Recovery from Addiction and the Role of Treatment Processes

A qualitative analysis of interviews with clients on an abstinence-based structured day-care programme

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Abstract

Despite the vast sums of money devoted to the treatment of drug and alcohol problems in the UK, the processes by which recovery from addiction occurs remain fairly unclear. Moreover, we know relatively little about the contribution of treatment interventions and processes in facilitating such recovery.

The present study involved a detailed qualitative analysis into the processes involved in addiction and recovery, from the experiences of addicts currently in treatment, or recovering addicts using aftercare services following treatment, for drug and/or alcohol problems (all of whom were currently abstinent). Semi-structured interviews were conducted with fifteen participants, who were recruited from a drug and alcohol service which provides an abstinence-based, structured day care (community rehabilitation) programme. A Grounded Theory approach was adopted to analyse the transcribed data.

Seven major themes emerged from the analysis, which are referred to as: the nature of addiction and its development; the reasons/factors for use; the negative effects of use; the process of realisation; behaviour change; treatment; and recovery. The results have been integrated to form a model, which aims to provide a picture of the processes involved in developing a problem/addiction, the processes involved in behaviour change, the role of treatment, as well as the potential path to recovery.

It is suggested that the substance misuse problem was very powerful in nature, and after a rather gradual progression from participants' initial use, it resulted in a complete preoccupation with using. This led to a range of negative effects, which seemed to get rapidly out of control. Despite experiencing various negative effects, a wide range of factors/reasons seemed to promote participants' continued use of substances. As the addiction developed, participants seemed to develop a realisation of the substance misuse problem and the need to change their behaviour, (influenced in part by an increase in the negative effects of use). The increase in the negative effects of use also seemed to be influential in tipping the balance in favour of behaviour change, rather than continued use, as these negatives gradually outweighed the opposing reasons/factors influencing continued use.

One of the most important factors in allowing successful behaviour change and promoting recovery was treatment, which seemed to produce a range of positive effects, although a range of other factors alongside treatment were also important in promoting behaviour change. In order to achieve the positive effects of treatment, certain positive

components/needs were reported to be essential. A number of difficulties encountered in treatment were also identified.

This study has provided important information – from clients themselves – on the many factors that are important in achieving abstinence, in allowing recovery to be maintained in the longer term, and in potentially allowing an eventual exit from addiction. If we are to improve the way that treatment is delivered and thereby reduce the problems that drugs and alcohol can cause to individuals, their families and friends, and communities we need to carry out research similar to this on a much larger scale. This qualitative approach must be adopted in studies with clients from a wide range of treatment services and interventions. This will allow us to enhance our understanding of specific forms of treatment service/intervention, as well as make more generalised statements about treatment and recovery per se. This work will facilitate the planning and delivery of future services. Needless to say, we also need to carry out research with people who have recovered from a substance misuse problem without recourse to a treatment service.

Introduction

Without doubt, drug and alcohol misuse and the problems associated with this are escalating within the UK. However, that is not to say that all those who misuse drugs and alcohol develop a problem or become addicted (or dependent). In reality, only a small minority develop an addiction, but for those who do it can result in unpleasant and potentially terrifying experiences/consequences, that can often be extremely difficult to escape from. That is not to say that recovery from addiction to drugs and alcohol is not possible. Indeed, contrary to the beliefs of many people, the reality is that many people do eventually recover.

However, the processes by which such a recovery comes about remains fairly unclear. Moreover, we know relatively little about the contribution of treatment interventions in facilitating such recovery. This is ironic given the vast sums of money (approximately £500 million per annum) devoted to the treatment of drug and alcohol problems. If we are to improve the provision of treatment services for people who are suffering from serious drug and alcohol problems, then it is essential that we better understand the processes underlying recovery from addiction and the role that treatment processes play.

One of the earliest and most widely quoted descriptions of the recovery from drug use is provided by Winick (1962), who viewed drug addiction as a self-limiting process, which most addicts 'mature out' of naturally, by the time they reach their mid-thirties. Winick (1962) based his analysis on arrest records of heroin users in the U.S., which showed that as age increased, the number of people being arrested for drug-related offences decreased. According to Winick (1962) 'maturing out' is a process by which the addict stops taking drugs, as the problems for which he/she originally began taking drugs, become less salient and less urgent. Winick's (1962) proposition was clearly important as it went against the dominant opinion at the time that addiction was a destructive and lifetime affair, with the only end being death (Prins, 1995; Robertson, 1998). Instead, it provided a more hopeful and optimistic view, suggesting that for some at least, addiction is a reversible process, and recovery is aided by the natural aging and maturing process. It is clear that Winick's (1962) contribution was fundamental in stimulating a considerable amount of research on addiction, work that was primarily aimed at proving or refuting his thesis (Prins, 1995).

