that the participants relate to their experiences is analyzed and interpreted. Because the participants during the interviews are free to develop topics they find important, the interviewer can follow the concerns of the participants. This approach permits the researcher to understand the psychological world of the participants; consequently, topics and insights that the researchers have been unaware of might be revealed (Smith & Osborn, 2003). Furthermore, because participants are free to develop the topics they find important, the approach allows ambiguities and contradictions to be articulated, and thereby analyzed and interpreted.

In the present study, the first step of the analysis was that the first author read and reread the interviews in their entirety and highlighted statements concerning alcohol consumption and self-perception. In the second step

both authors grouped the statements into subthemes, reaching a first level of abstraction of the data. In the third step the subthemes were grouped together, creating the four themes that are to be presented. At this stage a higher level of abstraction was reached. The four themes were repeatedly compared to the original data to assure that the analysis was grounded in the actual narratives. The fifth step was to connect the themes to each other in order to articulate a meaningful narrative about the narratives. In the final step the connections between the themes, and the narrative about the narratives, were compared with the interviews to ensure that the actual interviews and statements had not been distorted during the analysis.

RESULTS

Four themes emerged as important during the analysis. Those themes were labeled (1) inherent alcoholism, (2) personal experiences, (3) proper me and not me, (4) overwhelming demands. The themes, which are to be presented and discussed, are neither mutually exclusive, nor are they definite or clear-cut. Therefore, they are preferably seen as a conceptualization of an ambiguous and contradictory condition. Quotes from the interviews will hopefully show how these themes are grounded in the participants' understanding of themselves. The participants described themselves as alcoholics, and described their drinking behaviors as excessive or, "too much." Therefore, when the prior drinking behaviors described by the participants are discussed, the term *excessive drinking* is used.

Inherent Alcoholism

Throughout the interviews, the participants described themselves as inherently addicted and viewed alcoholism as an inevitable part of themselves. They sensed that they had a genetic predisposition to alcoholism, and an addictive personality that made them vulnerable to developing different addictive behaviors. For example, they could describe themselves as preoccupied with work, exercise, or intimate relationships to such an extent that they sensed that *addiction* was a proper term.

> I also think it has to do with an addictive personality. I have always pushed myself to the limits. I was a workaholic. And in a sense I liked it.... But that part of my personality also made me drink too much.

Alongside the description of alcoholism as an inevitable part of oneself, the participants understood themselves as representatives for people with alcoholism, "It is a disease.... It is so obvious, everyone ... we are all just the same." The view of oneself as inherently addicted was connected

to an understanding of alcoholism as an inherent disease. This could be explained in the following way, "It's a disease. Just like heart failure or diabetes.... I do not feel ashamed for what I have done. It was not me, it was the disease." In sum, the participants understood their alcoholism as a condition that was out of their control and described that they repeatedly had consumed alcohol against their better judgment, because they were alcoholics. They sensed that they had a genetic vulnerability, an addictive personality, and/or that they suffered from a disease. In other words, they viewed themselves as inevitable alcoholics and understood their excessive drinking as a consequence of their inherent alcoholism. In this way, they grasped an understanding of themselves and their alcoholism, and through this understanding they could avoid painful experiences of shortcomings and shame. They also sensed that it was possible to focus on the drinking behavior, and to refrain from alcohol.

Personal Experiences

Although the participants understood themselves as inherently addicted, they simultaneously expressed that their life experiences had been formative for their alcoholism. An illustration of this occurred when one of the participants started his narrative by saying, "To explain my drinking I have to talk about other things." He sensed that it was impossible to give a proper description of his alcoholism unless he described himself, his life experiences, and the difficult circumstances in his life, when he against his better judgment increased his drinking. Throughout the interviews, the participants repeatedly stated that their alcoholism could not be understood unless attention also was paid to their life history, and they underlined the importance of relationships and social context.

> When I was 17, I was drinking like an adult. Nice wines for dinner, always fine food and nice wines. I was engaged in a political party. The others were older and I wanted to be grown up and competent. I always want to be competent. And that was how we socialized. It was ... sort of an ideal I had ... In my family, when I grew up ... if something was celebrated, it was always celebrated with alcohol. Alcohol became so important....

