

The Experience of Recovering from a Substance Use Disorder

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by

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Abstract

Substance use disorder is an intricate societal phenomenon resulting from psychological and physiological dependence. The aim of this study was to gain an in-depth understanding of the lived experiences of individuals recovering from a substance use disorder. An interpretive phenomenological method was used to elicit the fundamentals of recovery as experienced by the participants. Random purposeful sampling was used and guaranteed that appropriate participants were selected. Data was collected through the use of semi-structured, in-depth, face-to-face interviews with four individuals. The collected data was then processed according to the three interpretive phenomenological principles namely, phenomenology, hermeneutics and idiography. Analysis was thereafter conducted using five steps, which led to two main themes emerged. The two thematic categories that emerged were (1) the ex-users' experiences of using substances and (2) experiences of recovering from a substance use disorder. Within the first thematic category two sub-themes developed which included: reasons for using substances, and when substance use became a dependency. The sub-themes that emerged in the second thematic category included: initiating recovery, recovery and treatment models, post-treatment, risk factors in recovery and supportive and protective factors in recovery.

Keywords: Substance use disorder, Recovery, Interpretive Phenomenological Analysis.

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Table of Contents

Abstract	2
Acknowledgements	3
Table of Contents	4
1. Introduction	10
1. Background and Rationale	10
2. Research Aims	11
3. Research Objectives	11
2. Literature Review	12
1. Introduction	12
2. How do we define the use of a substance?	12
3. Reasons for using substances	15
4. What is Recovery and how has it been understood?	15
1. Sobriety	17
2. Personal Health	17
3. Citizenship	17
5. Phases of Sobriety: Recovered versus Recovering	18
6. Treatment Methods for a Substance use disorder	19
1. Cognitive Behavioural Therapy (CBT)	22
2. 12-Step Facilitation Therapy	23
3. Family Behaviour Therapy (FBT)	24
4. Outpatient Treatment Programs	25
7. Risk and protective factors in recovery	25

1. Family and intimate partners	26
2. Friends and peers	26
3. Support groups	27
4. Engagement in Activities	28
5. Lack of coping skills	28
6. Motivational strategies	29
7. Treatment duration	29
8. The Experience of Recovery	29
1. Stigma	31
2. Creating an identity	31
3. The struggle of recovery	32
4. Externalising one's feelings	33
5. A sense of personal renewal	34
6. Quality of life	35
3. Methodology	36
1. Introduction	36
2. Interpretive Phenomenological Analysis (IPA)	36
3. Philosophical Foundations of IPA	37
1. Phenomenology	37
2. Hermeneutics	37
3. Idiography	38
4. The Research Design	39
5. Target Population and Participant Selection	40

1. Participants Demographics	42
1. R	42
2. J	42
3. S	42
4. Sh	43
6. Data Collection	43
7. Data Analysis	45
1. Familiarising oneself with the collected data	45
2. Identifying and labelling initial themes	45
3. Searching for connections between the themes	46
4. Producing a table of themes	46
5. Writing up the analysis	47
8. Reliability and Validity	47
1. Credibility	48
2. Transferability	48
3. Dependability	49
4. Confirmability	49
9. Ethical Considerations	49
1. Informed consent	50
2. Anonymity, privacy and confidentiality	50
3. Potential risk for emotional distress	50
4. Feedback to participants	50
4. Findings and Discussion	51

1. Introduction	51
2. Thematic Category 1: The ex-users' experiences of using substances	51
1.Reasons for Using Substances	51
1. Feeling the exhilaration	52
2. Coping Mechanism	52
3. Fitting in	53
4. Confidence	55
2. The dependency on a substance	55
1. An unrelenting pursuit	56
2. A Sense of Desperation	57
3. Physical reliance	58
3. Thematic Category 2: Recovering from a substance use disorder	59
1. The beginning of their recovery	59
1. Reasons for initiating their recovery	59
2. The necessity of accepting your powerlessness	61
3. The damages incurred to themselves and others	62
4. Being ready for recovery is essential	64
2. Recovery and Treatment Methods	65
1. Recovery or treatment paths taken	65
2. The experience of rehabilitation	66
3. Developing new coping mechanisms	70
3. The passing of time in recovery	72
1. Moving forward with their lives	72

2. The importance of setting goals	73
3. The power of reflection and positive growth	76
4. The effects of recovery relationships	77
4. Risk factors in recovery	78
1. The torment of cravings	79
2. Relapse	80
3. Family and friends	80
4. Mistrust	81
5. The lack of accessible treatment resources	82
6. Stigma	83
7. Feeling misunderstood	84
5. Supportive and protective factors in recovery	85
1. Receiving support from others	85
2. Putting boundaries in place	87
6. Conclusion	88
5. Conclusion	89
1. Introduction	89
2. Summary of the Study	89
3. Limitations	90
4. Recommendations	91
5. Conclusion	91
6. Research reflection	92
References	94

Appendix A: Letter to venue for data collection	110
Appendix B: Advertisement	111
Appendix C: Participation information and Consent Form	112
Appendix D: Semi-structured interview schedule	114
Appendix E: Distress Protocol	116
Appendix F: Counselling Resources	117

CHAPTER 1

Introduction

1.1. Background and Rationale

Substance use disorders in South Africa, especially in lower socio-economic areas of Cape Town in the Western Cape, have become a significant social problem (Herman, Stein, Seedat, & Moomal, 2011). Surveillance statistics indicate that newly-reported incidents of substance use disorders in Cape Town have been rising steadily (CTDCC, 2012; Parry et al., 2002). This has become a public health concern as substance users have been found to be at greater risk of contracting medical conditions, such as Tuberculosis, HIV, hepatitis B, hepatitis C, as well as the risk of general infections (Chander, Himelhoch, & Moore, 2006; El-Bassel, Witte, Wada, Gilbert, & Wallace, 2001; Marcus et al., 2004; Morojele et al, 2006; Parry, 2008). Even though these dire circumstances correlate with substance use, treatment options for recovery from a substance use disorder appear limited (Myers, Louw, & Pasche, 2010).

According to Hser, Longshore, and Anglin (2007), comprehensive research on understanding the lived experience of substance use disorders and recovery can yield findings that substantially improve both our understanding of long-term recovery and health services that are able to support recovery. Morojele, Parry, Brook, and Kekwaletswe (2012) further stated that a great deal of research is needed to better understand the processes involved in the continuity or discontinuity of drug abuse. Many treatment outcome studies have assessed recovery between six and 24 months post-discharge from treatment; however, more studies are required to look at users who have achieved five years or more of stable recovery, as it is at this point that the risk of relapse drops significantly (Shinebourne & Smith, 2011; White, 2007). This study aims to achieve this.

1.2. Research Aims

The aim of this research is to understand the experience of recovery from a substance use disorder, from the perspectives of ex-users, who have managed to abstain for at least five years. In gaining a better understanding of how these individuals makes sense of their substance use recovery, we may be able to contribute to research that focuses on substance use disorder treatment and rehabilitation.

1.3. Research Objectives

- To explore, in depth, how ex-users experience their recovery from a substance use disorder

Chapter 2

Literature Review

2.1. Introduction

“What is the lived experience of recovery from a substance use disorder for people who have maintained sobriety for longer than 5 years?”

This literature review explores a body of research that focuses on the meaning of recovery, treatment and recovery support and recovery management. The researcher will define the concepts ‘substance use disorder’ and ‘recovery’ so that the reader may better understand the aim of the research. The chapter is concluded by reflecting on research that has primarily focused on understanding peoples’ experiences of recovering from substance abuse.

2.2. How do we define the Use of a Substance?

Various definitions for the use of substances have been proposed, with similarities and discrepancies present. Some of the examples have seen the use of substances being defined in terms of a medical disease (Bettinardi-Angress & Angress, 2010), a learnt behaviour (McNeece & DiNitto, 2005; The Cabin Chiang Mai, 2013) and a family disease (Saatcioglu, Erim, & Cakmak, 2006). The Cabin Chiang Mai rehabilitation centre argues that substance use is learnt and therefore becomes a habitual response, whereas Bettinardi-Angress and Angress claim that substance use is linked to the neural pathways in an individual’s brain, which predisposes an individual to severe substance use. Saatcioglu et al., however, state that the substance user is the carrier of symptoms of domestic dysfunction, and emphasised that the substance user plays a significant role in the balance or imbalance of a family’s functioning. In addition to these definitions, there is the current definition of the *Diagnostic and Statistical Manual of Mental Disorders 5(DSM 5)*, which refers to the initial definitions of ‘substance abuse’ and ‘substance

dependency' as a 'substance use disorder' (American Psychiatric Association[APA], 2013) . As the DSM 5 is predominantly used in in-patient treatment facilities by health practitioners, it would be appropriate to base the definition of this research on it.

The DSM 5 describes a substance use disorder according to particular characteristics. The important features are the cognitive, behavioural and physiological symptoms that are present. Although impairment occurs in these areas of the individual's life, he or she continues substance use (APA, 2013). In addition, an underlying change occurs in the brain circuits that often persist beyond initial detoxification, as is often the circumstances with individuals with severe substance use. These changes that occur in the brain may result in apparent behavioural effects, which may be seen in the form of repeated relapses and intense cravings for substances when exposed to substance-related stimuli. These adverse substance-related effects may subside after long-term treatment (APA, 2013). The APA prescribes the following criteria for a substance use disorder:

1. The substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent use of the substance resulting in a failure to fulfil major role obligations at work, school, or home.
6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.

7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
8. Recurrent use of the substance in situations in which it is physically hazardous.
9. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for that substance (as specified in the DSM- 5 for each substance).
 - b. The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

In order to be diagnosed with Substance Use Disorder the individual must meet at least two of the 11 criteria for the diagnosis. Meeting two to three of the criteria indicates mild substance use disorder, meeting four to five criteria indicates moderate, and six to seven symptoms indicates a severe substance use disorder (APA, 2013).

This study therefore follows the understanding that a substance use disorder is a state in which the use of one or more substances results in clinically significant impairment or distress. With this understanding of substance use disorder, it is essential to discuss the reasons why

individuals may initiate and maintain their substance use. In doing so, the reader is able to witness the transformation that an individual undergoes from user to recovery.

2.3. Reasons for using Substances

In previous studies, when exploring participant's experiences of alcohol, there was a large focus by participants on the euphoria that the substances had produced (Boys, Marsden, & Strang, 2001). Participants described this feeling as a 'buzz', a 'high' and even a 'thrill' (Blair, 2011; Zakrzewski & Hector, 2004). Although alcohol is a depressant, there are stimulating effects that participants described as being enjoyable. Therefore, it is reasonably unsurprising that certain individuals of this study stated that they often felt bored when they were abstinent.

In Zakrzewski and Hector's (2004) and Morris' (n.d.) studies, participants said that they used alcohol as a way to escape feelings of low self-worth, shame, guilt, embarrassment, inadequacy, or insecurity. Additionally, Blair (2011) suggests that people may use substances as a way to cover painful memories of traumatic events. These findings were corroborated by Taylor and Stanton (2007) who argue that substance use has become a means to cope for some individuals.

In a study by Boys, Marsden and Strang (2001) participants stated that their top five reasons for using substances were to relax, become intoxicated, to have higher levels of energy when socialising, to enhance an activity, and to alleviate depressive moods.

It has also been found that a large amount of adolescents use substances due to peer pressure or the perceived need to fit in with a particular group of individuals (Reed & Rountree, 1997; Simons-Morton & Farhat, 2010).

2.4. What is Recovery and how has it been understood?

The process of recovery from a substance use disorder has proven to be a difficult process to understand due to various definitions and understandings for the term *recovery*. According to Laudet (2007) a clearer definition for ‘recovery’ is required. She argues that the lack of a clear definition may only hinder clinical and research work within the respective field. In addition, she proposes that it may also contribute to inconsistencies within reports of addiction treatment outcomes. Laudet’s (2007) study aimed to examine both recovery definitions and experiences amongst a sample of participants who identified themselves as being ‘in recovery’. Laudet’s study shows how different understandings of a substance use disorder often existed within various communities. The general public appeared to understand recovery as someone trying to stop using substances, whereas there was a more comprehensive, clinically informed and biopsychosocial definition that existed amongst health practitioners (Laudet, 2007). White (2007) proposed a criterion, to comprehensively define what recovery is. He argued that the definition needed to encapsulate recovery as (a) a lived experience for both families and the individual; (b) recovery experience as a connecting factor between recovery communities; (c) recovery as an outcome that can be measured by those who monitor and evaluate behavioural and mental health care systems; and (d) an organising goal and benchmark of accountability for service systems.

It has been suggested that recovery should be viewed as more than just a state of being within a particular time frame and that the focus should not merely be on abstaining from a substance (The Betty Ford Institute Consensus Panel, 2007). It is argued that recovery should be viewed as multidimensional, and states that treatment approaches that focus solely on abstaining from a substance, disregard the fact that a substance use disorder is often complexly interconnected with other existing social difficulties (White, 2007). According to the National

Institute on Drug Abuse (2009a), for treatment programs to be successful, there needs to be a focus on multiple needs of an individual. These needs include, but are not limited to medical, psychological, social, vocational, and legal concerns (National Institute on Drug Abuse [NIDA], 2009). The Betty Ford Institute Consensus Panel suggest that, in addition to abstinence, the health and social aspect of recovery is equally important as it would aim to reduce the risk of possible relapse. The Betty Ford Institute Consensus Panel (2007) proposes three aspects to be focused on during the recovery process, namely, *sobriety*, *personal health*, and *citizenship*. These three aspects aim to capture the multidimensional nature of recovery.

2.4.1. Sobriety. Fundamentally this is the focus on abstinence. However, it is not merely the abstinence from alcohol, but from all non-prescribed drugs, too (Pasareanu, Opsal, Vederhus, Kristensen, & Clausen, 2015; The Betty Ford Institute Consensus Panel, 2007). Sobriety is generally understood as a vital component to being ‘in recovery’; however it is not the only prerequisite. Recovery can be understood to fall into three different periods, namely *early*, *sustained* and *stable recovery* (White, 2007). Early recovery lasts for at least one month but less than one year; whereas sustained recovery lasts from at least one year onwards but still less than five years; and lastly stable recovery continues for at least five years (The Betty Ford Institute Consensus Panel, 2007; White, 2007).

2.4.2. Personal Health. This refers to the improved quality of an ex-user’s life (Pasareanu et al., 2015). The focus is on various aspects such as physical health, psychological health, independence and spirituality (White, 2007). Also, an individual may experience improved quality within their interpersonal relationships, be more productive in their occupation and have less or none legal ramifications (White, 2007).

2.4.3. Citizenship. This refers to the awareness, respect and consideration for those around the ex-user. These are the efforts at improving one's community through active participation (Pasareanu et al., 2015). Ultimately, this is an attempt to improve the quality of life for everyone living within the ex-user's community (Pasareanu et al., 2015). It may simply be understood as the concept of *giving back* to the community (The Betty Ford Institute Consensus Panel, 2007). McLellan (2010) further suggested that citizenship should not merely be related to the termination of socially harmful behaviour, but also the development of prosocial behaviours.

2.5. Phases of Sobriety: Recovered versus Recovering

Doukas and Cullen (2009) found that individuals who no longer use substances have described themselves as either *in recovery* or *recovering*. The notion of being *in recovery* describes an active, progressive process, which often includes treatment (Doukas & Cullen, 2009). Other individuals, however, may refer to themselves as *recovered*, which may suggest that stable abstinence is achieved and may presume that the process of recovery is over (Doukas & Cullen, 2009; The Betty Ford Institute Consensus Panel, 2007; White, 2007). Recovery, however, is often understood as a maintained lifestyle, rather than just a state of being (Doukas & Cullen, 2009). This understanding therefore lends itself more towards the label of "in recovery" or "recovering". Doukas and Cullen argue that recovery may be an ongoing process, suggesting that an individual is 'in recovery' for the rest of his or her life.

