

“It’s A Deficiency Disorder”. Clients Understanding of Substance and Behavioral Addictions and Treatment Needs: An Interview Study

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Received: July 28, 2016

Accepted: September 03, 2016

Published: September 06, 2016

Citation: Punzi E. 2016 “It’s A Deficiency Disorder”. Clients Understanding of Substance and Behavioral Addictions and Treatment Needs: An Interview Study. *J Reward Defic Syndr Addict Sci* 2(2): 46-54.

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Published by United Scientific Group

Introduction

During past decades, researchers and clinicians have acknowledged the co-occurrence of substance and behavioral addictions (excessive food intake, sexual activities, Internet use, gambling, exercise, and shopping). It has for example been shown that clients who attain abstinence from substances instead might “switch addiction” and develop excessive gambling [1, 2]. It has also been shown that clients might use substances and one or several behaviors concurrently [3, 4]. The phenomenon is complex and it is often difficult to distinguish between the switching of addictions and the concurrent use of substances and behaviors. In this study, the term co-occurring addictions refer to both the switching of addictions and the concurrent use of a variety of objects. Co-occurring addictions are not uncommon. It has been estimated that 58% of individuals with any addiction have 2-4 other co-occurring addictions [5]. When clients in substance abuse treatment had the opportunity to self-report behavioral addictions (sexual activities, food intake, gambling and exercise), 67% reported such difficulties [6]. Through brain imaging studies it is possible to evaluate underlying brain systems pathology and also visualize effectiveness of treatment [7] and through interview studies it is possible to investigate the shared phenomenology of addiction to substances and behaviors [8-10]. In line with this, some researchers view addiction to substances and behaviors as varying expressions of an underlying difficulty or deficiency [11-14]. The term behavioral addiction is however questioned. It has for example been noted that any behavior might be labeled as addictive and the term might thus come to lack meaning [4, 15]. Moreover, there are researchers who differentiate between substances and behaviors since some characteristics and prerequisites are specific to certain behaviors. Excessive Internet use is for example connected to accessibility to the Internet, and since older clients use the Internet to a lesser extent, their risk to develop excessive use is relatively low [16]. Moreover, difficulties with food intake and exercise should be considered with respect to questions of physical attractiveness, since such difficulties are connected to strivings for physical attractiveness [17]. With awareness of the many clients who struggle with one specific substance or behavior, and with awareness of the importance of investigating substances and behaviors separately, this paper concerns addiction as a syndrome that might take varying expressions.

Larkin and Griffiths [18] define addiction as a state in which an object is used to an extent that is beyond what is experienced as tolerable or desirable. This paper is written in accordance with this definition of addiction. It should however be noted that some researchers prefer the term compulsion, which acknowledges that individuals concerned tend to experience a demand to enact behaviors or consume substances [19-22]. Other researchers prefer the term impulse control disorder, which acknowledges the impulsivity that characterizes enactment [12, 22-25]. Yet others use the term reward deficiency syndrome, thereby underlying the inability to experience feelings of reward and satisfaction [14, 26, 27]. The

term addiction has also been questioned for being connected to a view of clients as suffering from an inherent dysfunction, a perception that might imply a sense of hopelessness that in turn might complicate recovery [18, 28]. Diagnostic terms are descriptive and accordingly do not aim at capturing how individuals concerned understand their difficulties and treatment needs. In clinical practice, it is however necessary to acknowledge the clients subjective experiences. Clients with excessive sexual activities need a variety of treatment interventions that are adequate with respect to the emotional and relational patterns of the individual concerned [29]. In line with this, compulsive buyers [20] as well as pathological gamblers [30] are heterogeneous groups and therefore it is necessary to investigate and provide a variety of treatment interventions. Moreover, the self-perception, life-world, and the clients understanding of her or his difficulties should guide treatment planning [2, 31-34]. Taken together it seems as if investigations of clients perspectives might contribute insight into the lived experience of co-occurring addictions and thus improve the possibility to provide successful treatment. Consequently, the purpose of this study was to investigate how clients with a history of co-occurring addictions understand their difficulties and their treatment needs.