Despite this contribution, and the fact that the maturing out thesis has been widely quoted in the addiction literature, Winick's (1962) work has been heavily criticised for failing to provide much information regarding the factors/circumstances under which

such a process of maturing out would take place. Prins (1995) argues that in order to gain such details more qualitative research is needed, for example, focusing on why and how people get into and out of addiction. Furthermore, although many subsequent studies have confirmed that a high proportion of addicts do stop using in their thirties (e.g. Waldorf, 1983; Biernacki, 1986; Prins, 1995), many disagree that the maturing out hypothesis provides the only explanation. In particular, a study by Swiestra (1987) provided an overview of 19 follow-up studies in the Netherlands. Although evidence was found to demonstrate classic 'maturing out' patterns under certain conditions, Swiestra did not agree with the theoretical explanations of Winick, and instead sided more with the views of Waldorf (1983), who identified numerous different routes out of addiction. As well as 'maturing out' of addiction, Waldorf (1983) argued that individuals can also 'drift' out of addiction; become alcoholic or mentally ill; give up due to religious/political conversion; 'retire' by giving up the drug while retaining certain aspects of the lifestyle; or change because their situation or environment has changed. Clearly, as the work of Waldorf (1983) demonstrates, the maturation thesis is increasingly seen as being only one of several explanations of how individuals may overcome their addiction (McIntosh and Mckeganey, 2002).

Another common approach in the substance misuse field involves describing addiction and recovery in terms of a series of stages or phases. For example, Frykholm (1985) proposed three phases of addiction referred to as experimental, adaptational, and compulsive, and three phases of de-addiction, where the process of becoming addicted is reversed. According to Frykholm (1985), the first phase of de-addiction involves a period of ambivalence; where the negative effects of drug use are increasingly felt resulting in a gradual desire to stop using drugs, which is generally offset by a continuation of pleasurable effects of drugs and a physical dependency on drugs. In contrast, in the treatment phase, attempts at detoxification become more sustained and drug-free periods grow longer. In this phase, the addict perceives a need for 'external control and support' and so seeks help, and also undergoes a radical reorientation in which he/she suddenly experiences a desire to fulfil the role of ex-addict. The final stage is referred to as emancipatory, and involves the period following detoxification when the addict effectively becomes an ex-addict and can remain 'clean' without external assistance (Frykholm, 1985).

Although Frykholm (1985) has provided a useful model of addiction, his work has been criticised for not allowing for spontaneous recovery from addiction. Other stage-based models, such as that of Waldorf's (1983) six-stage model, do allow for spontaneous recovery, as recovery is said to occur with or without treatment. In Waldorf's (1983)

model, the 3 phases of becoming addicted are referred to as experimentation, escalation and maintaining, and the corresponding 3 stages of de-addiction are referred to as the dysfunctional or 'going through changes' phase, the recovery phase, and the ex-addict phase. In the first phase, the negative effects of drug use begin to be felt and the addict may make forced or voluntary attempts to stop, which usually end in relapse. In contrast, in the recovery phase, the user makes a concerted effort to give up drugs, and recovery to the ex-addict phase is said to occur with or without treatment (Waldorf, 1983).

One of the most popular stage models of recovery was developed by Prochaska et al (1992), who propose that there are five stages in the process of change, involved in recovery. According to this 'stages of change' model, individuals' progress through a series of stages, beginning with 'precontemplation', which is the period before the user has considered stopping. Individuals then progress to the 'contemplation' stage, where the user begins to think about stopping, and on to the 'preparation' stage where the decision to stop occurs and efforts are made to prepare for stopping. Subsequently in the 'action' phase specific steps are taken to reduce drug use, and finally in the 'maintenance' stage non-using behaviour is consolidated and the individual becomes an ex-addict. According to the model, individuals can move back and forth stages or even skip stages, which fits in with the notion of addiction as a relapsing disorder. Despite its popularity, like the other models, this account has been questioned, for example, regarding whether addictive behaviour does actually involve movement through a series of stages. Nevertheless, it is clear that this model has much intuitive appeal, and has been influential in the development of various techniques for dealing with addictions, particularly Motivational Interviewing (Miller, 1983; Miller and Rollnick, 1991).