The Betty Ford Institute Consensus Panel (2007) suggests that those who have achieved stable recovery (five years or more) have a significant chance of remaining sober for a period of at least another year. However, it is argued that if an ex-user identifies as 'recovered' they may be susceptible to relapse (The Betty Ford Institute Consensus Panel, 2007). This, especially, if

the individual identifies as ‘recovered’ and no longer actively engages in recovery-orientated tasks, which may increase their risk of relapse.

White (2007) says that by defining recovery, one states who is or is not ‘in recovery’. By placing this particular standard for recovery it could either encourage or deter individuals from seeking assistance to address their substance use disorder. This reassurance or discouragement may be the result of substance users’ belief that they are being given a criterion for when recovery is or is not achieved (Doukas & Cullen, 2009; Laudet, 2007; White, 2007).

This study therefore follows the understanding that the recovery process is a “voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship (The Betty Ford Institute Consensus Panel, 2007, p.222)”.

2.6. Treatment Methods for a Substance Use Disorder

With a significant amount of South Africans are at risk of substance use disorder, researchers have advised that there should be a greater focus on recovery, which is often initiated by a process of treatment (Myers et al., 2010; Pasche & Myers, 2012). However, it has been identified that there is a lack of treatment resources in the South African context, owed to three shortcomings (Myers, Louw, & Fakier, 2008). These three shortcomings are (a) disorganised service delivery; (b) limited availability of cost-effective substance use treatment, and (3) infrastructural issues such as poor intersectoral partnerships. Currently, it is challenging to prescribe to treatment facilities what the best way to achieve recovery is (The Betty Ford Institute Consensus Panel, 2007). Various studies have suggested that there is no single means to seek recovery and that treatment should be tailored to address the individual’s needs (White & Godley, 2005; NIDA, 2009b). Therefore, treatment may occur in various settings, take various forms, and take place over differing lengths of time (Simpson, Joe, Rowan-Szal, & Greener,

1995; Smith & Segal, 2015; White, 2009). Treatment approaches continue to evolve and diversify, due to research and treatment feedback. Because substance use is often a long-standing disorder characterised by occasional relapses; a short-term, one-time treatment is usually not sufficient. For many, treatment is therefore a long-term process that involves multiple interventions and regular monitoring (NIDA, 2013). There exists a variety of evidence-based approaches to treating a substance use disorder (Smith & Segal, 2015). These treatment approaches may ultimately affect how an individual experiences the recovery process.

Studies have found that many individuals often enter treatment due to what they have experienced as hitting ‘rock bottom’ (Hanninen & Koski-Jannes, 1999; Laudet & Stanick, 2010). Those in recovery described ‘rock bottom’ as being a combination of multiple problems, which they could no longer deal with. Ex-users reported experiencing physiological, occupational, family and legal concerns, while others stated that physical illnesses precipitated their treatment (Faces & Voices of Recovery, 2012; Zakrzewski & Hector, 2004). Brecht, Anglin, and Dylan (2005) suggest that those who are experiencing legal concerns are often coerced into treatment by the judicial system. Their findings suggest that those who are coerced into treatment due to legal problems, are more likely to relapse than those who are coerced into treatment but don’t have legal problems (Brecht, Anglin, & Dylan, 2005). Copello, Welleman, and Templeton (2005) argue that family members can influence those with substance use disorders to seek help. They support the idea that family involvement can help engage the substance user in treatment. However, it should be noted that central to a recovery philosophy is the concept of choice (Padgett, Henwood, Abrams, & Drake, 2008). It has been noted that those in the early stages of seeking help for a substance use disorder are often ambivalent about giving up their substance of

choice permanently. Substance users often have difficulty imaging a life without using substance again (Mercer & Woody, 1999).

When substance users first abstain, they tend to be highly motivated as their substance free life is exciting, and their world appears full of possibilities (Alcoholrehab, 2015). However, as time passes, the novelty of recovery often fades away. A primary component of recovery from addiction is motivation. Researchers have identified that it is crucial for those seeking recovery to maintain their motivation, otherwise they increase their risk of relapsing (Horvath, Misra, Epner, & Cooper, 2015). Because of the strong correlation between treatment motivation and problem severity, it has been argued that those seeking treatment should be assessed for treatment motivation (Carey, Maisto, Carey, & Purnine, 2001).

White and Kurtz (2006) discuss three types of recovery processes, namely, abstinence-based recovery, moderation-based recovery, and medication-assisted recovery. Firstly, *abstinence based recovery*, looks at achieving complete abstinence from the primary drug(s) and the improper use of other psychoactive drugs. Secondly, *moderation-based recovery*, which is relatively controversial, proposes that users reduce their substance use to a level that no longer meets the criteria for a substance use disorder. Lastly, *medication-assisted recovery*, considers the use of pharmaceuticals to support recovery from addiction, along with the treatment of co-morbid physical or psychiatric symptoms.

These three types of recovery processes may be integrated into various treatment modalities, such as: a) the 12-step model; b) cognitive behavioural model; and c) family based treatment (Muck et al., 2001). Although these treatment models are different in form and the clients' overall experience of them, their collective aim would be to reduce the incidence of

problematic behaviour and social problems related to substance use (NIDA, 2009a; Nordqvist, 2009).

It was found that when initiating recovery, that doing a cost-benefit analysis was helpful (Pasareanu et al., 2015; Zakrzewski & Hector, 2004). This is a process whereby substance users compare the positive and adverse effects of their substance use. Often the adverse effects would outweigh the positive; however, this is not always the case (Zakrzewski & Hector, 2004). This practice has allowed active users the opportunity to decide upon whether they want to initiate and maintain recovery and has also assisted them in understanding how important recovery may be to them (Zakrzewski & Hector, 2004).

Most treatment programs begin with detoxification and medically-assisted withdrawal (NIDA, 2009; Simpson, 2004). Detoxification is the process whereby the body naturally clears itself of the substance or substances. Treatment facilities monitor this process closely to manage the acute and possibly dangerous physiological effects of suddenly stopping substance use (Simpson, 2004). Detoxification is often followed by a formal assessment. As detoxification is usually unpleasant and has potentially fatal side effects due to substance withdrawal, it is often managed with medication (NIDA, 2009). The medication is administered by a physician within treatment settings.

For the purpose of this research, four treatment modalities will be discussed. The modalities are, namely, Cognitive Behavioural Therapy (CBT), 12-Step Facilitation Therapy, Family Behaviour Therapy (FBT); and Outpatient Therapy.

2.6.1. Cognitive Behavioural Therapy (CBT). CBT was primarily developed as a method aimed at preventing relapse (NIDA, 2009). Cognitive-behavioural approaches are created on the idea that in the development of maladaptive behavioural patterns, like a substance

use disorder, learning processes play a critical role (Rangé & Robbe Mathias, 2012). Individuals in CBT therefore learn to identify and correct their problematic behaviours. This is done by relating a variety of skills that can be used to stop a substance use disorder, along with addressing a range of other problematic behaviour that often co-exists (Rangé & Robbe Mathias, 2012). A significant component of CBT is to anticipate any likely problems (Rangé & Robbe Mathias, 2012). The therapist thus assists in enhancing the patient's self-control by helping him or her develop effective coping skills (Rangé & Robbe Mathias, 2012). This is often achieved through exploring the following: (a) the positive and negative consequences of continued drug use, (b) self-monitoring to recognise cravings early and identify situations that might put one at risk for use or relapse and; (c) developing strategies for coping with cravings and avoiding high-risks situations (NIDA, 2009). Research suggests that the skills individuals learn through cognitive-behavioural therapy often remain after the completion of treatment. Current research is focusing on how to create more powerful effects with the combination of behavioural and medicinal treatment. (Rangé & Robbe Mathias, 2012)

2.6.2. 12-Step Facilitation Therapy. Twelve-step facilitation therapy is an active engagement strategy that aims to increase the likelihood of a substance user joining and becoming actively involved in 12-step self-help groups, therefore encouraging abstinence (NIDA, 2009). Nowinski, Baker and Carroll (1995) argue that three ideas are prevalent: (a) accepting, that substance use is a long-standing, progressive disease over which one has no control; that life has become unmanageable because of substances; that will-power alone is insufficient to overcome the problem; and that abstinence is the only alternative; (ab surrendering to a higher power by accepting the camaraderie and support structure of other

recovering individuals; and following the recovery activities laid out by the 12-step program; and (c) active involvement in 12-step meetings and related activities.

The efficacy of 12-step programs in treating alcohol abuse has been well established (Nowinski et al., 1995). However, research on its effectiveness for other forms of substance use disorders is relatively primitive. The treatment has however shown promise for helping substance users sustain their recovery (NIDA, 2009).

12-step support groups stress the importance of abstinence from all possible addictive substances or behaviours (Nowinski et al., 1995). These support groups aim to provide the recovering ex-user with a mutual group that is accepting of their substance use history. By allowing those who are in active use or in recovery to share their experience, they may realise that they are not alone in their endeavour. This may help reduce the stigma that is often experienced in recovery (Zakrzewski & Hector, 2004).

2.6.3. Family Behaviour Therapy (FBT). Family Behaviour Therapy, which has demonstrated positive results in both adults and adolescents, is aimed at addressing not only substance use problems, but other co-existing problems (NIDA, 2009). These problems may include, but are not limited to, conduct disorders, child mistreatment, depression, family conflict, and unemployment (Liddle, Rodriguez, Dakof, Kanzki, & Marvel, 2005). FBT combines behavioural contracting with crisis management and involves the substance user along with at least one significant other, such as a cohabiting partner or a parent (Copello et al., 2005; Liddle et al., 2005). Therapists seek to engage families in applying the behavioural strategies taught in sessions and in acquiring new skills to improve the home environment (Copello et al., 2005; NIDA, 2009).

The significant others are encouraged to develop behavioural goals for preventing substance use (Liddle et al.; 2005). These goals are largely related to the crisis management system put in place by the family. During each therapy session, the behavioural goals are reviewed, with rewards being provided by significant others when goals are accomplished. Those in treatment participate in treatment planning, whereby they choose specific interventions from a list of treatment options (Liddle et al.; 2005).

2.6.4. Outpatient Treatment Programs. Outpatient treatment facilities vary according to the type and intensity of the services offered (Center for Substance Abuse Treatment, 2006). This form of treatment usually costs less than inpatient treatment and is more suitable for those with jobs or dependents (NIDA, 2009b). In many outpatient treatment programs, group counselling plays a key role. Some outpatient programs are designed to treat medical and mental health problems in addition to the substance use disorder. Outpatient treatment often includes elements of Cognitive Behavioural Therapy, 12-Step Facilitation Therapy, and Family Behaviour Therapy (Center for Substance Abuse Treatment, 2006). Because individuals with substance use disorders typically have co- existing problems, treatment programs focusing primarily on abstinence from substances may be insufficient (NIDA, 2009a). Rather, multimodal programs addressing various aspects of psychological dysregulation, including behaviour modification, management of affect, and perhaps cognitive restructuring, are optimal.

In summary, effective treatment programs, for individuals with substance use disorders, are likely to be multimodal, to involve the family as much as possible, and to focus on aspects of substance involvement as well as related problems.

2.7. Risk and Protective Factors in Recovery

Individuals often risk relapsing due to experiencing cravings. Cravings are described as an intense need for a substance, whereby individuals will often go through extreme measures to be able to obtain and use their substance of choice (Swift, 1999). Various studies that have focused on promoting abstinence after treatment, have concentrated both on risk and protective factors (Charney, Zikos, & Gill, 2010; Laudet & Humphreys, 2013; Laudet & Stanick, 2010; Moos, 2007; Moos & Moos, 2007). These factors will be discussed accordingly.

2.7.1. Family and Intimate Partners. Marital status and family support are related to abstinence and tends to protect individuals against relapse to both alcohol and drug use (Copello et al., 2005; Laudet & Humphreys, 2013; Moos, 2007; Saatcioglu et al., 2006). In addition, higher levels of social support and better marital adjustment are associated with more positive drinking outcomes (Copello et al., 2005; Moos, 2007). Support from family helps create a reduced sense of isolation, an increased knowledge of substances and substance-related issues, and a greater empathy for the individual in recovery (Butler & Bauld, 2005).

In contrast, interpersonal problems with a partner and family conflict and criticism are powerful precipitants for relapse (Moos, 2007). Patients, who have more stressful relationships with their spouse or partner, at entry to treatment, are less likely to achieve abstinence and more likely to experience substance use problems after treatment (Moos, 2007). Angres and Bettinardi–Angres (2008) argue that it is important for those in recovery to amend their pre-existing relationships, which are often shown through new prosocial behaviours. They also added that it is important for those in recovery to set small relational milestones for themselves, rather than setting difficult goals for themselves that may appear unachievable. As part of recovery, it is often a goal that individuals should attempt to make amends with regards to their lost relationships. However, many experience difficulties with re-establishing bonds as families are

often exhausted by ex-users past behaviours (Morris, n.d.). Certain individuals expressed that they felt guilty when they became aware that their patterns of old, manipulative behaviour were beginning to resurface (Morris, n.d.).

2.7.2. Friends and Peers. Support from friends and peer groups can improve the process of remission (Best & Laudet, 2010; Laudet & Humphreys, 2013; Laudet & Stanick, 2010). The key factors associated with less substance use reflect an interrelated and supportive social network. Accordingly, individuals who have more friends and co-workers who encourage abstinence are more likely to achieve and sustain abstinence from substances (Laudet & Humphreys, 2013; Moos, 2007; White, 2009). Friends and peers who have abstinence-oriented norms and refrain from using substances stabilise the process of remission, whereas those who use substances raise the likelihood of relapse. Similar findings hold for tobacco, alcohol, and drug use. In relation to alcohol use, more non-drinking friends, and an increase in non-drinking friends after treatment, are associated with less heavy alcohol consumption at follow-up (Moos, 2007). With drug use, those in recovery who have a social network with fewer members who favour substance use, and who report less hindrance to maintaining abstinence (such as by reduced exposure to drugs or drug paraphernalia and lack of praise for the positive effects of drug use), are more likely to achieve and sustain remission (Moos, 2007).

2.7.3. Support Groups. Groups, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), are an important source of both abstinence-specific and general support. Participation in mutual aid groups and the recovery network that they provide is associated with less substance use and a higher likelihood of abstinence for both treated and untreated individuals. Hirschman (1992) proposed that those in active-use may better identify with ex-users, as current users often dismiss the opinions of family and friends as irrelevant, as they may

be viewed as unknowledgeable due to their inexperience with addiction.(Laudet & Stanick, 2010; Moos, 2007). McCrady (2004) writes that it is helpful for ex-users to seek additional support when in recovery. As recovery from a substance use disorder is a difficult process, ex-users are advised to gain support from those they are close to along with support groups. This may need to be done as a safety measure for when recovery appears to be overwhelming.

2.7.4. Engagement in Activities. Various studies argue that engagement in rewarding activities other than substance use is one of the key predictors of abstinence (Best & Laudet, 2010; White, 2009). Additionally, increased participation and integration in conventional activities are associated with a lower likelihood of relapse; while individuals who are socially isolated are more likely to relapse. Individuals who report high levels of religious involvement are more likely to recover from a substance use disorder. This may be because faith and spirituality help to manage life stressors foster an optimistic view towards life that leads to involvement in rewarding activities that do not involve substance use (Leigh, Bowen, & Marlatt, 2005; Moos, 2007; Pardini, Plante, Sherman, & Stump, 2000; White, 2008). Compared to individuals who favour short-term substance-related rewards, those who display more effort in obtaining rewards that do not involve substance use are more likely to achieve abstinence and tend to have a better long term prognosis (Moos, 2007). It is argued that it is important for ex-users to find new hobbies that will occupy themselves as feelings of boredom may increase an individual's risk of relapse significantly (Blair, 2011; Zakrzewski & Hector, 2004).