Material and Methods

It is not possible to present a complete overview of research concerning co-occurring addictions. One reason is that the varying terms produce a vast number of possible search combinations; another is that there are varying thresholds for defining a behavior as problematic or pathological. Yet another reason is that the field of addiction is investigated from a variety of perspectives, for example psychological, neurobiological, and sociological.

In the preparation of this paper, a systematic search was performed on psycINFO and PubMed between May 27 and June 3, 2016. The following keywords were used; behavioral addictions/process addictions/reward deficiency syndrome/multiple addictions/excessive behaviors, combined with clinical practice/treatment/subjective experiences/phenomenology. Original empirical articles that included clients and/or had a declared clinical focus were included. A number of articles

were excluded due to the chosen search procedure. This paper should therefore not be seen as representative for research concerning co-occurring addictions. It rather contributes a clinical perspective centered on the experiences of clients concerned.

Procedure

This study is a spin-off from a comprehensive research project concerning co-occurring addictions. Participants were recruited through information sheets, placed in the waiting room of an outdoor substance abuse treatment unit in the Swedish public health and social care system, aimed at clients with poly-substance abuse. Clients with a history of co-occurring addictions were asked to participate in an interview study. When the interviews were completed, the six participants in the comprehensive research project were asked to participate in an additional interview concerning their perception of addiction and treatment needs. Five participants participated in the additional interviews. The sixth participant wanted to devote time to his wife and children and therefore declined further participation.

The study was approved by the Regional Ethics Review Board, Sahlgrenska Academy, Gothenburg, Sweden. The participants were informed that they were free to discontinue their participation at any time without having to provide a reason. They were also informed that they were free to refrain from answering any question they considered difficult or distressing.

Participants

The participants, four men and one woman, have thus prior to this study participated in a research project in which they were interviewed about their addictions, childhood experiences, and current life situation. In addition, an experienced psychiatrist performed a Structured Clinical Interview for DSM-IV Axis I Disorders (SCID) [35].

The participants were given the assumed names Adam, Benjamin, Charles, David, and Felicia. Their prior substance abuse and behavioral addictions are presented in Table 1, psychiatric diagnosis and life situation are presented in Table 2. The participants were free from substances. Adam, Charles, and Felicia were also free from behavioral addictions. Benjamin

Table 1: Prior substance and behavioral addictions.

Assumed name	Age	Time of substance abstinence	Age of onset, substances	Substance addiction	Behavioral addictions
Adam	35	2 years	14	Alcohol, amphetamine, benzodiazepine	Binge eating, exercise, Internet, sexuality
Benjamin	39	1 years	13	Alcohol, amphetamine, benzodiazepine, cannabis	Binge eating, exercise, sexuality
Charles	30	2 years	14	Alcohol, amphetamine, benzodiazepine, cannabis	Binge eating, gambling, Internet, sexuality, shopping
David	44	2 years	13	Alcohol, amphetamine, benzodiazepine, cannabis	Binge eating, exercise, sexuality
Felicia	25	1 years	19	Alcohol, amphetamine, benzodiazepine	Binge eating, exercise, sexuality

Table 2: Current psychiatric difficulties and life situation.

Assumed name	Relationship status	Current DSM-IV Axis-I diagnosis	Global assessment of functioning	Employment status
Adam	Stable relationship	Bulimia, Depression, OCD	50	Working part-time
Benjamin	Single	PTSD	50	Retired early
Charles	Stable relationship	PTSD, Specific phobia	60	Working part-time
David	Single	None	75	Working full-time
Felicia	Stable relationship	None	65	Student

and David had decreased their behavioral addictions, but could still struggle with food intake and masturbation. They did not enact behaviors excessively but sensed that they should refrain from sexual activities and restrain eating habits since they perceived themselves as being at risk for overconsumption. The participants had been in treatment from one year up to several years. Treatment included supportive therapy with a social worker and/or psychiatric nurse once a week, and medication and contact with psychiatrist, when needed. Behavioral addictions had not been systematically identified or diagnosed. The behavioral addictions of the participants were thus self-reported.

Before achieving abstinence, the male participants had been temporarily employed and temporarily dependent on social welfare. The female participant had worked as a stripper and a prostitute. She had also repeatedly participated in sexual activities on the condition of others without having felt sexual satisfaction herself. There had been periods when she refrained from drugs and sexual activities and during those periods she worked as a nurse assistant.