The fact that a number of conflicting stage/phase models exist, means that there is necessarily some disagreement regarding the precise number of stages which individuals may pass through in order to overcome addiction. However, according to McIntosh and Mckeganey (2002), one of the features common to many of these models is the importance of a specific 'turning point', at which the decision to give up drugs is taken and/or consolidated (Prins, 1994; Simpson et al, 1986; Shaffer and Jones, 1989). Such a turning point has been variously described as an 'existential crisis', an 'epistemological shift' or as hitting 'rock bottom', but whatever the terminology used, it refers to the addict reaching a point in their drug-using career beyond which they are not prepared to go, and is often accompanied by some experience or event which stimulates/triggers the decision (McIntosh and Mckeganey, 2002).

According to McIntosh and Mckeganey (2002) another common area of addiction research focuses on identifying the factors and circumstances, which promote or impede the process of recovery. Although the reasons given by addicts can vary considerably from study to study, McIntosh and Mckeganey (2002) identify some of the more common and prominent themes. In particular, 'burn out' is reported to be one of the most frequent precursors to recovery, as it seems that sustaining a habit can become an exceptionally difficult and demanding task associated with many problems. This is demonstrated in numerous studies, like that of Frykholm (1985) and Simpson et al (1986), where addicts' main reason for stopping was that they were 'tired of the life' or words to that effect. McIntosh and Mckeganey (2002) point out the similarity of the 'burn out' explanation and Winick's (1962) 'maturing out' thesis (referred to previously), since both are products of changes, which could be said to occur naturally with the passage of time.

Several studies have also shown that the influence of significant others, such as partners or children can be important in the decision to quit (Waldorf, 1983; Frykholm, 1985; Simpson et al, 1986; Smart, 1994). For example, Simpson et al (1986) report that more than half of their sample stated 'family responsibilities' were important in their decision to stop, while about a third cited pressure from family members was important. Another important factor reported to be influential in the decision to stop is deteriorating health or the fear of health problems (Waldorf, 1983; Valliant, 1983; Simpson et al, 1986), as well as the occurrence of more general negative events such as a period in prison or the overdose or death of drug-using friends/associates (Shaffer, 1992; Edwards et al 1992).

Clearly the various research described has been influential in increasing our understanding of the various stages involved in addiction, as well as the various factors which correlate with recovery. However, according to McIntosh and Mckegeany (2002), with the exception of the work of Biernacki and Waldorf (Biernacki, 1986; Waldorf, 1983; Waldorf and Biernacki, 1981), we still know relatively little about the cognitive processes through which the decision to stop using drugs occurs. McIntosh and Mckeganey (2002) believe that the work of Waldorf and Biernacki is distinctive, since they have sought to explain the process of recovery in terms of the management of a spoiled identity, the argument being that the decision to stop taking drugs comes about when the users' addict identity conflicts with and creates problems with their other identities such as partner or parent, in ways that are unacceptable to the user.

Heavily influenced by the work of Biernacki and Waldorf, McIntosh and McKeganey (2002) conducted their own qualitative research on addiction and recovery, interviewing

70 ex-addicts. Without doubt, this detailed work has built on earlier addiction research, providing a number of much needed detailed insights, which clearly portray the views of ex-addicts. McIntosh and Mckeganey (2002) found that a similar range of factors/reasons to those already identified in the literature were influential in interviewees attempts to stop using. These reasons/factors included the impact of their drug use on family/significant others, the threat to ones health, to keep/get their partners of their back, to prevent their children being removed from them, a sense of weariness with the routine and demands involved in maintaining their drug use, the death of someone close due to drugs, and the threat of prison as a result of criminal activities engaged in to support their habit.

However, like Biernacki and Waldorf, McIntosh and Mckeganey (2002) strongly believe that the factor, which distinguishes apparently successful attempts from earlier attempts, has to do with the addicts' sense of identity. They argue that their research demonstrates that addicts are stimulated by a desire to restore what Goffman (1963) described as a 'spoiled identity', as they realise that they exhibit characteristics that are unacceptable to themselves and significant others. However, it should be noted that McIntosh and Mckeganey (2002) are not claiming that a desire to restore ones identity is sufficient for recovery on its own, as is made clear by the fact that there were instances where even this resolve did not work. Instead, they describe it as a cognitive shift that comes close to being a necessary condition for such change to occur.

McIntosh and Mckeganey (2002) suggest that the other factors (mentioned above) were seldom sufficient in themselves to promote permanent exit from drug misuse, arguing that their potential effect was mediated by the meaning which individuals ascribed to them and the implications that these interpretations had for their sense of self. McIntosh and Mckeganey (2002) argue that these factors act as a mirror to the self, by revealing to the addicts the nature and extent of their spoiled identity and by forcing them to review what they had become. Using the symbolic interactionist literature, McIntosh and Mckeganey (2002) suggest that one of the reasons why the process of deciding to give up drugs is a gradual and evolving one, is because it involves the individual accepting a negative definition of him/herself. It is believed that this will be resisted for as long as possible, due to the potential implications for the individual's sense of self worth.