Beyond descriptions of relationships, and social context, the participants also understood their alcoholism as connected to painful experiences. There were no descriptions of traumatic experiences. Rather, certain areas in life became increasingly difficult to handle until the participants reached a point where life was perceived as overwhelming, and alcohol became a momentary solution. The participant who said that it was necessary to "talk about other things" expressed himself in the following way:

> I was really badly treated at work, but I have always been "too nice." I should have said, "Don't go further, here's my limit." But that is how I am ... I spoke to my boss and the labor union, but I never really talked to anyone, for real. I should have raised my voice.... Instead, things got worse and I hid everything inside, as I've always done. Then one day, I couldn't cope with it anymore. I just felt panic when I went to work, and the panic grew. And a friend told me to have a glass of wine to relax. And I tried, and I thought ... just for a while....

So, parallel with the understanding of alcoholism as an inevitable part of oneself, and oneself as a representative for people with alcoholism, alcoholism was also understood against a background of painful personal experiences. Still it could be hard for the participants to understand the increasing drinking, "I've been thinking so much about this. I have been wondering, how did this alcoholism evolve? How could it happen?"

In sum, the participants not only understood themselves as inherent alcoholics, but also simultaneously saw their alcoholism as evolving out of their life experiences. They sensed that contextual factors and the culture surrounding alcohol had been formative for their alcoholism but gave prominence to painful experiences and difficulties in handling distress and adverse circumstances.

Proper Me and Not Me

When the participants described how they came to drink more than was tolerable and desirable, it emerged that they understood their alcoholism as an alien part of themselves. It was as if an ego-dystonic part took over, bought and consumed the alcohol, as described with the following words:

> It was like an inner force, which I couldn't control. I went from work.... I was going home ... but suddenly I was outside the liquor store. The car went by itself ... I cannot explain it. I was going home, that was what I was thinking, but there was this force that wanted to have alcohol. I knew ... this destructive lifestyle ... It wasn't me.

Repeatedly, the participants stated that engaging in excessive drinking was not a part of their proper selves neither was excessive drinking accepted by the proper self. It was important for the participants to underline that they had been raised to behave well, and to be competent. The not-me part that had acted out excessive drinking was the opposite of this ideal.

> You don't recognize yourself. Always a bad conscience ... towards kids, relatives, work. To lose one's driving license. To drink! The relatives were worried. You just don't behave like that! I wasn't raised that way. It's not in line with my vision, so to speak.

The participants also described painful experiences when they had been forced to question their perceptions of themselves. One participant recalled that in early adulthood he was a daredevil who was into extreme sports. His interest in extreme sports was authentic and a source of joy, but simultaneously he developed an identity that was centered on being adventurous and tough—an identity that he had to live up to. One day, he developed a serious infection, but did not allow himself to rest. He got exhausted and fainted. Suddenly he perceived himself as vulnerable, became terrified, and started questioning his life and himself.

> I wanted to maintain ... my status ... that is not the proper word, but I can't find any better.... I had never been vulnerable. It influenced my whole life, that single occasion.... It was so shameful. I was always brave and competent. I liked being competent and was good at what I did. I don't see any negative sides in that. But it was ... so hard ... not being brave and competent. The shame struck me, not being able to be what I wanted to be, or had been. That pain was harder than the negative effects of drinking. The alcohol was a side issue.... I drank to be able to continue being tough and managing to do things.

So, for the participants, the increasing drinking and the alcoholism were connected to distressing perceptions of themselves. However, the self was not a unitary entity. On the contrary, the self was ambiguous and consisted of conflicting parts. It was as if an alien part had enacted the excessive drinking, and that part regarded excessive drinking as ego-syntonic. Simultaneously, the proper me regarded excessive drinking as ego-dystonic. Due to these conflicting parts, drinking was enacted against better judgment.

Overwhelming Demands

A pervading theme was the participants' understanding of alcoholism as a response to overwhelming demands. The participants related that overwhelming demands could be connected both to their own demands on themselves to always be competent and to distressing experiences and circumstances. Overwhelming demands could concern, for example, not only unreasonable tasks and expectations at work, but also difficulties connected to family life. One participant was married and had four children. When one of the children became affected by a severe illness, he described the demands with the following words:

> Always hospitals and examinations ... and I had this demanding managerial position at work, and I became completely exhausted. I saw only work, also at home, all the time, my child needed care all the time. Work, work ... Of course alcohol makes it worse, but it felt easier. Nothing felt good anyway.