All five participants had grown up in families in which at least one parent had a severe substance abuse. The parents of Benjamin, Charles, and Felicia were also involved in criminal activities. Moreover, these three participants had been severely emotionally, physically, and sexually abused. Adam and David had been emotionally and physically abused and exposed to adults' sexual activities and use of pornography.

Interview

The aim of the interview was to support the participants to talk about their subjective experiences of addictions and treatment needs. With such an aim, an interview schedule based on open questions is recommended [36]. Follow-up questions served to support the participants to further describe their experiences. The schedule concerned three topics; (1) the participants' understanding of addiction, (2) the participant's understanding of treatment needs, (3) suggestions to clinicians. The interview schedule and examples of follow-up questions are presented in [Annex 1 \(Supplementary file\)](#).

The interviews lasted for 35-45 minutes and were performed by the author, who is also an experienced clinical psychologist. The interviews were audio-recorded and transcribed verbatim, including pauses and non-verbal expressions.

Analysis

The interviews were analyzed according to interpretative phenomenological analysis (IPA). In IPA, the experiences of the participants are in focus and the aim is to understand how individuals concerned understand the studied phenomenon [37]. The analysis remains close to the participant's narrative, yet enables interpretation [38]. The phenomenon is explored in detail and the analysis is based on an interview that follows the concerns of the participants. In order to make a detailed analysis, a relatively small group of participants is recommended [39]. This approach permits understanding of topics and insights that the researcher has been unaware of [38]. Each case is analyzed separately and thereafter similarities and differences across the cases are examined. Shared as well as individual understandings of the studied phenomenon are presented.

In the present study, the author read each interview separately, identifying statements relevant to the studied topic. In the second step, these statements were grouped into subthemes. In the third step, the subthemes were grouped together, creating the four themes that are to be presented. Thereby a higher level of abstraction was reached. The themes were repeatedly compared to the interview data, to assure that the data had not been distorted during the analysis. In the final step, the themes were related to each other in order to present a comprehensive narrative that represents the experiences of the participants. The themes are illustrated with quotes. Statements that could risk the anonymity of the participants were however excluded from quotations. This is marked with /.../. To further safeguard the privacy of the participants, quotations have sometimes been slightly changed. Neither the content nor the meaning have however been distorted. It would have been methodologically adequate to provide all quotes verbatim. Methodological and ethical questions however have to be balanced, and it was considered appropriate to safeguard the participants' privacy.

Results

In the analysis the following themes were identified; (1) A state of deficiency and dissatisfaction, (2) Time and comprehension, (3) Meaning, (4) Suggestions and criticism. Since the analysis was based on interviews in which the participants were encouraged to talk about their subjective

experiences, the identified themes are not mutually excluding, but rather provide structure to a complex phenomenon.

A state of deficiency and dissatisfaction

When the participants were asked to describe how they understood addiction, they spoke about a state of deficiency and dissatisfaction. No matter how much, or what, they consumed, they had never felt satisfied. Moreover, they felt dissatisfied with themselves. The participants understood addiction as a preoccupation with consumption that could concern a variety of objects. Charles described this preoccupation with the following words;

I can't get things out of my mind. I get obsessed. It doesn't matter if it's drugs or sex or candy /.../ It's the same pattern. I can't let go and it's a way to escape myself.

Addiction was described as a process in which one could escape oneself as well as experiences of deficiency, dissatisfaction, loneliness, and self-blame. Simultaneously addiction involved self-destructiveness; a confirmation of a negative self-perception. Such self-destructiveness was paradoxically connected to a triumphant feeling. As Benjamin said;

There's a strange relief when I do things I know I shouldn't, like masturbation or binge eating. It's like "Ha! Now I'm doing it"... I allow myself to do it to myself. The feelings are very mixed. Also with exercise: I know it's good to exercise but for me it's like "Here you are, you deserve this pain".

The male participants understood their addictions as self-destructive. Felicia saw her use of substances and sexual activities as self-destructive whereas her preoccupation with exercise was rooted in strivings to take care of herself but while exercising she became obsessed;

I start to exercise because I like it and I want to take care of myself. And that's fine. But I become obsessed. I go to the gym... But I'm never satisfied. I always sense that I should work out more. So I'm there more often, and I go on diets but it's not enough anyway. I exercise more and have more food restrains and think about it all the time. It becomes out of proportion. Then it's an addiction.