2.7.5. Lack of Coping Skills. Stressful life circumstances, such as interpersonal problems, are associated with poorer substance use outcomes and a higher likelihood of relapse (Moos, 2007). Similarly, more stressors, especially financial stressors, are associated with a lower likelihood of abstinence and a higher likelihood of relapse (Moos, 2007). Severe stressors

tend to be closely associated with poorer drinking outcomes among vulnerable individuals who lack coping skills and self-efficacy (Laudet & Stanick, 2010; Moos, 2007).

Perceived harm, due to of possible use, to oneself and to loved ones (e.g., threats to health, job, and friendships) is among the strongest predictors of abstinence and one of the key reasons for seeking recovery. As substance use is often a means to manage stress, it is argued that ex-users need to develop new coping mechanisms and steer clear of all substances (Dackis & O'Brien, 2001; Kelly, Magill, & Stout, 2009). Furthermore these researchers add that ex-users utilise coping mechanisms such as exercise, speaking to someone, meditation, relaxation techniques and avoiding caffeine.

Hirschman (1992) writes that it is important for ex-users to be cognisant that their behaviours are compulsive. She asserts that ex-users cannot change their compulsiveness, but should rather live within certain boundaries to assist their recovery. Additionally, ex-users should avoid high-risk situations that may increase an individual's risk of relapse. It was found that socioeconomic classes may influentially have an adverse effect on one's ability to achieve recovery, especially if there is added pressure for one to provide necessities to others (Hirschman, 1992).

2.7.6. Treatment Duration. The findings point to a general process whereby longer participation in treatment is associated with stabilization and/or improvement in protective resources and, in turn, these resources reinforce the long-term effects of treatment and mediate part of the influence of treatment on remission (Moos & Moos, 2007; Simpson et al., 1995). Compared to individuals with substantial protective resources, those who had no or few resources benefit minimally from participation in treatment (Moos & Moos, 2007). These individuals may need an initial brief motivational enhancement intervention and more intensive

health and social services to stabilise their life and provide new sources of satisfaction and rewards for reduced substance use (Moos & Moos, 2007).

2.8. The Experience of Recovery

Recovering from a substance use disorder is a relatively subjective experience and should therefore be understood from the perspective of each individual (Doukas & Cullen, 2009; Gibson, Acquah & Robinson, 2004; White, 2007). Doukas and Cullen (2009) argue that because recovery is subjective, the individuals themselves should be given the power to define their experiences. Various studies have given the participants the opportunity to voice their experiences (Shinebourne, 2011; Shinebourne & Smith, 2009, 2010; Zakrzewski & Hector, 2004).

Zakrzewski and Hector's (2004) study serves as an important reference to those who are interested in learning about the experience of a substance use disorder and recovery from the perspective of the ex-user. In their study it was important that the participants were able to express themselves in their own words, which was achieved through an existential-phenomenological method. Seven male between the ages of 32 and 65 years old were chosen, with the participants having been abstinent for between one and 25 years. It was proposed that a study of this nature could allow family members, friends, and others to understand more about what it is like to live with and recover from a substance abuse disorder.

In Shinebourne's (2011) study six female participants were asked to use poetic representations of their recovery experiences. The aim was to enhance previous research conducted by Shinebourne and Smith (2009, 2010) by contributing to the understanding of participants' experiences and meaning thereof. The participants of this study were able to express themselves poetically, whereby they created metaphors of their recovery experiences that could

be understood from a different perspective, one that was not previously viewed. The individuals were each given an opportunity to tell their unique story, in their own words.

Hirschman (1992) set a goal to explore the phenomenological accounts of individuals who have sought help through Narcotics Anonymous (N.A) as a means to recovery; and additionally interpreted the dynamics of group discussion. Her paper is based upon her experiences in N.A., as both a participant and as an observer. Hirschman provided a phenomenological description of how recovering substance users share their experiences with one another and to themselves within a support group.

2.8.1. Stigma. In Zakrzewski and Hector's (2004) study some of the participants wanted to be assured that the interviewers were themselves ex-users. Additionally, some participants also added that they would have refused to take part in the interview process if the interviewer was not an ex-user. Participants attributed this to the fact that they felt more comfortable sharing their experience with someone who had been through a similar experience. These findings are in line with previous studies that identify recovery or substance use disorder as a social taboo (Hopkins & Niemiec, 2007). Substance abusers may feel that they are unable to share their experiences, especially if they believe that they will be negatively viewed by others. Therefore participants may prefer to hide experiences that they believed may be stigmatised, even if they are in the recovering process (Zakrzewski & Hector, 2004).

As previously mentioned, those in recovery often feel negatively judged. Doukas and Cullen (2009) propose that those who identify with the 'recovering' label may feel stigmatised. Some of the reasons were that individuals believed that they are constantly reminded of a previous way of life, which may include memories that individuals are not necessarily contented to be reminded of (Doukas & Cullen, 2009). Individuals also expressed that this continuously

reminded them of the fact they may relapse at any moment and often resulted in them feeling discouraged and demotivated by these constant thoughts (Doukas & Cullen, 2009).

2.8.2. Creating an Identity. Furthermore, Doukas and Cullen suggest that there is a difference between an identity and a label. An ‘identity’ is chosen by an individual for themselves, where as a ‘label’ is given to an individual, often against their will. Doukas and Cullen (2009) concluded their study by suggesting that individuals with former substance abuse disorders should be allowed to be identified as ‘recovered’. This suggests that identity may change due to current circumstances and behavioural modifications (Doukas & Cullen, 2009). Additionally, in a study by Gibson et al. (2004) it was suggested that ex-users should be allowed to develop their own transformational narrative, whereby they are able to change their identity from user to non-user. These finding are further corroborated by McIntosh and McKeganey (2000) who argue that narratives of recovery were likely to form an important part of the process of constructing and/or reconstructing this sense of self.

2.8.3. The Struggle of Recovery. Previous studies have found participants describing their experience of the process of recovery as a long painful struggle along with feelings of emptiness (Morris, n.d.; Shinebourne, 2011). When asked to describe substance use disorder, powerful metaphors are often shared. In a study, one participant described her substance use disorder as ‘a boil full of poison’, which she felt represented the physiological and psychological pain and suffering that she experienced (Shinebourne, 2011, p.9). Furthermore, she stated that she endured lengthy periods of pain, which she wanted to ‘peel away’ and let go of so that she could begin recovery. She says that in doing so she is ‘letting the poison come out to the open before the pain can be resolved’. If one views a substance use disorder as ‘a wound’ and the

consequences thereof as ‘the poison’, then this metaphor aptly describes the difficulty that one experiences when attempting to seek recovery.

Some substance abusers may experience recovery from addiction as a brief practice. White (2007) describes this process as being transient, with previous researchers Matza (1964) and Waldorf (1983) referring to it as ‘drift’, rather than a conscious experience. “Drift” suggests that there is little in-depth involvement in treatment with no personal change having taken place (Matza, 1964; Waldorf, 1983; White; 2007). It is often found that recovery leaves no lasting mark on the individual’s personal identity. For others, recovering from substance use may become a defining feature of their lives, as it is a process of growth and change (Laudet, 2007; White & Kurtz, 2006).

2.8.4. Externalising one’s Feelings. A participant in Hirschman’s (1992) study shared that she was encouraged to write down her experiences of recovery. The participant had found that it assisted her in realising the negative consequences of her substance use and how despairing her life had become. Hirschman (1992) found this to be a considerable theme amongst members and suggested that those actively using substances need to deliberately challenge, recognise, and learn to admit that their substance use was detrimental.

When experiencing difficulties with possible relapse, ex-users have found it helpful to share their experiences and their feelings within group settings with other individuals who have had similar experiences. This restores a sense of commonality and normalcy, along with possibly reassuring the ex-user that it is better to abstain from substances (Hirschman, 1992). Participants have also expressed that it was often very difficult for them to understand and accept the extent and depth of their substance use as they would often be in a deep state of denial (Hirschman, 1992).

Certain individuals have expressed themselves through art therapy which was seen to have a positive therapeutic effect (Hagens, 2011). Additionally, some individuals feel that attending support groups is a way for them to externalise their particular concerns and problems. Another member also shared that interacting with someone that they previously had used substances with, elicited severe physiological effects in the form of diarrhoea, nausea and cramps (Hirschman, 1992).

Zakrzewski and Hector's (2004) participants had expressed that it was 'helpful' and 'comforting' to be able to share their experiences about alcoholism. The therapeutic nature of qualitative interviews is further supported by Chenail (1997) and DuWors (2002). DuWors' findings highlight the importance of giving an individual with a substance use disorder the opportunity to share his or her experiences with substances.

2.8.5. A Sense of Personal Renewal. In recovery, it is imperative for individuals to plan their way forward as life after rehabilitation is often very different in contrast to a life of active substance use (Anthony, 2000). A lack of preparation after treatment often creates the potential for an individual to struggle in their recovery. Planning is achieved by setting goals that are well-formulated, specific and realistic (Anthony, 2000). Goals may be described as either short-term or long-term and may assist in the individuals making positive changes in their lives. Although it is important for an individual to establish detailed goals and revisit those goals, it may be helpful to provide the individual with knowledge and experience that supports and facilitates their recovery (Anthony, 2000). It is suggested that ex-users may find it helpful to change their perspectives of what growth in their lives in recovery would be like versus a life in active use. Hanninen and Koski-Jannes (1999) argue that personal growth may take place in developing empathy and compassion for others, deepening ties with family and friends, and learning to

prioritise what is important to them. When in recovery, many individuals gain a significant amount of personal strength as well as a deep spiritual awakening (Green, Fullilove, & Fullilove, 1998). This is often attributed to the fact that ex-users experience a second chance in their lives. Other individuals have reported that a sense of personal renewal was experienced through the process of recovery (Larkin & Griffiths, 2002; Shinebourne, 2011). A participant in Shinebourne's (2011) study compared recovery to 'being able to see'. The participant vividly described a process of transformation and newness, a world of beauty, which was previously hidden by the 'mist' of substance use (Shinebourne, 2011).

2.8.6. Quality of Life. In a study by Pasareanu et al. (2015) it was found that the majority of patients, with a substance use disorder who were hospitalised, had a seriously impaired quality of life. These findings are supported by Srivastava, Bhatia, Rajender and Angad (2009) who argue that both higher levels of substance use and the severity of substance use correlate with poorer quality of life. However, Pasareanu et al.'s (2015) research showed that specialised substance use disorder treatment improved the quality of life for patients with substance use disorder. Additionally, the majority of participants felt that their quality of life had improved during the process of recovery.

Chapter 3:

Methodology

3.1. Introduction

This chapter outlines the research methodology, design, the theoretical and analytical stance and the procedures that were followed to carry out this study. The chapter aims to explain Interpretive Phenomenological Analysis (I.P.A.) as a research methodology, where the relevance of IPA is described in relation to the processes of conducting the current research.

The primary objective of this research was to understand the experience of recovering from a substance use disorder, from the perspectives of ex-users who have each managed to abstain from a substance use disorder for at least five years. In gaining a better understanding of how the individuals made sense of their substance use, the researcher was able to make recovery inferences that could contribute to research and understanding rehabilitation from a substance use disorder.

3.2. Interpretive Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis is a qualitative approach which has grown since Jonathan Smith first introduced it in 1996. IPA's primary concern is to provide a detailed narrative and understanding of the accounts of particular experiences or phenomena as told by an individual or a small number of individuals (Smith, Flowers & Larkin, 2009; Starks & Trinidad, 2007).

An important part of an IPA study is that people are given an opportunity to make sense of their experiences (Tolman & Brydon-Miller, 2001). Therefore the researcher needs to (a) describe people's experiences effectively and; (b) try to make sense of these experiences. IPA acknowledges, however, that the researcher's own ideas form the basis of the understanding of

the phenomenological world of the person or group that is being studied (Larkin, Watts, & Clifton, 2006). Essentially, this means that the researcher can never, entirely, know this personal world but can attempt to access it. IPA consists of three main pillars, namely phenomenology, hermeneutics, and idiography (Pietkiewicz & Smith, 2012; Smith & Osborn, 2007; Starks & Trinidad, 2007). These core ideas will now be discussed further.

3.3. Theoretical Foundations of Interpretive Phenomenological Analysis

3.3.1. Phenomenology. Phenomenology is the study of conscious experiences, which originated with the work of the Austrian-born, German philosopher Edmund Husserl (Larkin, Watts & Clifton, 2006; Pietkiewicz & Smith, 2012; Smith & Osborn, 2007). The assumption of phenomenology is that it avoids the idea of an objective reality. It is therefore a method of understanding from the perspective of the individual who has the specific experience (Howitt & Cramer, 2008). The organisation of the experience involves particular ideas and images, which together constitute the meaning of that particular experience (Larkin et al., 2006; Sokolowski, 2000). At the same time, the researcher looks into various aspects of an experience or phenomena, in an attempt to identify how it is unique. Phenomenological studies consequently look at how individuals perceive and talk about objects and experiences. Meaning is attributed to these experiences by the individual, rather than by a predetermined set of criteria established by the researcher. This is achieved through ‘bracketing’ whereby the researcher puts aside his or her preconceptions, allowing for the phenomena to speak for itself (Pietkiewicz & Smith, 2012).

3.3.2. Hermeneutics. Hermeneutics is the analysis of messages, and how the researcher examines and understands transcripts in particular (Smith, 2007; Howitt & Cramer, 2008; Sokolowski, 2000). In addition, Smith states that a text is not merely written work but may also be experiences that people interpret on a daily basis. To assist in the process of interpretation, the

researcher is required to understand the participant's mind-set and language and how these may shape or influence the participant's experiences (Pietkiewicz & Smith, 2012).

The importance of hermeneutics to IPA is due to its emphasis on understanding perspectives from another person's point of view (Howitt & Cramer, 2008). IPA researchers therefore attempt to put themselves in the shoes of the participant, while, however, being cognisant that it is not fully possible (Pietkiewicz & Smith, 2012; Smith, 2007). Meaning is then attributed to an individual's social and cultural experiences, where after hermeneutics is applied to conceptualise the meaning.

It is assumed that hermeneutics may be applied to many aspects of human activity as it studies the meaning and importance of a wide range of experiences. The experiences studied are primarily from the first-person perspective. The researcher looks at fragments of the text in relation to the whole text, which leads to the researcher understanding the meaning of the text (Smith & Osborn, 2007).

The analytical process of an IPA study may be described as a double hermeneutic or dual interpretation process, which is owed to the two meaning-making processes. Firstly, the participants create meaning of their experiences and, secondly, the researcher attempts to decode the participants' meanings to make sense of those specific meanings (Pietkiewicz & Smith, 2012).

3.3.3. Idiography. This is the in-depth analysis of a single case and understanding the individual perspectives of participants within their relative contexts (Larkin et al., 2006; Pietkiewicz & Smith, 2012). Idiography places an importance on exploring every case, before producing general ideas. This method diverges from conventional research aims. Typically, the researcher attempts to understand a particular phenomenon, and then determine the probability of

specific results under particular conditions. IPA, however, focuses largely on the specific rather than the general (Pietkiewicz & Smith, 2012). The results yielded from an in-depth analysis allow the researcher to move between themes generated and illustrates them with specific narratives. These narratives can then be compared to seek similarities and differences (Pietkiewicz & Smith, 2012).

3.4. The Research Design

A phenomenological, qualitative investigation was conducted, which sought to describe and interpret the ‘experience’ of recovering from a substance use disorder. A phenomenological stance allowed the researcher to explore, in depth, how participants understand their interpersonal and intrapersonal self. These two domains of self were understood in relation to their recovery from a substance use disorder.

Qualitative researchers are interested in understanding the meaning individuals have constructed, and aim to make sense of their world and their experiences within that world (Merriam & Merriam, 2009; Moriarty, 2011). Qualitative research therefore utilises approaches such as interviewing or case studies that allows a description of a setting or experience (Greenhalgh & Taylor, 1997). This form of research is an exercise that places the researcher in a particular setting (Hancock, Ockleford, & Windridge, 2007). It, thereafter, consists of a set of interpretive practices that make the characteristics of this setting apparent, with these practices transforming the setting. They transform the setting into a series of illustrations, including notes, interviews and conversations. At this level, qualitative research involves an interpretive approach within a particular context. Therefore, these researchers investigate phenomena in their natural settings, attempting to interpret it in terms of the meaning people attribute to them (Bricki & Green, 2007).