The life situation became increasingly painful and demanding, until he reached a point where everything felt hopeless and beyond control. In this highly distressing situation the married couple did not find a way to talk about the difficulties and how to handle them, and no counseling was offered. The participant knew that drinking did not solve anything and only aggravated the problems. However, everything felt hopeless, and with alcohol, the distress and demands could momentarily be escaped.

Interestingly, demands could also arise from within, as described in the following quote, "I've always been the one that should be very competent. I was raised to be competent. 'Look! He's so competent.' And I liked it in a way. Deficiencies were not allowed in my family." It was as if the participants sensed that they were not allowed to fail. It was so hard for them to admit that they did not have the strength to handle the situation, and to reach out for support. They described themselves as overly concerned with being successful and competent, or complying with expectations and demands from others. At the same time, their striving for competence, strength, and success had turned into a personal characteristic that they appreciated. Thus, they pushed themselves a little more. It was as if giving up, or admitting that their strength was a finite resource, was not an option for them.

Comprehensive Understanding

With thoughtful engagement, the participants described their alcoholism, and how they viewed themselves and their difficulties. In the narratives, there were descriptions of how alcohol initially was consumed in a more or less ordinary way, even if the participants in retrospect could question their underpinnings for drinking. The participants also described painful experiences, circumstances, and demands that were important for their increasing drinking. Furthermore, the participants described how they functioned when they had become alcoholics. Nevertheless, it was hard for the participants to articulate how they came to increase their alcohol consumption to a point where they developed alcoholism. The participants knew that they had acted against better judgment, but still they could not comprehend how they came to act against better judgment. It was remarkably hard for them to articulate thoughts on how they came to increase their drinking. In the narratives, there was a missing link regarding how ordinary consumption developed into alcoholism. Interestingly, this missing link concerned the specific aim of this study, namely to understand how individuals, against better judgment, repeatedly consume amounts of alcohol that exceed what is experienced as tolerable and desirable. It seems as the thought of oneself as an individual who could have hindered the process toward alcoholism, but instead gave in to excessive drinking, became overwhelming, and therefore this shortcoming had to be disavowed. When the participants were asked to describe how they came to increase their drinking, against better judgment, excessive drinking

was described as "not me" and as a disease, whereas thoughts on personal experiences, relationships, demands, and social context became conspicuous by their absence. Through experiencing excessive drinking as "not me," and simultaneously view oneself as a representative for the inherent addict, it became possible to shield oneself from painful thoughts of shortcomings, personal responsibility, guilt, and shame.

DISCUSSION

Dissociation seems to be an adequate concept for understanding the difficulties the participants had in articulating a coherent story, and a coherent perception of themselves regarding how they came to increase their drinking against better judgment. Therefore, the participants' understanding of themselves, and their disavowing of inabilities and shortcomings are considered with respect to dissociative processes. Thereafter, clinical implications of the findings are discussed, and some suggestions on how to approach dissociation, lack of self-coherence and acceptance of shortcomings, among individuals with a history of alcoholism, are presented.

Dissociation

Dissociation is a psychological process in which painful experiences become disavowed through disintegration of psychological functions and parts of the self (Holmes et al., 2005). In this process an ego-dystonic part comes to hold the painful experiences. This part becomes estranged and located outside the self. The individual is shielded not only from the painful experience but also from painful insights into oneself. Dissociation has numerous expressions and is conceptualized as a continuum from nonpathological "everyday" dissociation, over mild difficulties, to severe pathologies (Holmes et al., 2005; van der Hart, Nijenhuis, & Steele, 2006). Furthermore, dissociation is defined as a defense against painful experiences and as a distress. Dissociation is a beneficial defense when the disintegration supports the ability to withstand momentary distress. However, dissociation might become an automatic answer to a variety of experiences. As such, it limits the possibility to develop adequate reactions and strategies for managing distress and overwhelming experiences, and furthermore creates a self that lacks coherence.