When the participants were asked to specify when a behavior became an addiction they avoided discussions of specific amounts. Instead they spoke about unreasonable amounts and pondered the reasons as well as the consequences of consumption. The constant sense of deficiency and dissatisfaction with oneself was connected to lifelong experiences of loneliness and broken relations. David said that addiction should be labelled a "deficiency disorder". His expression captures how the participants understood addiction as a state of deficiency, connected to emotional and relational deprivation, which creates experiences of insatiability and dissatisfaction.

Time and comprehension

The participants understood addiction as a complex phenomenon that involved a variety of difficulties. From their perspective, recovery from addiction is not only about

refraining from substances and behaviors; it is about changing one's life. The old lifestyle was characterized by lies and broken relations. It was therefore important for the participants to be honest and develop trustful relations. In this process, the participants needed someone who listened and strived to understand them. Thereby they could move toward some sense of trust, in others as well as in themselves. Felicia said;

It has been important to have (name of therapist) to talk to. It gives a sense of not being alone... /.../ Someone is there for me for a longer time. It has been so rewarding that someone is there without wanting something in return from me.

This quote reminds us that the participants had experienced a variety of traumas, including abuse. Mistrust and disappointment connected to such experiences still complicated their life and recovery. There was a wish for genuine intimate and social relations though such relations were hard to achieve. Relations had been arenas for exploitation; the participants had both been used by others and had also used others, and such patterns were hard to change. Relations with professionals provided experience of trust and hope and were therefore important. The participants underlined that change takes time since there are so many parts of life that need to be dealt with; trust, traumas, own shortcomings, and the suffering one had caused others. Abstinence was the first step. When abstinence was reached, the participants had to face themselves and their life course, an experience that was even harder than gaining abstinence. Benjamin explained it with the following words;

The problems are not over when you stop doing drugs. For me... these years of... becoming abstinent, they have been really sorrowful and... tragic. I have been totally alone and many times I've been thinking about suicide. Sorrow returns... you remember everything and it is so hard... It takes a long time and you need company.

In treatment, the participants could talk about themselves, their difficulties, memories, and emotions, as well as their progress, in way and at a pace they felt comfortable with. They strived for comprehension, genuine relations, and balanced perceptions of themselves. Moreover, they wished to develop a relaxed approach toward food, sexuality, exercise, and other behaviors they had been pre-occupied with. Since their difficulties were complex, they sensed that long-term treatment was a prerequisite for recovery. Charles described recovery and the importance of relations with the following words;

It's like love, a relationship ... incredibly similar to a relationship. It's security. A partner. To remove that, or for a person to abandon it... support is needed. To dare to be sad, and grieve. It hurts. It's a loss. Because it's a farewell to security, a life, a relation. It awakens a grief you didn't even know of. Often it's turned to anger, because you're not used to handling sorrow. This has to be taken seriously. Maybe there was no hope or meaning in that life. And maybe this was as close to love as that person could get. You have to take it seriously. Don't reduce it. It's about love.

Meaning

Even though the participants described treatment as necessary for recovery, treatment was no miracle cure. Treatment takes place one or a few hours each week, on scheduled occasions. Overwhelming experiences, craving, loneliness, and sorrow do however not take place on scheduled occasions. The participants said that in order for true recovery to occur, they needed a social context and they needed to live a meaningful life. Lack of meaning was even described a risk for relapse since loneliness and frustration could be so overwhelming that being abstinent was perceived as useless; life was terrible anyway.

Religion, spirituality, and artistic expressions had been important for recovery and well being as well as for developing meaning. Adam and Charles described themselves as religious persons and their Christian faith was central for them. Benjamin described himself as a spiritual person and believed in "some kind of God". In the following quote, Charles talks about his Christian faith and what it means to him;

The first time I prayed... I had been through so much, and caused so much pain both to those I loved and to myself. I had decided to commit suicide. But then I thought, I'd give it one more chance... so I tried the only thing I hadn't tried. I fell down to me knees and I prayed to God for support. From that moment my life changed. /.../ Everything wasn't perfect, I had some relapses and backlashes. But I felt different. I didn't have to cope with everything alone.