A qualitative research design was deemed suitable for this study as it allowed the researcher to gain in-depth and descriptive information, rather than causal and effect information. By utilising a qualitative approach, the researcher was able to place himself within the context of the ex-user and gain valuable information about experiences within that particular context. Qualitative research allowed the participants to express themselves freely, rather than to be guided by the researcher. Additionally, it provided the potential for unique experiences to surface. The participants were therefore given an opportunity to describe their experiences in their own words.

The four participants of the current study are recovering from a substance use disorder and have been abstinent for at least five years. An in-depth, interpretive, inductive design was therefore well suited to allow the researcher to explore various facets of the ex-users' experiences of recovering from a substance use disorder. This was accomplished through dialogues whereby participants were able to make sense of their experiences.

3.5. Target Population and Participant Selection

Participants for this study were selected through purposeful random sampling, which is a strategy that is followed by IPA and other qualitative approaches (Coyne, 1997; Starks & Trinidad, 2007). Purposive selection is a non-probability sampling technique that allows the researcher to identify individuals who are perceived to be able to provide the most valuable insight into the research question (Swartz, de la Rey, Duncan, & Townsend, 2011). A specific criterion is then determined as to who does or does not qualify to participate in the study. An IPA researcher, when identifying and selecting their target population, would aim for a homogenous sample. A homogenous sample is determined by common interests, behaviour or characteristics

and allows the researcher to view similarities and discrepancies between the participants when analysis takes place (Pietkiewicz & Smith, 2012; Smith & Osborn, 2007).

Before selecting participants, the researcher needs to determine the number of people that will be interviewed. It is at this point that the researcher needs to determine whether an in-depth and comprehensive analysis or a more general account of a particular phenomenon will take place. As IPA research is more interested in creating an in-depth analysis, a small sample is deemed appropriate (Pietkiewicz & Smith, 2012; Smith et al., 2009). With a small sample size, the researcher is able to give full appreciation to each participant's account. The small sample size is also utilised due to the time-consuming nature of the interviews with the individual participants (Pietkiewicz & Smith, 2012). Large sample sizes are possible, and have taken place; however, they are a lot less common (Pietkiewicz & Smith, 2012).

The participants for this study were selected from individuals who each reported complete abstinence from substances for a period of at least five years. An advert was placed at a community centre, which often assists with substance and substance-related problems. The centre was chosen due to its reputability and ease of accessibility within the community. The researcher approached the community centre and informed the centre manager about the purpose and procedures of the research project. Permission was sought to place an advertisement about the research within the centre, whereby informing clients of the centre that they could contact the researcher if they were interested in taking part in the research. Potential participants were able to tear a piece of paper, off from the advertisement, which had the researchers contact details. The participants were then able to send a SMS to the researcher, where after he contacted them about participating in the study. Participants were able to maintain both anonymity and confidentiality as they did not have to interact with members of the community centre.

Four participants were purposively selected to participate because of their previous abuse of substances and the fact that they had sought help as a means to recovering and are at least five years free from substances. Several IPA authors have suggested that a small sample is sufficient considering the depth of IPA (Frost, 2011; Pietkiewicz & Smith, 2012; Smith et al., 2009; Smith & Osborn, 2007). As mentioned before, a small sample size is deemed appropriate due to the in-depth nature of the interviews. For the purpose of this study, the selection criteria were: a) an ex substance user, b) five years of abstinence. There was difficulty experienced when recruiting participants for the study. Three potential participants, who had all contacted the researcher and agreed to participate in the study, withdrew, due to health, legal and personal reasons, respectively.

3.5.1. Participant Demographics

3.5.1.1. R. The participant, aged 28, is a coloured male who has been abstinent for six years and one month at the time of the study. He had been primarily using methamphetamine (tik) and methaqualone (mandrax) for six years. Occasionally, he would use cannabis (dagga), methylenedioxy-methamphetamine (MDMA/ecstasy), crack-cocaine (rocks) and methcathinone (Cat). He is employed full-time in the formal sector, lives with his partner in a working class household and is completing his matric part-time.

3.5.1.2. J. He is a 26 years old, coloured male and has been abstinent for five years. He began using methamphetamine and methaqualone at the age of 15 and had been using for five years. He currently lives with his parents, does part-time work and has completed grade 10. He has a working class background.

3.5.1.3. S. He is currently 25 years old and began using cannabis and alcohol at the age of 14 and progressively used more. He has maintained his sobriety for five years. He is employed

full-time, lives with his parents in a middle class household and is currently engaged. He has completed two years of a degree in education and wishes to return to his studies one day. He is a coloured male.

3.5.1.4. Sh. He is a 33 years old, coloured male and has been abstinent for eight years. He had been using methamphetamine and MDMA for five years. He is employed full-time and lives with his daughter. He forms part of the working class.

3.6. Data Collection

The primary aim for an IPA researcher is to gather detailed, first-person accounts of experiences and phenomena about the research in question. Therefore in IPA, as in many forms of qualitative research, it is common for data to be collected through a series of interviews. These interviews may take place with focus groups or individual participants, or even both. Interviews allow a researcher to elicit a large amount of information about the participant's experiences through probing questions (Smith & Osborn, 2007). According to Alexander and Clare (2004), the interview process may be described as 'collaborative, emphasising that the participants are the primary experts' (p. 82). This approach is in line with the objectives of IPA research. In the majority of IPA studies, interviews are conducted face to face. However, there have been exceptions, occurring mostly due to pragmatic difficulties. In studies by Turner, Barlow and Illbery (2002) telephone interviews have been used, with the possible limitations being acknowledged. Other studies have also utilised E-mail interviews in addition to direct interviews (Murray, 2004; Murray & Harrison, 2004). Lastly, in research done by Reynolds (2003), both interview transcripts and written narratives were analysed. For the current study one-on-one interviews were conducted because it allowed the researcher to explore the individuals' experiences at greater depth. One-on-one interviews were also deemed appropriate due to the

personal nature of questions. Interviews were conducted in a mutually agreed upon venue, as to ensure the safety and comfort of both the researcher and participants.

It is suggested, when conducting IPA, that the researcher utilises semi-structured interview schedules (Howitt & Cramer, 2008). Semi-structured interview schedules have a previously determined set of interview questions; however, new questions are derived during the interview in response to the participants' answers. This feature allows for unanticipated issues to be explored in further detail. This approach gives the researcher a set of exploratory, open-ended questions which guide the interview, rather than dictating it. It, therefore, assists the researcher in gaining a deeper understanding of each of the participants' experiences (Smith et al., 2009; Smith & Osborn, 2007).

All interviews for the current research were conducted by the researcher, on an individual basis with the participants. No group interviews took place. The individual interviews lasted between one and two hours, and depended largely upon the participants' openness to share their experiences with the researcher. As suggested, by multiple researchers, interviews were digitally recorded to assist in the transcribing process (Howitt & Cramer, 2008; Smith & Osborn, 2007). Interviews were primarily conducted in the participants' preferred languages, with translation taking place as required. The predominant language was English, with Afrikaans being the only other language spoken. Due to the existential nature of the questions asked, it was important for the interviewer to monitor the mental state of the participant as it is common for the questions to elicit strong feelings and emotions from the participant. For this reason, a distress protocol was put in place, as to reduce the risk of harm to the participant. Notes were made during the interviews pertaining to the participant's mental state and comments made by the participant.

The researcher found that it was helpful to respond to comments made rather than to steer the experiences shared by the participant.

Due to both time constraints and the unavailability of the participants, post-interview, none of the interviews were followed up with an in-person interview. Participants were contacted via phone, as previously agreed to, to clarify any comments made in the interview. Once the interviews were concluded the researcher transcribed what was said as accurately as possible from the digital voice recordings.

3.7. Data Analysis

The data were analysed using an IPA approach, in an attempt to make sense of the participants' experiences and understanding thereof. With IPA, the researcher is required to describe the participant's experiences effectively and try to make sense of these experiences (Howitt & Cramer, 2008). The steps that were used to analyse the information will be discussed accordingly.

3.7.1. Familiarising Oneself with the Collected Data. The first step involved the researcher becoming familiar with what was said by participants (Howitt & Cramer, 2008; Pietkiewicz & Smith, 2012). This was achieved through reading the transcript multiple times. As there are no specific instructions about how this must be done, comments were made alongside the transcribed and printed words in an attempt to summarise and interpret the information. Initial comments were made along the left-hand side of the page. Further or more specific comments were then made on the right-hand side of the page. This allowed the researcher to produce detailed and comprehensive notes about what was said in the interviews.

3.7.2. Identifying and Labelling Initial Themes. The second step was marked by the re-reading of the transcripts to identify any significant themes that were identified according to

what was said by participants. The identification of themes was largely informed by the notes that were made by the researcher. Each theme was thereafter noted within a table and summarised as suggested by Howitt and Cramer (2008). Furthermore, Smith and Osborn (2007) suggest that the identified themes should be labelled using the participants' words and in accordance with what was said by the participants at an abstract level. At this stage, no attempt was made to neither omit nor select particular themes for distinct consideration.

3.7.3. Searching for Connections between the Themes. At the third stage, it was necessary for the researcher to reflect upon how the identified themes may be clustered to arrange for general or specific (sub-ordinate) themes (Howitt & Cramer, 2008; Pietkiewicz & Smith, 2012). This was achieved by considering the connections among the initial themes identified. The themes which appeared similar were clustered and specified under a more general label. According to Smith and Osborn (2007) it is imperative that the identified themes encapsulate what was said by the participants. Additional themes were omitted if they did not appear suitable within the larger clusters initially identified. Certain themes were omitted because they either did not fit in with the developing structure or did not have rich evidence within the transcript.

3.7.4. Producing a Table of Themes. The fourth stage commenced by listing the general themes together with their subordinate themes (Howitt & Cramer, 2008; Pietkiewicz & Smith, 2012). The themes were then ordered according to a balance between chronological order and the importance that the participants assigned to them beginning with the most significant subordinate theme following through to the least. This listing included a short phrase from a participant's account to illustrate the theme.

3.7.5. Writing up the Analysis. The fifth, and last, stage involved writing up the findings of the analysis (Howitt & Cramer, 2008; Pietkiewicz & Smith, 2012). The themes for the analysis are described and explained with verbatim extracts, which provide a rich and adequate illustration of the themes. During this stage, the researcher attempted to interpret what was said by the participants. It was then indicated where interpretations had taken place and how that interpretation was arrived at.

Smith and Osborn (2007) state that there are two ways of presenting the results in a thesis. The first entails a 'Results' and 'Discussion' section where the 'Results' section describes and explains the themes while the 'Discussion' section relates the themes to the existing literature on the topic. The alternative method was to having a combined 'Results and Discussion' section where the demonstration of each theme is followed by a discussion of the literature that is relevant to that theme. For this research paper, the results and discussion were integrated into a single chapter. This was demonstrated by providing verbatim extracts of the transcripts and then providing the analysis to it along with relating the extracts to relevant literature.

3.8. Reliability and Validity

To understand the meaning of reliability and validity, it is necessary to define the two concepts by consulting the work of authors writing on the topic of qualitative research (Golafshani, 2003; Shenton, 2004; Silverman, 2001). The two concepts shall be discussed and then related to this specific study.

Firstly, reliability is often used for assessing quantitative research; however, the idea may be used in all approaches of research. Information gathering through interviews may be viewed as a form of testing. A significant assessment then for any qualitative research would then

essentially be its quality. According to Eisner (1991), a good qualitative study should “understand a situation that would otherwise be enigmatic or confusing” (p. 58).

Secondly, validity is defined by various terms in qualitative studies (Golafshani, 2003). Validity is relatively dynamic in that it is noticeably grounded in the process and in aims of particular research focuses. Although some qualitative researchers have argued that the term validity is not applicable to qualitative research, they have at the same time realised the need for some kind of qualifying check or measure for their research.

Lincoln and Guba (1985) have proposed four criteria for assessing the reliability of qualitative research. The criterion has been offered as an alternate measure to the conventional quantitatively-orientated criteria. The four criteria include: (a) credibility; (b) transferability; (c) dependability and; (d) confirmability. These were deemed appropriate to qualitative research, rather than the more positivist ideas of internal and external validity, reliability and objectivity.

3.8.1. Credibility. According to Merriam (1998) credibility asks, “How congruent are the findings with reality?” This essentially means that the researcher ensures that the study measures or tests what is actually intended. The researcher, therefore, establishes that the results of the qualitative research are sound or plausible from the perspective of the participant in the research. Establishing the credibility of research may only be done from the perspectives of the participants. Hence the participants are the individuals who judge the credibility of the results (Trochim & Donnelly, 2006). This was achieved by having a telephonic follow-up with the participants after having made available to them a copy of the research findings. The findings were then confirmed with the participants.

3.8.2. Transferability. This is the degree to which the results, obtained from the research, can be generalised to other contexts (Trochim & Donnelly, 2006). Due to the nature of

this study, if practitioners or researchers consider an individual's situation to be similar to that described in the study, they may relate the findings to their situation. The researcher, however, focused on gaining a detailed narrative from a small number of individuals, rather than a general account from a large number of individuals. This approach was appropriate for IPA-based research.

3.8.3. Dependability. This is similar to the conventional quantitative idea of reliability, which focuses on the repeatability of a study (Trochim & Donnelly, 2006). A significant part of dependability, especially in qualitative research, is for the researcher to be cognisant about the ever-changing context within which research occurs. The research design is therefore seen as a sample model for future studies. The procedures of this research were thoroughly recorded for the checking and re-checking of data.

3.8.4. Confirmability. The idea of confirmability is similar to the notion of objectivity. It was therefore important for the researcher to ensure as far as possible that the findings were the result of the experiences of the participants, rather than a reflection of the researcher.

3.9. Ethical Considerations

Due to the explorative nature of qualitative research, it was imperative that ethical practices were duly followed. It is common for this form of research to elicit strong emotions from the participants. The researcher, therefore, followed the ethical practices as specified by the Rhodes University ethical committee. The research was firstly approved by the Department of Psychology Research Project and Ethical Review Committee. Secondly, it was approved by the Higher Degrees Research Ethics Committee and the Humanities Faculty's Higher Degrees Committee. Furthermore, the following ethical standards were adhered to:

3.9.1. Informed Consent. The participants were provided with a cover letter and consent form. Both documents indicated to the individuals that they would participate on a voluntary basis, informing participants of their right to withdraw from the study at any point. The following information was also discussed: (a) the nature and aim of the study, (b) the use of audio-tapes during interviews, (c) referral information for distressful situations, and (d) issues of confidentiality, privacy and anonymity (see Appendix)

3.9.2. Anonymity, Privacy and Confidentiality. Although the researcher was aware of the participants' names, no unique identifiers appear on the data records, analysis sheets or results records. Rather, single letter pseudonyms were utilised in the publication of the research report. All transcribed notes and audio recordings are being electronically stored in a secure place for three years, with the consent of the participants.

3.9.3. Potential Risk for Emotional Distress. It was anticipated that the study may elicit discomfort for certain individuals, largely due to the nature of the interviews. It was for this reason that a distress protocol was drafted prior to the interviews, as to reduce the risk of harm to the participants. Participants were informed about this potential risk in the cover letter. Appropriate referral information for counselling and containment was provided and discussed with the participants. At the end of the interviews, participants were debriefed to ensure that they were contained.

3.9.4. Feedback to Participants. The main findings of the research were provided to participants that requested feedback. These procedures ensured that the ethical standards and guidelines of Rhodes University and qualitative research were adhered to.

Chapter 4

Findings and Discussion

4.1. Introduction

The results and discussion were integrated into a single chapter. The findings were demonstrated by providing verbatim extracts of the transcripts. Thereafter analysis took place, with the extracts then being related to relevant literature.