Various Understandings, Various Selves

During the interviews, the participants understood their alcoholism from various perspectives, for example, as an inherent part of themselves, out of heritage, and simultaneously as a result of experience and demands that they had not been able to handle. These various understandings reflect how

individuals create an understandable narrative about themselves. According to McAdams (2001), the understanding of oneself is an evolving, dynamic narrative in which different, and sometimes opposing, experiences are integrated. No single, unambiguous narrative has the capacity to capture the life story and the self-perception of the individual. Various understandings of alcoholism, and of oneself, are, in other words, not inherently problematic. However, difficulties arise when dissociated parts of the self cannot be brought into a coherent story (Evans, 1988; Kellog & Tatarsky, 2012; McAdams, 2001; Weegman, 2005). The participants in this study knew that they themselves had enacted the excessive drinking. This insight conflicted with their view of themselves as competent and dutiful. Therefore, the insight was highly distressing and had to be disavowed. The anxiety became momentarily mitigated when the participants perceived excessive drinking as enacted by "the addict." However, the addict was a dissociated part, and as such, counteracted coherence of the self and the narrative. Unfortunately, the sense of not understanding oneself in itself became distressing and therefore had to be disavowed. Thus, the dissociative defense against distress paradoxically fueled the distress.

Disavowal of Inability and Shortcomings

For our participants, the distress was connected to painful experiences of being vulnerable and/or unable to live up to demands from others, or from oneself. The difficulty of accepting vulnerability, inability, and shortcomings was described as lifelong, and therefore experiences connected to shortcomings had been repeatedly dissociated. As long as life was perceived as manageable, and as long as demands were not overwhelming, this dissociation could to some extent support the ability to withstand momentary distress. However, when distress connected to vulnerability and shortcomings became overwhelming, the participants sensed that they lacked the ability to calm themselves and instead turned to alcohol to mitigate the distress. Paradoxically however, drinking alcohol was perceived as a shortcoming. Thus, the painful experiences of vulnerability and inability became even more pronounced and therefore had to be disavowed. Through a spiraling process of dissociation, the initial experience of shortcomings and the increased drinking came to be placed outside the proper me. When shortcomings and drinking were dissociated, it became possible to maintain a view of the proper me as competent and able to live up to demands. Unfortunately, this process increased the gap between what was perceived as the proper me and what was perceived as not me. A negative process of dissociation, distress, and increasing drinking was thereby developed and maintained.

At the heart of the spiraling dissociation and the developing alcoholism was a perception that one had to be competent and able to live up to

demands. This perception had become ego-syntonic, and thus, the competent me became equated with the proper me, and there was no place for shortcomings. Characteristics that were connected to inability and shortcomings were placed in the dissociated part, and this part came to hold "the addict." One part of the self was perceived as the proper, competent me. Another part was perceived as the addicted one. One part consumed increasing amounts of alcohol, whereas another part simultaneously held the judgment toward the drinker. In light of these dissociative processes, it becomes possible to understand the process of drinking against better judgment.

The connection between alcoholism, lack of self-coherence, and dissociation is well known (Evans, 1988; Weegman, 2005). However, it seems that dissociation has been examined primarily among individuals who have been victims of abuse and neglect during childhood (Evans, 1988) and/or suffer from severe psychological difficulties, such as personality disorders (McDowell, Levin, & Nunes, 1999) and posttraumatic stress disorder (Goldstein et al., 2011; Najavits & Walsh, 2012). These studies show how, for example, dissociative identity disorder and severe dissociative episodes contribute to the development of addiction and complicate the treatment process. For the participants in this study, dissociative processes were milder and centered on the struggle to maintain an image of oneself as competent and able to live up to expectations and demands, both from others and from oneself. However, even if the dissociative processes were mild compared to those dissociative processes that have been thoroughly described in earlier studies, they had considerable impact on the individuals and their alcoholism.

Clinical Challenges and Implications

Because dissociative processes seem to have considerable impact, it is important that dissociative processes are properly acknowledged in treatment (Chapman, 1992). However, dissociative processes are hard to identify (Chapman, 1992). Because dissociation occurs outside cognitive awareness, the individual is not capable of describing the dissociative process. However, the effects of dissociation are experienced and can be described by the client, and thus can be perceived by the clinician (Holmes et al., 2005; Weegman, 2005).

Based on what was related by the participants in this study, it might be beneficial to view alcoholism among socially stable individuals as a syndrome of shortcomings that have been dissociated. For an individual who lives under the demand to be competent and invulnerable, personal deficiencies, like inability and shortcomings, become unacceptable. When the perceived personal deficiencies become increasingly distressing, they fuel dissociative processes. A "not me" part comes to hold the dissociated experiences, and this part is held responsible for the increasing alcohol consumption. Thus, the

distance between the ego-syntonic, competent self-part and the ego-dystonic self-part increases, and so does the distress. A clinical challenge is to support the client to integrate the "not me" part, so that personal deficiencies and shortcomings slowly might be accepted, instead of overwhelming (Chapman, 1992; Evans, 1988).