According to McIntosh and Mckeganey (2002), the most clear reference to identity was in terms of giving up 'for yourself', as many participants made it clear that you would be unlikely to succeed if you sought to stop for the sake of others, the implication being that success would only come if you did it for yourself, i.e. for the sake of your own identity.

McIntosh and Mckeganey (2002) believe that one of the problems with stopping for reasons other than the self, is that the drug is frequently considered more powerful than a whole range of very good reasons for stopping, and so the only realistic prospect of overcoming this power comes when the drug-using identity is being rejected. According to McIntosh and Mckeganey (2002), the majority of participants referred to identity in terms of the negative impact that their lives as addicts had on their sense of self, which was generally reported in the form of a deep unhappiness at the person they had become. Sometimes the addicts' sense of revulsion at what they had become was associated with a belief that they had become a 'different' person during their addiction, although a memory of their former drug-free selves sometimes remained. Indeed the presence of this residual memory sometimes played a vital role in the decision to quit, as it enabled addicts to recognise the extent to which their identities had been damaged by their addiction, and provided seeds of hope for the future because this memory enshrined within it the belief that they did not have to be the people they had become (McIntosh and Mckeganey, 2002). Although McIntosh and Mckeganey (2002) strongly emphasise the importance of the recognition of a spoiled identity they do concede that this is insufficient on its own to achieve recovery, and that it went hand in hand with a desire for a new identity and different lifestyle, as well as the need to believe that change was feasible, since without this, any inclination to alter behaviour would simply disappear (McIntosh and Mckeganey, 2002).

Although much of the relevant research emphasises various aspects in the recovery process, it seems that in order to fully understand the recovery process, one first needs to develop an understanding/better appreciation of the nature of addiction and how it develops. This need in highlighted by McIntosh and Mckeganey (2002), who begin their work by examining the processes of becoming addicted, since they believe that an appreciation of the conditions and circumstances under which participants became addicted, is essential to gaining an understanding of the place of drugs in peoples lives, and some of the significant issues they had to address in giving them up.

In terms of the development of addiction, McIntosh and McKeganey's (2002) findings echo those of other research, reporting a typical finding of experimentation with softer drugs in early teens followed by a progression to more powerful drugs and regular use in later teens/early twenties. The main reasons for participants' initial drug use were curiosity and a desire to comply with the expectations of others, especially peers, although taking drugs in order to cope with problems in their life was also a factor for a small minority. In terms of the progression to regular use, participants offered a combination of explanations/factors influencing this transition including an unconscious

'drift' rather than as a result of a deliberate decision; the influence of relationships or peer groups who provided opportunity and encouragement to use more regularly; boredom resulting from unemployment or poor recreational activities; to cope with life problems and escape from reality; or to overcome feelings of personal inadequacy, such as shyness or lack of confidence. In contrast, participants' escalating use was driven by a continuing desire to experiment and find new 'highs', as well as the need to satisfy ever-rising tolerance thresholds (McIntosh and McKeganey, 2002).

According to McIntosh and McKeganey (2002), recognition by individuals that they were addicted could take anything from a few weeks to several months, depending on the drug being used and the addicts' ability to support their habit. For most of the interviewees, recognition usually came with the experience of withdrawal symptoms and the realisation that they needed drugs to function normally, which often came when they were deprived of them for some reasons, such as a lack of money. Occasionally, family/friends would inform addicts that they thought they had a problem, although this was less common that one might expect. It is also clear from the study, that once addicts became dependent their lives became dominated by the need to feed their habit, with the need to obtain money becoming their overriding preoccupation. Often this led to lives involving manipulation and deception of others, and engaging in crime such as theft/shoplifting. Much of the sample also ended up spending a period in prison, and experiencing deterioration in health as a consequence of their use.

In terms of recovery, McIntosh and McKeganey (2002) found that alongside cognitive and perceptual shifts, important changes in the pharmacological effects of drugs plays a major part in the addict's decision to stop using. It seems that the realisation that the drug is no longer a positive part of an addict's life represents an important turning point, a view that is backed up by numerous researchers (Stimson and Oppenheimer, 1982; Frykholm, 1985; Prins, 1994). Unlike other literature, the experience of rock bottom-like experiences was not a universal or necessary condition for successful recovery in McIntosh and Mckeganey's (2002) study. Like Biernacki (1986), McIntosh and Mckeganey (2002) identified two principal routes out of drug use, the rock bottom type or exit via rational decisions, the main difference being, having to stop in the former and wanting to stop in the latter. As is the case in other studies (Prins, 1994; Biernacki, 1986), deciding to give up drugs was surrounded by a great deal of ambivalence for the participants in McIntosh and Mckeganey's (2002) sample. There was a clear conflict between a desire to change and a reluctance to give up the drug. Indeed, it seems that ambivalence is endemic to the lives of addicts and is present for a large part of their drug-using career. Overall, McIntosh and Mckeganey (2002) believe that the findings

from their detailed study have helped to enhance the understanding of the process by which addicts appear to 'mature out' of addiction, arguing that it is closely related to the recognition of a spoiled identity, and the factors, which promote this recognition and encourage/facilitate the decision to change.