The analysis revealed numerous sub-themes, which were then grouped into two main thematic categories, aligned to the objectives of the study. The thematic categories are as follows: a) the ex-users' experiences of using substances and a) the ex-users' experiences of recovering from a substance use disorder. The numerous themes that developed under each thematic category are followed by a discussion.

The participants felt that it was essential to first explain the experience of their substance use and then their experience of recovery, so that the researcher could better understand and contextualise the transformation of the experiences of using substances to recovering from substance use.

4.2. Thematic Category 1: The Ex-Users' Experiences of Using Substances.

Results under discussion in this section are the participants' reasons for using a substance and/or substances and when substance use became a clinically significant disorder for them.

4.2.1. Reasons for Using Substances. The first key area raised and discussed during the interviews was the participants' initiation into substances. In this, four main themes appeared that highlighted facets of the participants' reasons for using substances, namely: euphoria, coping mechanism, fitting in, and confidence.

4.2.1.1. Feeling the Exhilaration. It became apparent that the use of substances was primarily maintained by the bliss that is created when using substances that is available to them.

This is captured in the following extracts:

Sh: *“Well, the higher you are, right... the better you feel”*

J: *“Drugs make you feel good ... It’s the best feeling in the world”*

R: *“Because the drugs made you feel good”*

Using substances reportedly created an immense feeling of enjoyment that few other activities were able to recreate; often resulting in the continued use of the substances. These findings are corroborated by previous research that suggests that euphoria induced by using a substance has often resulted in maintained use of the substance (Blair, 2011; Boys, Marsden, & Strang, 2001; Zakrzewski & Hector, 2004). The participants of the current study did however express that there were additional underlying reasons for initiating and maintaining their use. These reasons included using as a coping mechanisms, peer pressure and confidence which are discussed accordingly.

4.2.1.2. Coping Mechanism. A concern that had been raised was the perceived inability to effectively deal with the emotional and social difficulties that affected them. These often included intrapersonal and familial difficulties. This is highlighted in the following extract:

S: *“It was a coping mechanism at the time yes... I wasn’t able to communicate... It was always harder for me to deal with the reality of what people thought... I would say it was more of an escape... Dealing with things such as... family problems or social problems”*

The participant believed that he did not have access to any form of emotional support and felt that he was not able to share his feelings with anyone, relating to the confusion that he was experiencing about his sexuality. Essentially, being intoxicated allowed the participant to subdue

his strong feelings of confusion about his sexuality. Additionally, both of his parents had remarried, which also created a lot of tension for him, especially between him and his mother's new husband. This resulted in the participant experiencing an overwhelming amount of anger that would only dissipate when he used cannabis and alcohol. However, the masking of emotions was merely temporary and shortening in effectivity, which led the participant to consume cannabis more frequently as his tolerance built up. Zakrzewski and Hector's (2004) argue that individuals often become intoxicated to temporarily cope with stressful circumstances that the individual is unable to share with others. Furthermore, Taylor and Stanton (2007) corroborate these findings by suggesting that excessive substance use is a way for particular individuals to cope with intense emotions, especially if they believe that they do not have access to resources available.

4.2.1.3. *Fitting In.* Initiating and experimenting with substances was reportedly a way of being accepted by their peers. These findings are supported by sources that suggest that a large amount of adolescents feel coerced into using substances by their peers or feel that substances will allow them to fit in with a particular group of individuals (Reed & Rountree, 1997; Simons-Morton & Farhat, 2010). It should be noted that the majority of initiating and experimenting with substances had taken place in the adolescent phase. Three of the four participants of this study began using substances in their adolescent years.

Furthermore, it was brought up that a participant's desire to be accepted by others often resulted in him being in unfamiliar environments, which led to intense feelings of anxiety, especially when interacting with others. These environments included going to bars and parties, often interacting with people whom he did not necessarily know. It appeared that substances were his only perceived manner to gain this acceptance, which he also required to help reduce

his inhibitions. He would often become intoxicated to appear calm; however, it appeared that his anxiety and substance use became heightened, as he continued to find himself in these challenging situations. Additionally, there was a belief that his substance use would allow him to conform to the behaviour that he believed others wanted him to display - behaviour that he may otherwise have been uncomfortable displaying. The following extract is evident of his thoughts:

S: *“I had a big fear of... I was more of an introvert..... the quiet type... So only when I would drink... Going out to parties... I think I would be more in conversation and I’d speak more to people and adapt to their ways in that moment... otherwise I was very to myself when I was sober.”*

Similarly, another participant believed that using substances allowed him to gain access to interacting with other people:

R: *“Drugs brought you closer to people you thought was your friends...but when you come to realise afterwards... that when you now off it... off drugs... then you look back at it... it was all just fake, everything revolved around drugs... I did, and the people I hung out with... revolved around it”*

However, when reflecting on these interactions, he strongly believed that it was mainly focused on surrounding himself around those who were also using substances. It appeared that a relationship of this nature allowed him access to gaining substances, but also gave him the opportunity to be part of a group of people where substance use was acceptable. He described the interactions as being superficial though, as his ‘using friends’ did not have his best interests at heart. It was therefore never ‘friendship’. Essentially, this participant found companionships, albeit detrimental to him, which made his maladaptive behaviour feel acceptable. It appeared that

these ‘friends’ assisted in maintaining his substance use, as they welcomed his presence and behaviour while everyone else had shunned him.

4.2.1.4. Confidence. A minor theme that developed was that of self-assurance. A participant expressed that he had a relatively poor self-concept. He reported that substances made him feel temporarily self-assured, allowing him the opportunity to engage in several activities that he would not otherwise attempt when sober. These findings are corroborated by research that found individuals use substances as a means to escape feelings of low self-worth, inadequacy, inhibition, and insecurity (Morris, n.d.; Zakrzewski & Hector, 2004). The following extract is evidence of how the participant no longer felt inhibited by a lack of confidence, when intoxicated:

J: *“Drugs make you feel good and it gives you all the confidence you need to do anything that you want.”*

Initially, the substance use was a means to break this constraint; however, the participant slowly became entangled in an unrelenting and continuous cycle of substance use. He felt that it no longer mattered what the activity was, as the mere need to use was more important. This initial use can be seen to move from casual use to a state of dependency, which shall be discussed further.

4.2.2. The Dependency on a Substance. The participants had highlighted what they believed was the migration from casual substance use towards a substance dependency. Three main sub-themes emerged from this key area, namely: a constant chase, a sense of desperation, and a physical dependency.

4.2.2.1. An Unrelenting Pursuit. Participants expressed that they were no longer able to maintain casual substance use as they had become dependent on the substance. This is evident in the following statements:

Sh: *“You never seem to get enough... and when you don’t have... you’ll do almost anything to get a fix”*

R: *“Everything revolved around drugs... you actually tik yourself fucked up until you can’t anymore”*

These extracts describe the persistent need to acquire substances. Upon further enquiry, it was reported that there was an apparent inability to move through their daily routines without substance use. Ironically, participants would rarely complete the tasks that were required of them after they had used the substances.

Another participant stated that he had a preference towards a particular type of cannabis. He explained that the preference was due to the feeling of euphoria it created. In addition to the preference, the participant stated that he was relentlessly in search of acquiring more of the specific cannabis, known as ‘indoor’.

S: *“I would say now very casually I was just on weed... But I know now what type of weed I was on... There was a specific type of weed that I was addicted to... It was indoor... I know I must smoke indoor... not knowing at the time... that... I had actually stolen money for weed.”*

Furthermore, the participant expressed a great amount of shame, as he explained how he had begun stealing money to acquire the substance, solely to re-experience the euphoria that the specific cannabis created. It was interesting to observe that the participant felt a great need to explain that an individual can be dependent on cannabis and that there are adverse behaviours

that are associated with the use thereof. The participant reported that many people perceive cannabis to be a relatively harmless substance; however, he argued that this is not the case.

4.2.2.2. A Sense of Desperation. With the movement from casual substance use towards a dependency, some of the participants felt that they began displaying acts of desperation. This is evident in the follows extracts:

R: *“Even if you didn’t have money today... you’d go sit by people that you knew might... or do something to get money... Back then... you can fucking sell ice to a fucking Eskimo... you can think... people think drug addicts are stupid... I will tell you now... if you get a puncture on the road and you need... you don’t have a jack or something... that man will make a plan whether he must ask you just to life so he can slide bricks under the car to make it higher... he will make a plan.”*

S: *There’d be times during my class periods where I would smoke weed... or would have a bottle of coke... but in it would be orange juice and vodka”*

Participants conveyed feeling desperate because of the extent that they would go to acquire drugs. They described what they believed was extreme lengths, often putting themselves in dangerous social settings or situations, merely to acquire a small sum of money or substances itself. Swift (1999) supports these findings by arguing that individuals will often go through extreme measures to be able to use their substance of choice or what is available to them.

A participant explained that he would often find himself amongst individuals that he never knew, or those that he knew were dangerous. However, he says that at the time his single purpose was to be intoxicated, without considering any dangers to himself. Furthermore he explained how he would find any means possible to procure money from people, so that he could purchase substances. He described how he would frequently try to sell anything, sometimes even

stolen goods. Additionally, he had described how he had intricately planned to break into a family member's home and stole a large sum of money from their business, which is run from their home.

Another participant also described how he would use substances in a risky environment; such as consuming substances at school. Upon reflection, there was a significant amount of shame expressed, especially as he had put his academic work in jeopardy.

4.2.2.3. Physical Reliance. Lastly, a participant described experiencing an immense physical dependency towards methamphetamine. This is described in the succeeding statement:

R: *"like your body its now used to that all the time, and yes your mind also, but more so the body man... like your body just doesn't function right without drugs... I could feel the brain hit the inside of my head and its painful... I'd actually have to hold my head... Like it just heightens that withdrawal... so the next time you come to withdrawals the cycle, if you wanna call it that... because it is almost like a cycle... you use, withdraw, use to fix that withdrawal... withdraw again... use to fix that withdrawal... withdraw again and back again... and so it goes on. And what makes the withdrawal even harder is and worse is when you use... get your withdrawals and satisfy your withdrawals with more drugs"*

The participant explained how he had experienced severe stomach cramps and fatigue when he had not used substances for a short period of time. Essentially, this was when he was experiencing withdrawals. Methamphetamine served as an effective pain relief, until the effects wore off, then he would have to use it again. The above extract is evident that the participant became largely dependent on the substance for relieving the physical withdrawals he was experiencing. There was a perceived need by the participant that he required methamphetamine

to be functional in his daily life. He expressed that it became a reoccurring cycle as he explained how the physical pain would be more intense when he was not using, only for him to relieve it with further substance use. Darke , Kaye, McKetin and Duflou (2008) supports these findings and suggest that these symptoms, as experienced by the participant, often result from cessation of a substance, especially methamphetamine. Further withdrawal symptoms often include fatigue, sleep disturbances, appetite disturbances, depressed mood, irritability, psychomotor retardation and anxiety (Darke et al., 2008).

4.3. Thematic Category 2: Recovering from a Substance Use Disorder.

Issues in this thematic category address the experiences that ex-users have had when recovering from substance abuse. The main themes within this category are: initiating recovery; treatment and recovery methods; post treatment (new opportunities); risks factors in recovery; and supportive and protective factors in recovery.

4.3.1. The Beginning of Their Recovery. Themes discussed here include: why initiate recovery; accepting your powerlessness; why you should stop; and being ready for recovery.

4.3.1.1. Reasons for Initiating Their Recovery. It had been reported that there had been a large amount of contemplation by participants into their decision to stop using substances and therefore seek recovery. This is apparent in the following extracts:

Sh: *“One day I just looked in the mirror. I was not happy with what I saw... I realised that I needed to stop”*

J: *“I almost got killed many times... my family also didn’t want anything to do with me... I did lose my job. My whole life was falling apart”*

R: *“Because I just didn’t want that anymore... I missed my family, I missed my friends. my true friends... I missed what I had in life before... because when I was at the end*

when I made that decision, I had fockall... I had fuckall, fuckall, fuckall... I didn't even have a decent pair of shoes... I just didn't want that life anymore..."

Through self-reflection, the participants felt the need to make the decision to initiate their recovery from substance use. They were not happy with the overall person they were becoming and added that they no longer valued their lives and that of others. In previous research conducted, the participants had described these circumstances as 'hitting rock bottom', which symbolises a circumstance where an individual believes that he or she has lost everything (Hanninen & Koski-Jannes, 1999; Laudet & Stanick, 2010). Essentially 'rock bottom' is a subjective experience, as the socioeconomic, familial and psychological circumstances are different for all individuals. Additionally, participants of the current study expressed feeling a great sense of loss, as a result of their substance use, which appeared to cause a large degree of disappointment. This loss was largely evident in their familial, social, and occupational dimensions, which was severely hampered by their substance use. These findings correlate with studies that have demonstrated that substance use has severe adverse occupational, legal and familial effects (Faces & Voices of Recovery, 2012; Zakrzewski & Hector, 2004).

A participant described how he was booked into an in-patient rehabilitative centre against his will, rather than initiating his recovery by choice as the other participants had. The participant's initial reaction is demonstrated in the following extract:

S: *"It was a big transition because I didn't have a choice... I was told 'you're going to rehab'...I was more like, 'oh my god' you in the kak now...I am in this phase where I have been caught out, red handed. How do you deal with the fact that you've been caught red-handed?"*

Preceding his admission, the participant was unaware that his family knew about his alcohol and cannabis use. Nonetheless, although he was being forced into treatment, the participant did not show much resistance as he believed this would only intensify his family's already firm and unforeseen reaction to acknowledging his substance use. According to Copello et al. (2005), it may be helpful for family members to intervene and influence the individual with a substance use disorder to seek help. However, Padgett et al. (2008) argues that it is imperative for individuals to be able to exercise the right to make their own decisions in seeking recovery. By allowing individuals to exercise their own power, they may be more motivated to engage in the recovery process. In this instance, the participant believed that going to an in-patient treatment facility was his only choice, as he feared that his family might have disowned him had he resisted their efforts. It appears that the fear of the participant helped motivate him to remain in recovery. An important step in initiating recovery, which entails accepting your powerlessness to a substance will be discussed next.

4.3.1.2. The Necessity of Accepting your Powerlessness. Participants described how they had to accept their powerlessness to the substance so that they could begin their recovery. This is evident in the following extract:

S: *"Like I didn't want to deal with the fact that I was an addict... I got very offended when people said 'oh, but you're an addict, you're a drug addict'... and I could never understand it... but my addiction was an addiction"*

R: *"And like three years into that I never thought there was anything wrong with me until I opened my eyes"*

Understanding one's vulnerability to a substance has been described as process, rather than a once-off event, whereby the individual needed to be honest with themselves instead of

being in denial about the adverse effects that substances had on them. The participants understood this as their first main step towards actively engaging in their recovery. Accepting your powerlessness to a substance is largely supported by 12-step facilitation therapy, which includes groups support such as N.A. (Nowinski, Baker, & Carroll, 1995). Accepting their powerlessness to a substance acted as a catalyst for the participants in their recovery.

Additionally, they were able to appreciate why they could no longer use any substances. They reported that to fully appreciate and sustain recovery, they had to acknowledge that substance use was detrimental. It appears that those in denial about their substance use and its effects only serve to hinder their chances of recovery.

4.3.1.3. The Damages Incurred to Themselves and Others. When discussing the need to accept their powerlessness to substances, the participants spoke about understanding the negative consequences of their substance use, often referred to as ‘damages’. This was done either through self-reflection or being informed by others, such as family or friends. Pasareanu et al. (2015) describes this process as a cost-benefit analysis, suggesting that it allows individuals considering recovery to compare the positive and adverse effects of their substance use. The following extracts describe the participants’ experiences of exploring their damages:

S: *“The damages was the worst because. They put you in a room and your parents... everyone’s parents is sitting on that side... and all the addicts is sitting on this side... So you sit there and you really can’t respond because they’re telling you exactly what they’re feeling... I could see the hurt on my mother’s face... I saw how disappointed she was... ”*

The above extract describes a participant’s experience of learning about his damages while he was admitted to an in-patient treatment facility. The participant remembers feeling a

great amount of shame when hearing about how hurt his family was by his actions. However, he also felt anger and humiliation when he was made to listen to his damages while sitting in front of all the families.