It is important to acknowledge that the participants in this study had been to 12-Step treatment, in which a part of treatment is to educate the clients about alcohol as a disease, and furthermore to make them accept that they are alcoholics. This intervention technique might be labeled as a strengthening of the defenses. Strengthening the defenses is regarded as an appropriate technique when supporting clients through crises (Rockland, 2003). Achieving abstinence should be perceived as a crisis, because achieving abstinence is highly distressing, physically and psychologically. During the process of achieving abstinence, it is reasonably inadequate to acknowledge questions of self-perception and how one came to drink excessively against better judgment. Another part of 12-Step treatment is to strengthen the identity of recovery, as a way to help build a new life (Kellog & Tatarsky, 2012). In this treatment phase, dissociative processes might be seen as an example of a beneficial defense. However, dissociation is in the long run not only a beneficial defense but also a possible distress that hinders adequate handling of shortcomings and overwhelming experiences. Moreover, dissociation is a hindrance for achieving self-coherence (Holmes et al., 2005; Sachs, 2003; Weegman, 2005). Automatic dissociation therefore has to be acknowledged in the prolonged treatment process; otherwise, dissociative processes might be risk factors for relapse (Chapman, 1992; Evans, 1988).

We would therefore like to suggest that clinicians working with socially stable clients with a history of alcoholism seek to understand how their clients perceive shortcomings, and themselves. If the client perceives that the alcoholism is connected to distress regarding shortcomings, it is important to analyze this connection, with awareness of the possibility of dissociative processes. Potentially dissociated parts have to be integrated and accepted, so that the clients slowly become able to perceive inability and shortcomings as part of human existence, and therefore also of themselves (Evans, 1988). However, acceptance is not easily achieved, and treatment of dissociation is highly complex (Holmes et al., 2005). Furthermore, while one part of the client might be concerned about achieving abstinence, another part of the client might identify with the addict (Kellog & Tatarsky, 2012). The integrative process therefore has to be handled with therapeutic skill and sensitivity and has to be adapted to the psychological needs, and the multiple self-parts, of the client (Kellog & Tatarsky, 2012; Parker & Guest, 2001). It is distressing to admit shortcomings, and for the participants in this study, merely the thought of personal shortcomings was distressing. The therapeutic process of integration therefore has to be gradual, so that the individual is

not overwhelmed by distress connected to shortcomings. Clinicians working with clients with a history of alcoholism should therefore create a treatment context characterized by patience and empathic understanding of the psychological world of the client. In such a context the client will hopefully be able to integrate dissociated parts, and achieve acceptance of shortcomings, and of oneself.

Limitations

There are several limitations in this study. First, during the interviews, the interviewer described to the participants how she perceived their narratives. This was done to give the participant the opportunity to correct misunderstandings. This technique might, however, have led the participants to develop topics that were perceived as important by the interviewer, even though the topic was not inherently important for the participants. On the other hand, IPA is a method that allows researchers to make use of their expert knowledge, thereby acknowledging the interactive aspects of interviewing (Smith et al., 2005). Furthermore, the participants were in 12-Step after-care that included education about alcoholism as a disease, and this treatment intervention might have influenced the narratives. However, the technique of moving beyond established terms and diagnostic labels, asking participants to describe their personal experiences, might have counteracted this influence.

It is important to take into considerations that this study concerned socially stable individuals without severe psychiatric difficulties. For them, shortcomings and personal demands to be competent were distressing. Results from this study should not be applied to clients with severe psychiatric difficulties and traumatic childhood experiences, because their distress reasonably concerns other experiences, affects, and perceptions.

The aim of the study was to achieve knowledge about how socially stable individuals with a history of alcoholism understand their alcoholism, and themselves. The understanding was retrospective. As a suggestion, future studies should examine how individuals with so-called risk consumption of alcohol understand their drinking and themselves and analyze the narratives with awareness of dissociative processes. Such a study might contribute knowledge that is important for hindering the development of alcoholism.

Finally, we find it important to note that in a work like this, some statements that were important to the participants are absent in the final report. We are not able to reproduce every topic or experience that was important to the participants. We truly appreciate the efforts the participants made to explain how they experienced themselves and their difficulties, and hopefully, we have reflected on their narratives without too many misunderstandings or distortions.

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