Further important insights into the nature of the recovery process come from George Vaillant, who followed drinkers for forty years, and looked at how those who have pulled out of their difficulties have succeeded. Unlike some, Vaillant (1996) does not believe there is a specific age where addicts recover, arguing that the notion of 'burnout' in middle life is a misinterpretation of the relatively smooth attrition among drug-dependent individuals. According to Vaillant (1996), the critical factors in achieving abstinence do not seem to be maturation, treatment or even a stable pre-morbid personality or social adjustment, but instead recovery seems to depend on the severity of addiction, and on the individual encountering the right kind of natural healing experience. Vaillant (1996) argues that there are three general factors contributing to stable remission, which can operate at any stage in the life cycle. The first factor is when there is mild substance abuse, which lasts only for a short period, and a simple change in life circumstances may lead to complete remission. This is illustrated in Robins' (1993) research, which shows that a change in environment for many servicemen returning from the Vietnam War, resulted in remission, indicating the important role that social context may play in addiction and recovery. The second factor is very severe dependence, which seems paradoxical, but evidence suggests that severity i.e. getting tired/hitting rock bottom may be favourable for recovery (Vallient, 1996). The third factor is the fortuitous occurrence of life experiences, which disrupt entrenched habits, and minimise relapse. These experiences include acquiring a substitute behaviour that competes with the addiction, encountering compulsory supervision, discovering new sources of hope and self-esteem, and finding new people to love to whom the addict is not 'in debt'. According to Vallient these experiences are mutually reinforcing circumstances, found most reliably in Cognitive Behavioural Therapy (CBT) programmes and in groups like AA. Literature reviews of remission from various addictions by Brownell et al (1986), Stall and Biernacki (1986), and Miller (1993) confirm these life experiences to be important.

It seems that the potential role of treatment within the recovery process has been downplayed in a sense, with findings such as those of Waldorf and Biernacki (1979), Stall and Biernacki (1986), and Cunningham (1999), suggesting that the proportion of addicts who manage to overcome addiction without formal treatment may be even greater than or equal to the proportion who recover following treatment for their addiction. However, the importance of treatment continues to be demonstrated in studies like that of

McIntosh and Mekeganey (2002), where the interviewees expressed a deep appreciation of various treatment services, such as counselling and support, and detoxification and rehabilitation services. There is also evidence to suggest that treatment of different kinds can produce various benefits (see Edwards, 2000), as well as evidence to suggest that many years later patients will remember the intervention of some treatment/professional as being significantly related to their recovery (Edwards et al, 1987). However, since research demonstrates that a range of competently applied treatments with different theoretical underpinnings are likely to give roughly the same kinds of success rates, it is somewhat difficult to establish what aspects of treatment are particularly effective. Even though the positive components of treatment remains unclear, it is possible that positive treatments may have in common the capacity to catalyse and support natural processes of recovery (Edwards, 2000). Although 'maturing out' has traditionally been applied to the process by which some addicts give up drugs 'naturally' without the aid of treatment (Winick, 1962; Biernacki, 1986; Prins, 1994), researchers like McIntosh and McKeganey (2002) believe that this is too narrow a view of the processes going on. They argue that it is possible for the 'maturing process' to apply as much to those addicts who overcome their addiction with the assistance of treatment, since it is the decision to stop that is important, and whether this occurs with or without treatment is of secondary importance (McIntosh and McKeganey, 2002).