In contrast, another participant described shock as he spoke about the damages that he had brought upon himself through substance use. He was shocked as he could not believe how he could put himself through the physical and mental anguish. The following extracts are evidence of his thoughts:

R: *“And now you’re not eating, so you’re malnourished... and that’s why you become a skeleton... It was all just fake... in actual fact I was just killing myself... and chilling with people that weren’t really my friends... I was blinded by addiction... like I couldn’t see further than the drugs and the people I was... so I was blinded to the rest of the world”*

In addition to self-reflection, these participants expressed their concern towards other users, as they were able to observe the damages that substance use had caused to other users. Because they were able to empathise with other users, due to their personal experiences, they were better able to understand the adverse effects it could cause in their lives and the lives of other users. The participants believed that it was emotionally easier to observe and speak about the dangers of substance use by highlighting the damages that it had caused to others, rather than having to admit to their own powerlessness and damages. Hanninen and Koski-Jannes (1999) suggest that personal growth may take place in recovery in developing empathy and compassion for others.

Lastly, a participant spoke of the difficulties he experienced at the early stages of wanting to initiate recovery. He described feeling uncomfortable with the thought of having to abstain from all substances and having to endure the process of recovery. He explained that although he

knew the substances were harmful, it was challenging to think about not experiencing the euphoria and other ‘positive’ effects that goes with using. These findings are corroborated by Buddy (2015) who suggests that it is not uncommon for individuals to be ambivalent about initiating recovery. This is evident in the following statement:

R: *“That’s why I’m saying you need to really, really want it... because you’re gonna be pulled in two directions at that time... there’s times when I was in rehab... I fucking jumped the wall or walked out by the front gate and I came and I got on a train and a I bought me drugs and went back... you tell me what person would wanna change... but walks out of rehab, gets on a train, travels kilometres to get drugs and goes back to rehab... inside the building... just so that he can start using again and then act like everything is normal.”*

Although a considerable amount of individuals understand why they want to remain abstinent, it is not surprising for some of them to return back to active substance use. Ambivalence appears to be a result of a poor outlook on one’s future. It seems to be difficult for individuals to remain sober when they believe that their quality of life has not improved and often return to substance as the euphoria is missed.

4.3.1.4. Being Ready for Recovery is Essential. Before fully committing themselves to the process of recovery, the participants explained that they had to be ready to begin this process.

Sh: *“The beginning was terrible... I felt like I was climbing walls”*

S: *“I would say at the beginning it was very difficult”*

The participants described the painstaking experience of having to initiate their recovery. However, they voiced that even though they wanted to do this, they continued to experience great difficulty. A participant believed that to initiate his recovery he needed to be highly

motivated. He needed to understand why he truly wanted to achieve recovery and believed that this would help to maintain his sobriety. This is evident in the following extract:

R: *“If you really, really want something na, it shouldn’t be hard getting it... it shouldn’t be hard to get it out of you... you just need to change the mind-set first... now for me, that’s why I’m saying in the beginning it was hard, because the mind-set wasn’t right... if you want it from within here [points to heart] ... in your heart... And you know why you’re doing it... then it’s not hard”*

Horvath, Misra, Epner and Cooper (2015) have found similar results and suggest that by understanding why the individual had sought treatment, they would be more motivated to maintain their recovery. Furthermore, researchers have identified that it is crucial for those seeking recovery to maintain their motivation, otherwise they increase their risk of relapsing (Horvath et al., 2015). Motivation appears to be a significant aspect that should be present throughout recovery. It is believed to help an individual initiate and maintain recovery, but also to prosper in other facets of life when sobriety is achieved.

4.3.2. Recovery and Treatment Methods. The following theme addresses issues related to the participants’ experiences within recovery. Three main themes developed from this key area: recovery or treatment method chosen; the experience of rehabilitation; and developing new coping mechanisms.

4.3.2.1. Recovery or Treatment paths taken. It became apparent that different means to seek recovery had been taken. This is evident in the following extracts:

Sh: *“I would say that I was in a process of natural recovery”*

J: *“I follow the 12 steps”*

S: *“They believed in the 12 steps... and... you know... going to... Narcotic Anonymous every Wednesday night... going to a meeting”*

The above quotes are evident of diverse paths that were chosen by the participants to seek recovery. The first person’s ‘natural recovery’, was a process whereby he did not engage in any treatment programmes, but utilised the support of others to help him maintain abstinence. The second participant actively participated in N.A., whereas the third was admitted to an in-patient facility where he attended N.A. support groups as well.

However, the fourth participant believed that outpatient and inpatient treatment had complemented each other in his recovery. He described his experiences in multiple in-patient treatment facilities, stating that it was only in his last admission that he was prepared to maintain his sobriety. The following extract shows his thoughts on the two methods:

R: *“For me... one can’t work without the other”*

The participant believed that he stood a better chance of recovering when he was involved in both forms of treatment. It is argued that there is no single method to seek recovery, as individuals often choose different recovery means according to the resources that are available to them (White & Godley, 2005; NIDA, 2009b). However, there are a variety of evidence-based approaches to treating a substance use disorder (Gateway Foundation, 2015; Smith & Segal, 2015). It could be argued that individuals therefore do not have a choice if only certain resources are available. However, these individuals are still required to make the decision to use this resource, unless they are being coerced by family or the legal system.

4.3.2.2. The Experience of Rehabilitation. Varying accounts, positive and negative, of experiences within a treatment environment were shared. It was believed that these experiences

had a significant impact on the participant's recovery process. This is evident in the following extracts:

J: *"It is the best 'cause it did learn me to take life one day at a time... and that is how to have a successful recovery"*

The participants had predominantly felt positively about their experiences within the treatment environments. A participant felt that Narcotics Anonymous had taught him a great deal of patience. This led to a sense of relief as he believed that he was previously rushing his recovery, which often put him at risk of relapse due to the immense pressure he had put himself under. The idea of 'one step at a time' is central to N.A. and stresses that recovering substance users allow themselves time to recover (Nowinski et al.; 1995).

S: *"When you first go in there... you think oh my god I'm doomed. Like, I'm actually an addict now... but, you're there for the first week... you've seen people that are there for two weeks... Rehab was a safe haven for me"*

R: *"They stimulate the mind... They make you aware of what reality actually is... and they do that by asking you certain questions... even like sums, painting, making stuff... just bring you back in touch with reality... What's helping you to change your mind set from active addiction... you still gonna now have that same mind-set..."*

Another participant was primarily unsure of what to expect when he first entered in-patient rehabilitation. He described it as a death sentence at first; however, when interacting with individuals whom had been at the facility for longer than him, he was able to identify with them and realise the importance of him being admitted. Laudet and Stanick (2010) suggest that it could be helpful for those initiating recovery to reflect on and learn from personal experiences of those who are currently in recovery. Additionally, a participant shared a similar idea, in that he

enjoyed the mental stimulation that inpatient treatment provided. The participant was largely engaged in cognitive behavioural therapy which helped him to identify and correct his problematic behaviours. Rangé and Robbe Mathias (2012) argues that this is achieved by linking a variety of skills that can be used to stop a substance use disorder, along with addressing a range of other problematic behaviour that often co-exists.

In addition to their positive experiences, the participants had shared what they deemed to be negative experiences within the treatment environment. The following extracts display the participants' thoughts:

S: *“Going in was a terrifying experience. That moment you walk into rehab... everything they check... they check your body, they check for razors, they check if you're suicidal... for tablets”*

This participant shared his initial thoughts on being admitted to an inpatient facility. He experienced the harshness of the treatment program as relatively traumatising for him. He believed that he was stripped of all his privileges. He did, however, concede that he could appreciate the benefit of this firm, yet caring, procedure while he was still admitted.

The same participant experienced difficulties with outpatient treatment programs, shortly after being discharged from the in-patient treatment centre. While he was admitted to the rehabilitative centre he was deeply involved in N.A. groups; however, once he was discharged, he experienced difficulties attending N.A. as his family did not fully believe that the method was helpful and therefore did not support him attending the groups. He felt highly demotivated by his family's attitude and soon withdrew from attending N.A. groups altogether. As is evident in the extract, previous studies argue that the recovering individual is placed at risk if he or she does

not receive support from their family (Copello et al., 2005; Moos, 2007). The participant's thoughts are shared in the following extract:

S: *“And because the family support didn't believe in Narcotic Anonymous... that I had at the time... Uhm... he believed that talking about your past all the time is not good... but he didn't understand the concept of Narcotic Anonymous... So when you don't have support outside of rehab it becomes very, very difficult...”*

Another participant, who also attended N.A., believed that he did not largely benefit from the support groups, but did acknowledge that he has seen its benefits towards others. He believed that he did not benefit well as he found it challenging to confide in others, as he had poor experiences where he felt that his confidentiality was breached by members of N.A. As acknowledged by the participant, support groups such as N.A. have been shown to be effective in the recovery from a substance use disorder; however, it is important for the user to feel comfortable and to actively engage in the support groups (NIDA, 2009; Nowinski et al., 1995). This participant, therefore, had an accessible resource become unavailable to him, which essentially reduced his support structure and placed him at an increased risk of relapse. Fortunately, he had expressed that there were other methods that existed that assisted with his recovery. His thoughts are shown in the following extract:

R: *“NA doesn't do it for me... There are other ways of getting around problems... People in NA... there is privacy, but within those walls... only for that hour”*

Lastly, the participant became largely frustrated by the people, whom he came into contact with, in a state-run rehabilitative facility. The participant had waited three months to be admitted to a treatment facility, but felt a great amount of anger and disappointment as he was often harassed and verbally abused by other patients. He believed that these experiences were a

hindrance to his recovery as it had largely placed him at risk of relapse. This is evident in the following extract:

R: *“There’s more criminals inside there and gangsters inside there, than actually people that wants to be helped”*

The participant believed that these individuals were not positively motivated to seek treatment, but merely chose rehabilitation as an alternative to escape the juridical system. It is interesting to note, that this participant, too, was admitted to a treatment facility (on a different occasion) by the juridical system. It appears that his frustration is as a result of others perceivably jeopardising his recovery at a time where his motivation was elevated, and not entirely by the way he was treated.

4.3.2.3. Developing New Coping Mechanisms. After the initiation of various treatment processes, the participants shared the importance of having to develop skills to cope with their daily challenges. These findings are supported by research that has shown the importance of having to develop alternative and healthy management strategies, as opposed to using substances to deal with disputes (Laudet & Stanick, 2010; Moos, 2007). Developing innovative approaches of coping was viewed by participants as an integral part of maintaining their abstinence. The participants’ initial views are as follows:

S: *“There’s no drugs to turn to. So you have to sit there and deal with those emotions... And it’s like intense... Then how do you deal with it sober... the worst part of coming out of rehab is the fact that... You still have your parents to deal with.”*

The participants’ shared their views about having to learn to manage their lifestyles without the use of substances. This adjustment towards their abstinence posed a great challenge, as previously there was a natural tendency to use substances in stressful situations. Hirschman

(1992) suggests that people in recovery need to remain cognisant that their behaviours are often compulsive, which essentially means that ex-users should develop prosocial behaviours and frequently reflect upon the value of these behaviours. The participants' experiences are as follows:

S: *"Obviously you try and remember the tools that you learnt... and you're trying to grapple on that... I say the serenity pray... Even now... and I say it to myself every morning"*

R: *"But once you're equipped with that skills... It just makes it so much easier"*

The above extracts are evident of the participants' need and ability to adapt their coping strategies when they were faced with various challenges. It became evident that the participants utilised different methods that were available to them, in the attempt to achieve abstinence. Even once management skills were developed, the participants still experienced difficulty to cope within the environments they once came from or moved into. This is evident in the following extracts:

S: *"After rehab was the worst... I cried when I left rehab... I cried for weeks on end because I was like what the fuck am I gonna do no... I went through a big stage of depression"*

Participants reported confusion that led to frustration when they were faced with the life that awaited them after they had sought treatment. There was often uncertainty about what direction to take after treatment. A participant reported that he became depressed due to not having set goals and a sense of direction set for him. Other participants described the long-winded journeys that they had to go through to get themselves into a state of stable recovery.

They explained the importance of patience in recovery, but that they would often become demoralised if they did not notice results. Their thoughts about moving forward are as follows:

Sh: *“It really took me a few years to get back on my feet”*

S: *“I think the biggest part is... just to try everyday”*

R: *“I can tell you now... It didn’t come so overnight”*

The above extracts are evident of the need to focus on recovery after initial treatment has been sought. Participants believed that they needed to maintain their focus for a long time as recovery was a long-term process. The following theme shall address these experiences after treatment had been initiated.

4.3.3. The Passing of Time in Recovery. The following theme describes the participants’ experiences of life after treatment had been sought. Four main sub-themes emerged from this key area: moving forward; setting goals; learning about yourself; and effects on relationships.

4.3.3.1. Moving Forward with Their Lives. The participants placed emphasis on their experiences of their daily lives after they had sought treatment. Pasareanu et al. (2015) had found that it was common for individuals to have an impaired quality of life before they had sought treatment. In accordance with these previous findings, the participants unanimously felt that their quality of life had improved during their process of recovery. The following extracts are evidence of their thoughts in conjunction with their progress:

J: *“My whole life is much better... My relationships with people and in everything I do”*

Sh: *“I am more focused on life... I’ve also got a job... I’ve been at this company longer than I have at any other company”*

S: *“They said you’ll see the small gifts... even though you’re not seeing it now... if I can sit here now I can honestly say the gifts that I’ve come across... small gifts... even by getting a job... I’m two years at this job that I have and that was after being in rehab”*

R: *“With no drugs... it’s a joy... I really enjoyed the last six years of my life... It made me mature... made me realise life isn’t easy, you need to work at life... It’s like... It gave me lots of knowledge... it blessed me with a lot of knowledge”*

The participants expressed a great sense of accomplishment about the progress that they were making and showed a large amount of gratitude towards their own efforts. They also expressed feeling a lot more cognisant of what was occurring in their lives. They had realised that their lives became more structured, which in effect provided them with containment. It appears, however, that the quality of life of the participants did not merely increase with sobriety alone. It was the result of sobriety in connection with prosocial and recovery-orientated behaviour.

4.3.3.2. The Importance of Setting Goals. A prominent feature was the difficulty participants had faced when planning their way forward. Emphasis was placed on the need to set both short and long term goals. In recovery, it is imperative for individuals to plan their way forward as life after rehabilitation is often very different to a life of active substance use (Elements Behavioral Health, 2010). Those in recovery often display an initial excitement centred on sobriety and the idea of progressing in their lives. However, participants would become frustrated when they did not always know what choices to make. Their perceptions about their goals are as follows:

S: *“I chose to leave my studies... it was a dumb choice to make... Knowing that I do want to get out of my work environment and I do want to go study further... but obviously the funds are not there”*

A participant spoke about how he regretted having left his studies, especially as he was at an advanced stage. This he had done in the early stages of his recovery and upon reflection concluded it was not a good decision. He believed the choice was made at a time when he did not set milestones, which left him hesitant about what goals he needed to achieve and therefore had made a rash decision. However, after much deliberation, he had set the goal of resuming his studies in the future so that he could complete his academic degree. This, he believes, has provided him with motivation to also maintain his sobriety. Although it is important for an individual to establish detailed goals and revisit those goals, it may be helpful in early recovery to provide an individual with knowledge and guidance that supports and facilitates his or her recovery (Elements Behavioral Health, 2010)

Upon further questioning pertaining to goal setting, the participants stated that they needed to prioritise and be patient in their recovery. They felt that in early recovery it was not so, frequently resulting in frustration and discouragement. The evidence of their thoughts is as follows:

S: *“When you're in recovery you need to prioritise a lot... I found it difficult... ‘cause I want to do everything in whole... You always try and move forward... but then you actually move 10 steps back... but you moving one step forward... Realistically you have to set a 10 year plan for yourself”*

It is believed that one needs to display a degree of perseverance as participants were often dissuaded by the lack of visible progress being made in their recovery, especially within the

earlier phase of recovery. With their growth in awareness, they had to set various milestones so that they were not discouraged. Anthony (2000) corroborates these findings by suggesting that ex-users may find it helpful to change their perspectives of what growth is in their recovery versus a life in active use. Anthony (2000) also writes that it is vital for those in recovery to set small milestones for themselves, rather than setting difficult goals that may appear unachievable and therefore demotivate individuals. A lack of preparation after treatment often creates the potential for an individual to struggle in their recovery. Sufficient recovery planning is achieved by setting goals that are well-formulated, specific and realistically achievable (American Addiction Centers, 2014).