Religion and spirituality gave Adam, Benjamin, and Charles sensed a sense of connectedness that eased loneliness and deficiency. They felt connected to God, to the world as a whole, and to other human beings. This connectedness gave a sense of responsibility and provided a guide for how to behave, as well as a sense that one could rely on someone and something outside oneself.

Also artistic expressions had been important for recovery. Adam played in a rock band and expressed that he did not know if he had survived without music and his band mates. For Benjamin and Charles, literature had been supportive. Through literature they could forget themselves and their difficulties, understand something about themselves and others, and develop their phantasy and imagination. Benjamin was part of a book club. He said that literature as well as the contact with the other members was crucial for his recovery. David and Felicia engaged in dance. For them it was rewarding to connect to their bodies in a non-sexualized way. David described dancing with the following words;

At first I felt a little stupid and... ashamed. Should I dance? Me? With this body? (laughs at himself) But after some time I thought "What the..." (laughs) I said to myself; I don't have to care about how I look or what others think. And I thought that these women, 'cause I'm the only man in the group... they won't judge me. So I just devoted myself to the music and danced. And... what joy! For the first time in my life I was inside my body and I actually liked my body and what it could do. Now, dancing has become a natural part of my life.

Religion and artistic expressions also provided a context in which the participants could contribute to others. They sensed that as human beings, we are connected to each other, and while addiction is about consuming, life is also about contributing. Through contributing the participants experienced meaning. With Charles words;

That's why I wanted to participate in this study. I need to tell... to comprehend. I also want to contribute. If you are able to write about my experiences and if that is helpful for someone else... then I'm satisfied. And even if you are the only one who is helped... my suffering was not totally meaningless.

Suggestions and criticism

When the participants were asked to give advice to clinicians, they underlined that clinicians have a difficult job and that it is unreasonable to expect clinicians to solve the complex difficulties their clients experience. Moreover, the participants said that they had become experts in excusing themselves for using substances and behaviors, and described how they simultaneously had wanted to refrain from, and use, substances and behaviors. Therefore, they advised clinicians to remind their clients that abstinence from substances should be first priority. Abstinence was understood as a prerequisite for being able to recover from behavioral addictions as well as from emotional and relational difficulties. Clinicians were advised to be patient and empathic but yet firm, not permitting excuses for addiction. Since the participants' addictions had been driven by a sense of deficiency and insatiability, they doubted that medication was a solution to addiction since clients would be dissatisfied no matter how much medication they received. Medication was understood as supportive when life became overwhelming but the participants sensed that it was dangerous to prescribe continuous medication since medication could become another object to abuse. Moreover, the participants sensed that it is dangerous if clinicians become naïve concerning substance abuse. Adam, Charles, and David were members of Narcotics Anonymous (NA). They said that one advantage of NA is that it is hard to deceive other NA members. Adam described NA with the following words;

For me it was important to be questioned by those with own experience of addiction. /.../ During my first time as an NA member I said that I was free from drugs but I wasn't. The others saw through me and confronted me with my lies. And that was exactly what I needed... You who are working with this cannot compare yourself to those with own experiences"

The participants were also somewhat critical toward the treatments they had been through, and were in, and described occasions when clinicians had been patronizing. Patronizing attitudes could exist alongside a well-meaning attitude. Clinicians could for example become occupied by their own perspective, and try to convince the client to adapt the perspective of the clinician. Such argumentations could create a sense that clients and clinicians were opponents, whereby doubt could be invoked, as expressed in the following quote from Charles;

My therapist does not appreciate me going to NA. She

says it might draw me away from therapy. I've started thinking that maybe I should quit seeing her 'cause ... if she cannot support me in this... is she really supporting me?

The participants also sensed that clinicians could neglect the suffering that was connected to addiction as well as to traumatic experiences. Felicia sometimes felt that she needed to protect her therapist from her suffering and from knowledge about the abuse she had been through. She understood that this was her own perception. Nevertheless, she underlined that clinicians should support their clients to discuss shameful and traumatic experiences so that clients do not whitewash their narratives. When David had tried to talk about his excessive sexual activities and his despise toward his body and himself, his therapist had not responded. He longed for a mutual sexual relation with a partner and sensed that it was important for his recovery to discuss difficulties with sexuality. The participants advised clinicians to be receptive about shameful and anxiety provoking topics and in sensitive ways ask their clients about suffering and traumas, and be prepared to listen.