Even though research suggests that there are people that recover without the need for treatment, there is still a significant proportion who require treatment, which has led to the conclusion by some that treatment is a modest but worthwhile facilitator of natural recovery. According to Edwards, Marshall and Cook (1997), although treatment is one of a number of interactive influences that can play a part in recovery, it can be helpful in many ways, for example it can help to nudge the person towards a more constructive way of seeing things or enhance self-efficacy. Edwards (2000) has drawn together relevant research to provide a useful summary of how people usually get better from drinking problems, and some of the ways that treatment can support recovery. Firstly, addicts have to believe that change is feasible, and skilled therapists can be helpful in enhancing self-efficacy. Addicts need to be motivated, and specific treatments such as motivational interviewing can be used here, with much emphasis being placed on the need to be ready to change, due to the growing popularity of Prochaska and DiClemente's (1992) model of change. Since recovery involves movement towards a goal, therapists can also be helpful in clarifying appropriate goals. It is clear that successful recovery involves avoiding relapse, which can be done through learning various psychological skills, e.g. CBT, and with building of supportive networks, which can be achieved through groups like AA. Finally, since change must feel good for it to be

held, a major part of treatment often involves helping people to find rewarding substitutes for their use. Treatment research also points to the reality of between-person variation, in the sense that what one person gains from therapy may be different to someone else's gain (Edwards et al, 1997).

Clearly addiction and recovery are contentious and complex issues, and as Edwards et al (1997) note there is great variation between individuals and definitely no one single pathway to recovery. Despite this variation, there is no doubt that the increased interest in this area of research, particularly the detailed work of McIntosh and Mckeganey (2002), has significantly improved our understanding of some of the process involved in addiction and recovery. However, there is clearly a continuing debate regarding some issues, indicating the need for further research. Also, with the exception of McIntosh and McKeganey's (2002) recent study, there seems to be a lack of qualitative research in this field, and therefore it is very likely that there is still a considerable amount yet to be discovered and understood about addiction and recovery. The need for further qualitative research is reinforced by Prins (1995), who points to the need to examine for example, how and why people get into and out of drug addiction, since studies like Winick's (1962) failed to provide any hints as to the factors/circumstances involves in 'maturing out'. Although the work of McIntosh and Mckeganey has been paramount in starting to fill this gap, it is clear that there is still a need for more qualitative to further develop our understanding. The need for more research is further highlighted by McIntosh and McKeganey (2002), who point out that even though it is commonplace within health and social care services to obtain the views of clients, and to include these views in the planning and delivery of services, this remains a rarity within the substance misuse field. Clearly this reinforces the need for more research, which aims to explore the views of addicts regarding their experiences of addiction and recovery. As McIntosh and McKeganey's (2002) study demonstrates, recovering addicts are perfectly capable of providing a considered and informative account of their recovery and the factors that have helped them.

In light of these considerations, the overall aim of the current study was to conduct qualitative research, exploring in detail the views of addicts regarding their addiction. According to Smith (2001), qualitative research is important since it allows an attempt is made to capture the richness of the emerging themes rather than reducing participants' responses to quantitative categories. Smith (2001) also describes the 'natural fit' that exists between qualitative research and semi-structured interviews, since this method allows much more flexibility than the more conventional structured interview, questionnaire or survey, as the respondent can give a fuller picture and the researcher is

free to follow up interesting avenues that emerge in the interview.

The specific aim of this pilot study was to conduct detailed qualitative research on nature of addiction, the process of recovery, and the potential role of treatment within this. The research was exploratory in nature, and it was hoped that by getting detailed reports from recovering addicts, important issues would emerge that would help to provide a clearer insight into individuals' experiences of addiction and recovery. Although some addicts appear to recover without any recourse to treatment, it is clear that many addicts engage in lengthy and extensive contact with treatment agencies, and since treatment is likely to be of considerable importance, at least to a proportion of addicts, it was felt that it was important that its potential role within the process of recovery should also be examined. This research examines the nature of both drug and alcohol addiction, rather than focusing primarily on one or the other, since it was thought that despite some clear difference between drugs and alcohol, the process of becoming addicted and recovering from substance misuse addiction, whether it be drugs and/or alcohol, involves commonalities. Furthermore, it seems that many individuals experience a problem with both types of substances or replace/substitute one with the other when attempting to give up.

The interview material was analysed using a Grounded Theory approach (Strauss and Corbin, 1990), which allowed a conceptual framework to emerge from the data, and is different from other methods in the sense that it allows the generation of theory that closely approximates the reality it represents, rather than the testing of theory. The inductive nature of this method assumes an openness and flexibility of approach, which is advantageous since it allows the researcher to follow the leads gained from the data (Charmaz, 2001). This approach can also help the analyst break through the biases and assumptions that can be brought to or developed during the research process (Strauss and Corbin, 1990).