The participants shared some of the experiences that they felt was progression for them. A participant believed that it was not merely felt by him, but was achieved together along with his fiancé. For this participant, there was a lot of emphasis placed on progressing together, rather than by himself, which in turn served to motivate him, too. This is evident by the following extract:

S: *“That the breadwinner just doesn’t consist of one person... It consists of two people... and it’s always that other person that will help you through that recovery.”*

Moreover, other participants spoke about materialistic items that they had gained. There was a great sense of attainment as the participants spoke about their ability to plan and save up financially towards objects that they struggled with previously due to their substance use. Also, the participants’ behaviours had been positively reinforced by others. This occurred when they had received gifts, which did not happen previously as there was no trust present. Regaining peoples’ trust was a significant step for the participants as this symbolised a reconnection with certain people.

S: *“They said you’ll see the small gifts... even though you’re not seeing it now”*

R: *“Material things... stuff I never had... like I have an apartment now, full of stuff. Yes I didn’t buy all of it. I was blessed with a lot of it... But where in my active addiction would people bless me with stuff like that... I have things I can call my own also that I bought for myself...”*

Previous studies have found that individuals often set a goal to make amends with regards to their lost or damaged relationships with family members or friends. However, many experience difficulties with re-establishing bonds as family members are often exhausted by the ex-users’ past behaviours (Morris, n.d.). By making amends, those in recovery often report that family and friends begin to trust them again. However, this may be a lengthy process. It should be noted that not all relationships are mended through behavioural changes.

4.3.3.3. The Power of Reflection and Positive Growth. It was reported that the participants had engaged in activities that taught them self-reflective skills. This process of learning took place through psychoeducation and with further self-reflection. This is evident in the following extracts:

S: *“They did this yoga experiment where they take you back into your childhood... Not realising that it actually started in your childhood... Not knowing who I was as an individual... Always conforming to others or what others had said about me.”*

It was believed that if it were not for their recovery from substance abuse, there were aspects of themselves that they would not have learnt. They felt that by understanding what may have led to substance use, they may be better able to protect themselves from further compulsive behaviours and possible relapse. Through reflection, participants were also able to be cognisant of the growth that was taking place through their recovery.

S: *“It’s a constant change... Constant development in myself... But it’s also a lot of gifts along the way where you have to remind yourself that you’re constantly moving forward”*

R: *“I do think of drugs. I think of it often. Doesn’t mean I’m an addict... I think of it because I remind myself of where I’ve come from... Yes especially if they’re not using anymore. So why do they not improve when I could?”*

Another participant believes that through introspection he is currently able to be mindful of his behaviour and is therefore more attentive of his decision making process. Additionally, he reported that he regularly thought about substances and his substance use. He considered this a deterrent from further substance use, and believed it did not place him at risk of relapse. Furthermore, it kept him motivated in working towards the goals he had set for himself.

4.3.3.4. The Effects of Recovery on Relationships. During the interviews, it became apparent that both substance use and recovery had a significant, extensive and often long-lasting effect on relationships. Angres and Bettinardi–Angres (2008) writes that it is therefore important for those in recovery to amend their pre-existing relationships, which is often achieved through developing prosocial behaviours. The following extract is evident of the nature of the relationships a participant had when he was actively using substances:

Sh: *“All the relationships I had were challenging... both family and friends... I was moody all the time... I didn’t want to be close to anyone.”*

However, the participant noted that there was considerable positive attitude in the relationships that he had with others when he was no longer using substances. This distinction in relationships appeared to be a significant theme amongst the participants. The participants were deeply encouraged by the ability of family and friends to forgive their substance-related behaviour, allowing them to re-establish relationships that were once fragmented. However,

Morris (n.d.) found that many individuals in recovery experience difficulties with re-establishing bonds as family are often exhausted by ex-users past behaviours. Certain individuals in Morris' study expressed that they felt guilty when their patterns of old, manipulative behaviour was beginning to resurface. The participants' thoughts on family relationships are evident in the following extracts:

Sh: *"I have good reports from them all... They cannot be happier... I have definitely become closer to my family and friends."*

R: *"Another positive thing is the relationships in my life... you know... my brother, my mother, my father... Reigniting old friendships like, you know... anything and everything."*

Additionally, participants spoke about the contrast in the new friendships formed while recovering. They experienced a sense of pride, attributed to friendships based on common interests and understandings, rather than being centred on substance use. This is evident in the following extracts:

J: *"They are very different, 'cause they will always try to support me in whatever I do"*

Sh: *"The friendships though they are different... these friendships were built on hardships."*

R: *"Instead of people coming closer to me, I brought people closer to me."*

S: *"You're not where you were before... where you had nothing... now you've got a family again... learning to trust you."*

4.3.4. Risk Factors in Recovery. Sub-themes that will be discussed include: cravings; family and friends; lack of treatment resources; stigma; and feeling misunderstood.

4.3.4.1. The Torment of Cravings. A prominent area that surfaced during interviews was the cravings that participants experienced. Cravings are described as an intense need for a substance, whereby individuals will often go through extreme measures to be able to use their substance of choice (Swift, 1999). Individuals often risk relapsing when they experience these sensations. The participants' thoughts on cravings were as follows:

J: *"There will be things that trigger cravings. But [the] sooner you deal with it, the better it is for you 'cause cravings never go away... That is something that you have to live with for the rest of your life and it can be triggered at any time so you must be careful."*

"You know when they say in rehab... people, places and things... that just the truth."

The participant was relatively vocal about experiencing cravings during his recovery. Additionally, there was a consensus amongst the participants that these feelings would occur but that the yearning for substances did diminish as they dealt more actively in recovery-based activities. Furthermore, these feelings were relatively unpredictable, which was why it is important for those recovering to understand how to manage the feelings in a healthy manner. Participants did, however, express that there were instances where they could not cope with the overwhelming feelings. The participants' thoughts on relapsing are as follows:

S: *"As a recovering addict or as an addict... you always gonna push yourself down... 'cause that's what you remember of yourself... I did have my relapses along the way... but it wasn't to an intensifying situation where I couldn't let go... you will always have that moment where you think... fuck, I can't do this anymore."*

R: *"Every time I relapsed it's because I went to go hangout with people. Or I found myself in positions where I wanted to use drugs... because of myself."*

The participants explained that there was a strong internal battle that had occurred before they relapsed. They were conflicted between the euphoria and the damages that the substances could potentially cause. The inclination to use substances was largely perpetuated by the participants' negative thoughts about themselves. They shared that it was important to speak to others when experiencing difficulties with possible relapse. Ex-users reportedly have found it helpful to speak to individuals who have had similar cravings as they may have possibly reassured the ex-user that it is better to abstain (Hirschman, 1992).

4.3.4.2. Relapse. Furthermore, a participant described how disappointed he was with himself, as he believed that his relapses were purely his responsibility. His accountability was confirmed in the following extract:

R: *“Kyk hier [look here] ... you make it risk factors yourself... at the end of the day someone comes to me with drugs... they knock on my door, I let them in... so I'm entertaining it... it becomes a risk because they here with drugs now”*

Essentially, the participant felt that he was significantly accountable as to whether or not he would experience cravings. He explained that those in recovery needed to minimise high-risk situations in order to reduce the possibility of experiencing cravings.

4.3.4.3. Family and Friends. It was reported by the participants that people whom they often interacted with during their recovery had often placed them unknowingly at risk. Studies have shown that those with interpersonal problems such as family conflict are powerful precipitants of relapse (Moos, 2007). This is evident in the following extract:

S: *“If people's gonna push you down and reminding you constantly of your past... My step-father will always be the remaining factor and say.... ‘oh, but this is what he did and*

this is how he is now, but he's still doing that' ... and without... there's always assumptions involved... Where my father's family was...we'll just stay away."

Some of the participants described how the behaviour and attitude of certain family members had placed them at risk. Participants were relatively discouraged when they felt that certain people had treated them poorly, especially if it was believed that these people should have encouraged them in their recovery.

4.3.4.4. Mistrust. Moos (2007) wrote that those in recovery who have more stressful relationships have an increased chance of relapse and are more likely to experience substance use problems after treatment. Additionally, it was reported that their family's lack of trust placed them at greater risk. Ironically, the participant's families were attempting to protect them from relapsing, which they were able to appreciate later. This is evident in the following extracts:

S: *"People say they support you, but every turn you take... take a drug test... So it was very intimidating. I think they did it for about a year... taking a drug test every day."*

R: *"You know that they don't trust you... and even though they don't do it purposely... they make it known that they don't trust you."*

Additionally, the participants expressed how they had experienced active users as a risk. They believed that this was a form of peer pressure as active users would knowingly try to manipulate the participants into using substances. The participants had shared their frustration with this occurrence as they had frequently experienced it. This is evident in the following extracts:

J: *"Those who are not in recovery will always try to have a bad influence on you."*

R: *"When you get that person and you're gonna be like 'hi'... and carry on walking... and they're gonna be like jy jou [hey you], is this now how you treat me?"*

The participants believed that users would try to persuade them back into active-use as they had known that the participants had used substances before. Users were often mindful that they could illicit strong cravings within the individual who is abstinent.

4.3.4.5. The Lack of Accessible Treatment Resources. A minor theme emerged after a participant reported that he had experienced the initial difficulty with access to treatment resources, which he believes had caused difficulties in his recovery. His thoughts about the inaccessibility of resources are as follows:

R: *“South Africa needs to do something about their formalised methods, because the private sector is huge compared to the government sector... There is help to help addicts... but it’s just vrek [very] expensive... And because a lot of addicts bullshit at the same time.”*

The participant spoke about the initial difficulty he had in gaining access to state-owned rehabilitative facilities. He attributed this difficulty to the large amount of users seeking help; however, there was not sufficient space to accommodate them timeously in an affordable treatment centre. Private rehabilitative clinics were available, but their expensive nature made them inaccessible to many people. According to Myers et al. (2008) it has been identified that there are a lack of treatment resources in the South African context. The participant expressed the following about those he experienced in rehabilitative centres:

R: *“They need to look at a person’s ways, like really sum a person up... and you shouldn’t do that in life... but you must really sum that person up.”*

The participant shared his frustration about particular individuals whom he encountered while admitted to a state-owned treatment facility. The participant encountered a significant amount of individuals whom he believed to be uninterested in seeking recovery and believed that

they posed a risk to others within the treatment facility. Although relatively controversial, the participant suggested that a screening process be developed for admission to treatment facilities so that the programs may be run as efficiently and safely as possible for those seeking help. Because of the strong correlation between treatment motivation and substance use severity, it has been argued in previous studies that those seeking treatment should be assessed for treatment motivation (Carey, Maisto, Carey, & Purnine, 2001). It was therefore suggested that a treatment motivation measure should be used to assess the level of motivation of individuals before they are admitted to in-patient treatment facilities. It is believed that an assessment of this nature would assist in treatment costs and treatment efficacy.

4.3.4.6. Stigma. Consistently, the participants undergoing study reported that they frequently felt judged for the lifestyle choices that they had previously made when they were actively using substances. The following extracts are evidence of this:

Sh: *“I believe that I am still recovering from the stigma of being a drug addict... its really tough.”*

S: *“So people always brand you for who you are... what you did.”*

R: *“You’re using drugs all the years... you decide to stop drugs... and you live a happy life after that, but you still get classified as a recovery addict... ‘till the day you die.”*

The participants expressed how they were often misjudged due to their previous substance usage, which often resulted in feelings of isolation and insecurities. These problems were often perpetuated by their close family, friends and even those they had experienced in treatment environments. One of the participants challenged the notion of stigma more vocally than the rest. He stated that others, who have never been users, are often quick to negatively label and ostracise those who have. He believes that this is due to the sensitive and serious nature of

the substance use problems that exists in our communities, which often affect a large amount of people, even those who are not users. The participant had compared a woman who was physically and emotionally abused by her husband for many years to an individual who had used substances for a long period. The participant argued that the woman would not be labelled as ‘recovering from abuse’ whereas he would often be referred to as an ‘ex-user’ or ‘recovering addict’. It appears that society often perceives substance use as self-inflicted abuse and physical or emotional abuse as not. The participant highlighted this contrast to demonstrate how individuals should be mindful of the labels that are afforded to others and their possible adverse effects.

These findings are in line with previous studies that suggest that individuals often experience stigma when recovering from a substance use disorder as it is viewed as substance use is viewed as a social taboo (Doukas & Cullen, 2009; Hopkins & Niemiec, 2007). These studies found that individuals often felt discouraged and demotivated by these constant reminders of their substance use, which may include memories that individuals are not necessarily contented to be reminded of. This places those in recovery as an increased risk of relapsing.

4.3.4.7. Feeling Misunderstood. Some of the participants reported feeling irritated when others were not able to empathise with them. Participants believed this to be the result of others assuming that they knew what the participants were experiencing, rather than taking the time to understand their feelings. This often resulted in the participants distancing themselves from the support systems that they managed to obtain. The follow extracts are evident of this:

Sh: *“It’s a hinder[ance] when others try to put themselves in your shoes... and... they tell you that they know what you going through.”*

S: *“When people don’t understand you... and they understand your past... but they don’t understand you now... It will always be a challenge... People won’t understand until they put a group of recovering addicts in one room and a sober person will sit there, or a non-addict... and they actually listen until they have been there and they have been in that persons shoes.”*

Research shows that it is often helpful for those in recovery to share their experiences and their feelings with other individuals who have had similar experiences (Hirschman, 1992). This research suggests that by identifying with other individuals and feeling understood by them helps to restore a sense of cohesion and normalcy. Hirschman (1992) further suggests that those in recovery may feel better understood by ex-users who are currently in recovery; as current users often dismiss the opinions of family and friends as irrelevant as non-users may be viewed as unknowledgeable due to their perceived lack of understanding and experience with substance use.

4.3.5. Supportive and Protective Factors in Recovery. The last theme is related to receiving support and dealing with threats.

4.3.5.1. Receiving Support from Others. The participants reflected on how support had influenced their recovery. Their thoughts on support are as follows:

Sh: *“You need all the moral support that you can get... Those in addiction... they really do need all the support that they can get... the challenge that they are facing, it is huge.”*

J: *“It’s the best... they will always remind me of where I came from... you need to know where you came from to know where you going.”*

S: *“So it was my safe haven because I could speak and say what I had felt.”*

The participants attributed a large amount of importance to the interactions with others who were supportive of their recovery. This proved to be fundamental as the support the individuals received influenced their ability to maintain their sobriety. The participants reported that the likelihood of them maintaining their sobriety was increased when they had more access to consistent support from family and friends. Literature seems to support these findings that the support that an individual receives from their family is strongly related to that individual being able to maintain abstinence (Copello et al., 2005; Laudet & Humphreys, 2013; Moos, 2007; Saatcioglu et al., 2006). Additionally, support from friends and peer groups have also shown to have a positive effect on individuals being able to maintain their recovery (Best & Laudet, 2010; Laudet & Humphreys, 2013; Laudet & Stanick, 2010)

Also, the participants reported feeling a great sense of relief when sharing their experiences with others. This is evident in the following quotes:

R: *“It always helps to talk about it... It does help a lot actually... for all if its people closed to you... then you can speak to them and they can understand where you’re coming from... It’s always good to talk about it... it just feels like there a ligting [relief] off the shoulders... and for all with someone you know.”*

S: *“Me going back... speaking about it was a real eye opener... I think for her [fiancé] as well... ‘cause I don’t really speak about rehab with her... I don’t think she knew the emotions that came with it.”*

The participants felt that it was vital for them to share their experiences with people they were close to, as well as those who showed them compassion. They believed that it was more helpful and productive for their recovery to share their experiences with those that they knew who would be willing to assist, rather than with people who were merely interested in gossip.