Discussion

According to the participants in this study, addiction to substances and behaviors might be understood as a state of deficiency and dissatisfaction that fuel a sense of insatiability. The participants had been preoccupied with consumption but no matter how much, or what, they consumed, they had been unable to feel satisfied. The deficiency, insatiability, and inability to feel satisfied, might be interpreted as characteristic for the experience of addiction of a variety of objects. Moreover, the participants understood addiction as a form of self-destructiveness and simultaneously as an escape from oneself. They also perceived addiction as a lifestyle and underlined that addiction is a complex phenomenon that needs to be understood with respect to negative self-perceptions, traumatic experiences, broken relations, lack of meaning, and loneliness.

Addiction has been proposed as a proper term for behaviors that are not distressing in themselves but may be enacted excessively and thus cause distress, whereas compulsivity has been proposed as a proper term for behaviors that are unwanted and irrational [19]. The behaviors described by the participants in study stud are however difficult to define as either non-distressing or unwanted and irrational. The participants rather described mixed feelings toward the objects they had been preoccupied with. The present study thus shows that it might be counterproductive to strive for an unambiguous definition of addiction, since such strivings might underestimate the complex and paradoxical characteristic of addiction.

It has been proposed that research on behavioral addictions should be less directed toward questions of definitions and more toward clients experiences, and how to enhance treatment outcome [2, 9, 40]. Moreover, substance abuse treatment needs to be holistic and address a variety of difficulties among clients concerned [6, 14]. The need to address a variety of difficulties is in line with findings that show that overuse of alcohol, drugs, nicotine, and food seem to reflect a dysfunction of the D2 dopamine receptors [41].

Since the results from the present study are in accordance with prior results from genetic studies, reward deficiency syndrome seems to be an appropriate term for co-occurring addictions, impulsive and compulsive behaviors. Hopefully, this study provides insight into the lived experience of co-occurring addictions and thus contributes understanding of the suffering as well as the capability of changing one's life-course described by the participants.

Clients in recovery from substance and behavioral addiction need a variety of interventions that create a holistic treatment, centered on long-term benefits [11, 14]. Prior studies have for example shown that clients need support to strengthen their self-perception and they also need support to repair and develop social and intimate relations [10, 21]. Moreover, new relations seem to motivate recovery [42] and attachment to the clinician is important for successful treatment [43]. It has also been proposed that clients need to reflect on their relations since such reflection interfere with tendencies to become preoccupied by oneself and one's present desire [44]. The present study contributes insight into the importance of the relation between client and clinician. The participants underlined their need to develop trustful, non-exploiting relations, and clinicians became important in this process. Clinicians were described as companions, rather than experts. The relation could however be threatened if the clinician became eager to convince the client that he or she knew the solution or had a superior perspective. Clients in recovery from addiction not only attach to their therapists but also come to identify with them [43]. A tentative thought is that the relation to the clinician becomes prototypical for new relations. It should however be noticed that in clinical relations, the clinician is there to support the client. Relations outside treatment are more reciprocal in nature and thus more demanding. Therefore, the importance of trustful clinical relations should not be taken as an indication that clinicians should be over-protective toward their clients. Relations are never perfect and as clinician we should not create such an ideal but rather support our clients to talk about difficulties, including misunderstandings and disappointment in the clinical relation. Individuals with addiction have often experienced broken relations and separations and need support to change such patterns [45]. Based on the results in this study it is suggested that clinicians should be able to admit misunderstandings and differences vis-à-vis their clients, thereby supporting a balanced approach toward oneself as well as toward relations. Simultaneously, it is important to acknowledge the self-destructive side to addiction and support clients to question themselves without engaging in self-blame, thereby decreasing the risk for self-punishment.