The individuals in the study were either a number of weeks into their treatment programme (and therefore clean from alcohol or illegal drugs), or recovering addicts, who had completed the treatment programme, and continued to use the aftercare available from the treatment centre. Participants therefore referred to past events which had influenced the development of their addiction and their path to various treatments and/or recovery, as well as commenting on their current treatment and/or recovery experiences. Obviously such retrospective data has potential difficulties associated with it, such as the problem of recall and the possibility that events and circumstances might be reinterpreted or presented in ways that suit the individuals current

perspective/perception of self (McIntosh and Mckeganey, 2002). Although it is obviously important to bear in mind any potential biases, as McIntosh and Mckeganey (2002) point out, the alternative of following a cohort of addicts was not viable due to the length of time it would have taken, the associated expense, and difficulties of following up clients.

Finally, with respect to the terminology used in this paper, user refers to people using both alcohol and/or drugs, and being clean refers to being clean from both alcohol and drugs.

Method

Participants

The sample contained fifteen participants, all of whom were recovering from a drug/alcohol addiction. The participants were recruited from a drug and alcohol service, which provides an abstinence-based structured day care (community rehabilitation) programme.

Seven of the participants were female, and eight were male. All were adults, although the addiction had often first developed during their teenage years. The duration of addiction varied, although it had generally lasted for a period of at least several years.

The participants were at various stages of their addiction/recovery process. Most of the participants were currently on the treatment programme, several had come back onto the programme after being unsuccessful the first time/relapsing, and others were in recovery and using the aftercare offered by the programme.

Seven of the participants described themselves as having an alcohol problem, and seven described themselves as having a drug problem, three of whom had a problem with heroin and four of whom had a polydrug problem. The other participant had a problem with both alcohol and heroin.

Procedure

The project was set up in collaboration with a drug and alcohol agency, which provided contacts and facilitated the organisation of the interviews. No incentive was offered to the participants during recruitment. Before the interview commenced, a standardised plan of the interview was read out to each participant, and they were assured of confidentiality and anonyminity. Participants were also informed that they were under no

obligation to answer any questions that they were uncomfortable with, and that they were free to pause for a break or terminate the interview at any time. Each participant was then asked to sign and date a standardised consent form.

A qualitative design, using semi-structured interviews was adopted (see Appendix C, pp. 86-88). The interviews explored the way in which the participants viewed their addiction and recovery, and the potential role of treatment within recovery. After each interview was completed the participant was thanked for their time and co-operation. The interview recordings, which ranged from 24 to 60 minutes, were subsequently transcribed onto Microsoft Word. A Grounded Theory approach was used to analyse the data, which allowed for the emergence of themes and concepts from the interview data (Strauss and Corbin, 1990).

Results

A number of significant themes emerged from the grounded theory analysis of the interview data. Each theme is made up of a series of concepts, and in many cases these concepts have been grouped together into sub-themes, which exist within the given theme. To avoid any ambiguity the themes are presented in separate sections, with each section beginning with an overview of the concepts (and if applicable the sub-themes) contained within the overall theme. Following a brief definition/explanation of the overall theme, there is a more detailed interpretation of the data, where each of the concepts and the sub-themes are examined in depth. This analysis is frequently exemplified by extracts from the interviews.

The analysis of the data revealed seven main themes:

1. The nature of addiction and its development
2. Reasons/factors for use
3. Negative effects of use
4. The process of realisation
5. Behaviour change
6. Treatment
7. Recovery

1. The nature of addiction and its development:

Concepts:

- Powerful nature of addiction
- Preoccupation with addiction
- Gradual progression of the problem
- Rapid escalation of use and deterioration
- Rapid progression and deterioration from lapse to relapse
- Changing person

Although each participant's account of their addiction was very individualistic, a number of common concepts emerged in relation to the nature of the addiction, and the way in which it developed.

The majority referred in some way to the **powerful nature of their addiction**. They used various descriptions such as feeling that the addiction 'took hold' of them in some way, that they lacked any control over it, or they felt 'trapped' by the addiction. The following quotations provide:

> "...The disease can take over and control you, manipulate you as a person. And you can manipulate others around you when you're under the influence of alcohol or drugs; it's very, very powerful..."

> "...It just spiralled out of control, it just went mad..."

> "...There was no way out...I could see no way out of this...I felt there was absolutely nothing I could do, I thought I was going to die..."

For many of the participants, this powerful nature seemed to lead to a period where they became completely **preoccupied with their substance**(s) of choice:

> "...All you care about is where you're gonna get (heroin) from, where you're gonna get money from. I mean even if I had gear on the day, I'd be thinking abut tomorrow and the next day, where I'd get my money. It's no life..."

> "...Drink it just comes first, it really does come first. Your whole energy isn't around courses and doing well, it's just where's your next bottle coming from..."