Participants reported that they often felt that others were more interested in what they had done when using substances, rather than focusing on the goals that the participants had set for their recovery.

4.3.5.2. Putting Boundaries in Place. In addition to receiving support, the participants identified the importance of having to eliminate threats in recovery, with respect to family members. Their thoughts are as follows:

Sh: *“You or your family... should put strict rules in place for you to follow.”*

R: *“Like be maybe sitting in the lounge... and I needed to go to the toilet... but there was someone in that toilet here on the one side of the house... I then needed to go to the other toilet... walking through my parents’ bedroom... they would just let me walk in there... just like that and go pee... they would let me... but one of them would walk in after me shortly and maybe not make it... like say... we are here to watch you... but just like maybe do random things... to not make it noticeable... but... to keep an eye...”*

S: *“So it was... it was very difficult... a very difficult transition to coming out of rehab because people say they support you... but every turn you take or you going to the shop... and you come back... ag... take a drug test... So it was, like, very intimidating... I think they did it for about a year... taking a drug test every day.”*

Some firm measures were put in place by their families to prevent them from further substance use. In initial recovery, the participants appeared reluctant to accept the boundaries by their family members; however, upon reflection, they were highly appreciative of their family’s efforts. One of the participants expressed how it was helpful that his family discussed, with him, the measures that they would implement rather than simply imposing it on him. These findings are supported by Family Behaviour Therapy (FBT), which has demonstrated positive results in

both adults and adolescents, and is aimed at addressing not only substance use problems, but other co-existing problems (NIDA, 2009). FBT combines behavioural contracting with crisis management and involves the patient along with at least one significant other, such as a cohabiting partner or a parent (Copello et al., 2005; Liddle et al., 2005). Patients participate in treatment planning, whereby they choose specific interventions from a list of treatment options (Liddle et al.; 2005).

4.4. Conclusion

The interpretive phenomenological method of the current study has shown the complex nature of the lived experience of recovering from a substance use disorder. The results of this research provided a description of recovery as was experienced by the four participants. These experiences were then grouped according to the themes that developed within key areas that emerged. The outcomes and implications of the present study will be discussed in Chapter five.

Chapter 5

Conclusion

5.1. Introduction

Chapter Five provides a summary of the present study and highlights the limitations and recommendations for the research. The outcomes of the study focus on the results obtained from the research as well as the methodology used to represent the researcher's goals. The inferences of the study reflect applicable observations and understandings that developed through this research method and how these could be integrated into future research or implemented into current substance-related programmes.

5.2. Summary of the Study

This present study explored ex-users "lived experience of recovering from a substance use disorder, " from middle class socioeconomic communities within Cape Town. Taking into account the serious nature of this social problem, it has become vital to explore how individuals make sense of their need to seek recovery.

A review of the literature regarding the recovery from substance abuse raises a concern about the limited amount of research on this topic, especially considering the varying socioeconomic communities in the Western Cape, South Africa. The majority of studies piloted within the South African context with regards to substance abuse, has largely focused on the reasons for individuals substance addictions, as well as factors associated with the onset of substance abuse. Few studies have focused on understanding the recovery process from a substance use disorder. It is important to pursue studies focusing on these individuals, as they are the ones who are currently experiencing the recovery process itself. Research of this nature is

imperative as it may inform policy and interventions which will assist treatment programs, family members and or significant others in dealing with this issue.

This study sought to explore the ex-users lived experiences by allowing them to share their experiences that they endured during the time that they were seeking help and undergoing the recovery process from a substance use disorder. The level of understanding which the researcher sought to engage with was the meaning which ex-users ascribed to their experiences.

All of the participants expressed the distressing nature, for themselves and others, of their experience of having a substance use disorder. They further communicated with the researcher their understandings of the emotional, psychological, physical, spiritual and financial implications of their substance use disorder. When making sense of their experiences, many of the participants had reflected upon the recovery process: they considered how their personal decisions may have affected their families and also their recovery. The participants acknowledged that it was initially challenging to accept the fact that they had a severe problem, which affected their lives significantly.

5.3. Limitations

The limited amount of empirical research studies on ex-users " experiences of recovering from a substance use disorder was a challenge, especially during the analysis stage of this research. The majority of participants appeared to project their experiences on all of those who have used substances and or those recovering from a substance use disorder. However, this may be attributed to the sensitive nature of the current research, which may make it difficult for users to explore the implications of their substance use. Additionally, the delicate nature of this study may have resulted in the difficulty with gaining a bigger sample size, as potential participants may have been reluctant to disclose personal information with an unfamiliar person.

Furthermore, the participants used alcohol and varying illicit substances, therefore it cannot be determined that the experiences as described by the participants can be attributed to the use of a particular substance. The participants also showed a varying amount of denial regarding their substance use which has the potential to influence the accuracy of their accounts and thus detracted from the descriptions of the lived experience of their recovery from a substance use disorder.

Lastly, qualitative research is limited in its ability to generalise the findings of the specific research, however, the study may be transferred to a similar social setting.

5.4. Recommendations

The lack of literature on ex-users' 'lived experiences of their recovery from a substance use disorder' is considered a rationale for conducting further studies in this area.

The findings of this study suggest that those who are recovering from a substance use disorder may suffer from the effects of their substance use, even many years after they became abstinent. It may be valuable to explore the experiences of individuals in recovery, from various socioeconomic communities, as this may essentially affect what resources are available for recovery. Future studies could focus more specifically on the various pathways that individuals may chose as a means to recovery, as was reported by participants of the current study.

Furthermore, it may be beneficial to explore the experiences of individuals who have managed to stay abstinent for an extended period of time.

5.5. Conclusion

The exploration into the lived experience of recovering from a substance use disorder through this study has underlined the significance and requirement of such research. The phenomenological approach and methodology of this study has proven to be constructive in

developing insight into the psychological experiences of substance use recovery and how this knowledge can be used to supplement understanding of the dynamics of a substance use disorder. The knowledge and understanding of the psychological aspect of a substance use disorder highlights the significance of continued research into the phenomenon which can be transformed into more effective means of opposing this rapidly developing social problem.

5.6. Research Reflection

During the conceptualisation of this project, I had asked myself: “Why am I interested in exploring the perspectives of ex-users?” and “What is it that I am trying to accomplish?” Conducting this research has provided me with a wealth of knowledge about substance use and its co-existing problems, but also much about research itself, which I hope to pursue in the future. My interest in this area of substance use began during my adolescent years, when I witnessed many of my community members and even some friends and family members, falling prey to the evils of substance use.

While I understood that my curiosity should not guide my questions posed, this topic gave me an opportunity to comprehend and engage with many of the unanswered questions that I had been sitting with for many years. Many of these questions were answered during the interviews with the participants. Throughout the research process, I needed to remain cognisant giving the participants an opportunity to share their experiences, which in no way was guided by my previous experiences with those who have had a substance use disorder. As an instrument of data collection, it may be that participants were reluctant to share certain in-depth information as I have not personally dealt with a substance use disorder. Participants may believe that their experiences are being judged adversely by me as the researcher and could therefore hold back on particular information. Data collection may have been conducted in an environment that was

accessible to me, rather than conducted on a population that may have provided me with more information pertaining to the research question at hand.

It was a privilege to share in the experiences of my participants. I felt a great sense of gratitude and respect towards them for stepping up and sharing in their experiences to potentially help others. All of the interviews proceeded with good rapport between me and the participants.

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Appendix A: Letter to Venue for Data Collection

To whom it may concern:

Re: data collection on substance abuse

I, Brett van der Schyff, am a student at Rhodes University. I have proposed a Master's thesis project on '**The Experience of Recovering from a Substance Use Disorder**'. The study will take place during the course of 2015, for which I will need to conduct interviews.

I would like to receive permission to contact male clients who have previously participated in your outpatient rehabilitative program. If permission is granted, clients will be contacted to determine whether they will be willing to participate in this research, from which three participants will be chosen.

All information collected from individuals will be done with duly informed consent from the participating individual and that he can refuse participation with no negative consequences for said individual.

Yours sincerely,

Brett van der Schyff

Appendix B: Advertisement

The Experience of Recovering from a Substance Use Disorder

A Student from the Psychology Department of Rhodes University is conducting research on the experience of individuals who have managed to recovery from a substance use disorder. The research is a requirement for a Master of Arts degree in Clinical Psychology.

Requirements:

- Ex substance user
- Five years of abstinence

If you are interested, please contact:

Brett van der Schyff

on

0845875874 or bcarl@telkomsa.net

Appendix C: Participation Information and Consent Form

Dear Participant:

I, Brett van der Schyff, am a student at Rhodes University in the Psychology Department under the supervision of Mr E. Fouten. You are invited to participate in a research project entitled: ‘The Experience of Recovering from a Substance Use Disorder’. The purpose of this research is to understand the experience of recovering from a substance use disorder from the perspective of ex-substance users in an attempt to comprehensively understand the recovery from a substance use problem. The research was firstly approved by the Department of Psychology Research Project and Ethical Review Committee of Rhodes University. Secondly, it was approved by the Higher Degrees Research Ethics Committee and the Humanities Faculty’s Higher Degrees Committee.

The following interview was developed to ask you a few questions regarding substance abuse. It is our aim to contribute to research that looks at substance use recovery and rehabilitation. There are identified risks from participating in this research, with information to support systems being provided to each participant.

The interview is confidential. Participation in this research is completely voluntary and you may refuse to participate, at any time, without consequences. The interview will take up to three hours to complete. You will receive no compensation for participating in the research study. Neither the researcher nor the University has a conflict of interest with the results. The data collected from this study will be kept in a locked cabinet for three years.

To insure safe and proper research procedures, auditors of Rhodes University will be granted direct access to the research data without violating the confidentiality of the participants. Further

information regarding the research can be obtained from Brett van der Schyff on bcarl@telkomsa.net or my faculty advisor Mr E. Fouten in the Psychology Department at Rhodes University, who may be contacted on +27(0)46 603 8003 or e.fouten@ru.ac.za.

If you would like to know the results of this research, contact Brett van der Schyff on bcarl@telkomsa.net. Thank you for your consideration. Your help is greatly appreciated.

Your signature below indicates that you have read the above information, are at least 18 years of age and agree to participate in ‘**The Experience of Recovering from a Substance Use Disorder**’.

Printed Name (Optional)

Signature

Date

Appendix D: Semi-structured Interview Schedule

Biographical details:

1. What is your age?
2. Length of the period of drug abuse?
3. What substance were you using?

Initial question:

- “How would you describe the experience of your process of recovering?”

Probing questions:

- Please describe what it feels like when you are in active addiction/actively using.
- How do you make sense of your decision to quit using substances?
 - Were there any specific life experiences that were related to your decision to quit?
- What is it like to have the assistance of others in your recovery?
 - How does the assistance help or hinder you?
- There are often risk factors that may deter you while recovering, what are your thoughts on this?

- What effect, if any, has recovery had on other areas of your life?
- Would you describe yourself as being recovered or in recovering?
 - How does it feel like to be in recovery or recovered?
- Substance abuse treatment has ‘formalised methods’ (compared to natural recovery).
How would you describe the experience to learn these methods/steps?
- Can you tell me about other settings / places / times when work of recovery, other than in a rehabilitation setting?
- What is your perception of those not in recovery versus those who are?
- How do your family and friends feel about your participation in recovery?
- Can you describe the friendships you may have formed during recovery?
 - Are these friendships different/similar to friendships outside of the recovery context?
- What would you say to someone currently abusing a substance, who is considering seeking recovery?
- Overall, is there anything I have not asked that you would like to add about your experiences in recovery?

Appendix E: Distress Protocol

Distress Protocol: The protocol for managing distress in the context of the research interview

1. Distress:

If a participant indicates they are experiencing a high level of stress or emotional distress OR exhibit behaviours suggestive that the interview is too stressful such as uncontrolled crying, shaking etc, then the researcher will proceed with the following steps.

2. Response to distress

Stop the interview. The researcher will offer immediate support to the participant.

Assess mental status by exploring the following:

- Tell me what thoughts you are having?
- Tell me what you are feeling right now?
- Do you feel you are able to go on about your day?
- Do you feel safe?

3. Review :

If the participant feels that they are able to carry on then the interview shall be resumed.

If participant is unable to carry on, step 4 shall be carried out.

4. Response to review:

- The interview shall be discontinued.
- The participant will be encouraged to contact a mental health provider from the details provide by the researcher. Otherwise they may contact any other mental health care provider.

5. Follow up

The participant shall be followed up with a courtesy call, if they consent.

Encourage the participant to call either if he/she experiences increased distress in the hours/days following the focus group. The participant will be encouraged to contact the researcher (post-interview) if they experience any form of distress as a consequence of the interview process.

Appendix F: Counselling Resources

LifeLine Southern Africa

24-hour crisis intervention service

- Free, confidential telephone counselling
- National counselling line: 0861-322-322
- Website: www.lifeline.org.za

Alcoholics Anonymous SA

Worldwide fellowship for alcoholics supporting those choosing to be sober

- National helpline: 0861 HELPAA (435 722)

Al-Anon

Al-Anon Family Groups is for the families and friends of problem drinkers, with a special section – Alateen – for children of alcoholics, and a group for adult children of alcoholics.

- Helpline: 0861 ALANON (25 26 66)
- Main office: (021) 595-4508
- E-mail: help@alanon.org.za
- Website: www.alanon.org.za

Narcotics Anonymous SA

NA is a non-profit organisation for recovering drug addicts who meet regularly to help each other stay clean.

- National 24-hour helpline: 083 900 MY NA (083 900 69 62)
- Website: www.na.org.za

SA National Council on Alcoholism and Drug Dependence

Sanca provides specialised and affordable prevention and treatment services for alcohol and other drug dependence.

- Sanca - Western Cape:
- (021) 945 4080/1
- www.sancawc.co.za

Department of Social Development's Substance Abuse Line

Offers support, guidance and help for people addicted to drugs and alcohol as well as their families. Run in partnership with the SA Depression and Anxiety Group.

- National toll-free helpline: 0800 12 13 14 or SMS 32312

SA Depression and Anxiety Group

- Suicide crisis line: 0800 567 567 or SMS 31393 (8am - 8pm, seven days a week)
- Help line: (011) 262-6396 (8am - 8pm, seven days a week)
- Website: www.sadac.org

Family and Marriage Association of SA

Famsa supports families through stressful situations: offers counselling and education to strengthen marriage and other relationships in the family.

- National office: (011) 975-7106/7
- E-mail: national@famsa.org.za
- Website: www.famsa.org.za

New World Foundation

Guidance, advice and counselling are offered. After an intake session, clients will be referred to the relevant institutions. Counselling by a professional psychologist is also an option for the more affected cases.

- The Advice Office is open from:
Monday to Friday, 09.00 – 12.30
Monday to Friday from 14.30 for appointments only
- Grindal Avenue, Lavender Hill, Cape Town
Tel: +27 21 701 1150
Fax: +27 21 701 9592

CAFDA - Child and Family Centre

- provides individual counselling including
- provides group support including behaviour modification

CAFDA Family Centre, Corner Prince George Drive and 8th Avenue, GRASSY PARK, 7941
Postal Address: P O Box 211, RETREAT, 7965
Telephone: 021 706-2050
Fax: 021 706-0765
Email: fundraiser@cafda.co.za