According to the participants, first treatment priority is to refrain from substances. Thereafter it is possible to refrain from behaviors, and work through broken relations, traumatic experiences, and negative self-perceptions. The need to comprehend oneself and develop a new meaningful life was underlined, a process that takes time and effort. The participants understood treatment as an opportunity to talk about themselves, their difficulties, and their emotions. Simultaneously, shameful and sensitive topics had been neglected during treatment. Clinicians were therefore advised

to be receptive about shameful and anxiety-provoking difficulties, and the consequences of traumatic experiences. Prior studies have shown that treatment concerning sexual difficulties should support disclosure of sensitive topics otherwise clients might appear improved without having solved their difficulties [46, 47]. The participants' descriptions of how sensitive topics had been neglected should therefore be taken seriously and clinicians should be supported to approach such topics.

The deficiency and the insatiability that characterize the subjective experience of addiction also need to be acknowledged in treatment. Unreasonable expectations might be counteracted if clinicians approach their clients with patience and well-reasoned inactivity thereby lowering the risk that dissatisfaction and insatiability will direct itself toward a new object or a perceived solution. Clinicians should rather direct attention toward long-term treatment goals, abstinence, the complexity of addiction, and the lifestyle connected to it.

Religion, and a relation to God, could counteract loneliness and thus be important for recovery. Religion also provided a sense of responsibility that counteracted the addiction lifestyle. Prior studies have shown that clients in recovery from addiction perceive religion and congregational life as a supporting context in which one takes responsibility and develop reciprocal relations [21]. Individuals who have recovered with support of Alcoholics Anonymous (AA) seem to appreciate the spiritual/existential value-based parts of AA [48]. A tentative thought is that the participants in this study appreciated that religious and spiritual systems acknowledge that as human beings, we are all deficient and we all need guidelines and a frame for how to behave. With such a perspective, the deficiency described by the participants might be perceived as less threatening and they might feel less deviant. Also artistic expressions supported recovery. Just like religion, artistic expressions provided meaning as well as supportive contexts that became alternatives to the addiction lifestyle. It should be noted that even though treatment interventions had been crucial for the participants, they also stressed the importance of everyday activities such as engagement in self-help groups, congregations, and artistic expressions. A tentative thought is that clinicians could encourage clients to engage in activities outside treatment, or even integrate treatment with a variety of activities.

Limitations and future studies

There are limitations to the present study. The study concerns a small number of participants who volunteered to be interviewed. The findings should therefore not be seen as representative for all individuals who struggle with substances and behaviors. The findings do however contribute understandings of co-occurring addictions and recovery that are important to clinical practice.

The study is also limited by the chosen methodology. The interview schedule as well as the analysis did not include a definition of addiction, and the interviews were open-ended. This excluded investigations of specific characteristics of addiction, such as experiences of tolerance and withdrawal. The results are thus somewhat imprecise. On the other

hand, the study investigated the subjective experiences of the participants. If they had been given a definition of addiction, and if the interview questions had been specified, it had been difficult to encourage the participants to relate their subjective experiences. It is also limiting to investigate a range of substances and behaviors altogether since the gained knowledge might become somewhat imprecise.

One serious limitation is that only one woman participated. Some of her experiences, for example those concerning sexuality and exercise, differed from the experiences among the male participants. Further studies should therefore investigate female experiences of co-occurring addictions. Further studies should also acknowledge the role of religion, spirituality, and artistic expressions, as well as the relation between client and clinician and investigate whether these topics are important for other clients in substance abuse treatment.

Conclusions

According to the participants in this study, addiction might be seen as a state of deficiency, insatiability, and dissatisfaction in which excessive consumption is driven by an idea about satisfaction. The excessive consumption of substances and behaviours is also fuelled by self-destructiveness. This means that addiction is simultaneously an escape and a self-imposed suffering. The participants also understood addiction as connected to emotional suffering, traumatic childhood experiences, negative self-perceptions, and difficulties to establish and maintain trustful relations. Since both addiction and recovery were understood as complex processes, the participants sensed that long-term treatment that supported comprehension was needed. Religion, spirituality, and artistic expressions, and also engagement in NA, had provided opportunities for non-exploiting relations, counteracted deficiency, and supported recovery and sense of meaning. It thus seems important that clinicians encourage clients to engage in supporting activities outside treatment.

According to the participants, clinicians should remind their clients about the need to refrain from substances, since this is first priority and a prerequisite for the ability to recover from behavioral addictions and emotional and relational suffering. Simultaneously, clinicians should be receptive, and listen actively to their clients and take their difficulties seriously, especially those who are connected to traumatic and/or shameful experiences.

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