As the previous quotes demonstrate, for many participants their substance misuse seemed to take over their life, particularly in the later stages of their problem as their life tended to revolve more and more around using. They reached a stage where they were dictated to by their addiction, rather than having any sense of control or choice. The following quote typifies how the participants' substance(s) of choice become an integral part of their lives:

> "...The thought of going for a day without alcohol was unthinkable, it became so much part of my life so it wasn't a question of ...alcohol not being there, it was just...part of my life..."

In terms of the way the addiction developed, most of the participants described a **gradual progression** to more excessive and problematic use, developing slowly over a relatively long period. This progression usually lasted several years following their initial use:

> "...So it was just a slow progression really from when I started in my mid 20s til I think I was 34...it started with wine and then over a period of years...it ended up I was a binge drinker on vodka..."

In contrast, participants generally described later periods (usually at the **peak** of habit or **post-dependency**) as involving **rapid changes**, both in terms of their use spiralling out of control and in terms of a general deterioration

> "...Eventually you become dependent on it without realising it and your tolerance levels go up...you start needing a drink in the afternoon...and in the morning and that's when it all starts to fall rapidly down...it's a rapid downslide..."

Similarly, periods of lapse were also described as involving **rapid progressions from lapse to relapse.** This again was in terms of the participants' use and deterioration in the participant 'in themselves', as a result of the negative effects of their use (for examples of the negative effects see theme 3).

With regard to the implications of the addiction, it was clear that for many participants their substance misuse problem led to a significant **changing of the person**, in terms of their life, lifestyle, perspective, identity etc. This was demonstrated by the fact that participants often noted the differences between themselves as a 'using' and 'clean'

person, implying that the substance misuse had changed them in some way:

> "...you've got your addict and you've got your normal self and your addict will always try and pull you back down to where you were before..."

2. Reasons/factors for use:

Concepts:

- **SUB-THEME: Initial use**
  - Experimentation
  - High availability
  - Enjoyment
  - Negative feelings
  - Life problems
  - Background factors

- **SUB-THEME: Continued/excessive use**
  - High availability, enjoyment, negative feelings, life problems
  - Physical dependence
  - Escapism from substance misuse problem
  - Barriers to behaviour change

- **SUB-THEME: Lapse/relapse**
  - High availability, negative feelings, life problems
  - Failure to cope with cravings
  - Withdrawal of substitute prescriptions too quickly
  - Complacency
  - Other factors

There were numerous reasons and/or factors influencing participants' use of various substances. Although these factors were highly individualistic, a number of common factors emerged from the data, which were sub-categorised into reasons/factors influencing **initial use**, influencing **continued or excessive use**, and influencing **lapse/relapse**. Although each reason/factor is presented as a separate concept, in reality it was often a combination of these concepts that influenced participants use:

> "...I couldn't put my finger on one reason why, but then again I don't believe there is any one reason why, I think it's a combination (of factors)..."

Initial use

A range of factors emerged as influential in determining when and why participants **initially** came into contact with various substances, the most common of which being **experimentation**. For the majority of participants this involved teenage experimentation with peers and/or a range of different substances. This was generally (although not always) due to choice rather than force or peer pressure to use. Another common factor influencing initial use was the **high availability** of substances. This referred to a wide range of reasons, such as being in close contact with using relatives and being offered substances by them, having lots of money (and therefore increasing the potential availability of various substances), or mixing in 'boozy' work/social circles:

> "...I went to work on the cruise liners for nearly 3 years and that was a very boozy social life...alcohol was there...for the having and very cheaply as well..."

Another factor which was influential in many participants' initial use was **enjoyment**, whether it was enjoyment of the taste or the effects of the substance, with some participants describing their reasons for use as a search or desire to get a 'buzz'.

Many participants also reported that part of the reason for their initial use was a response to various **negative feelings**, such as stress, loneliness, depression, boredom and insecurity etc. Often the use was reasoned as their way of coping, suppressing or escaping from these negative feelings. One of the clearest examples of this involved participants using drugs/alcohol as a way of coping with their insecurity and building their confidence to better cope in social situations.

Many participants also reported that their initial use was influenced by various **life problems**, such as bereavement, relationship problems, work stress etc. Again the use was often viewed as a coping mechanism or escapism from various life problems:

> "...it just felt like my world was falling apart, at that age (teenager) you don't know how to deal with it and heroin just blocked all the pain, all the fear..."

A final factor that was viewed as potentially influential in several participants' initial use was termed **background factors**, and mostly included difficulties experienced by participants in their childhood, such as abuse, or the death of a parent. Generally, these were viewed more as contributing factors rather than actual reasons for using.

Continued/excessive use

In terms of the factors and reasons for participants' **continued/excessive use**, a number of concepts reported as reasons/factors for initial use continued to be influential. These were **negative feelings**, **enjoyment** and continued search for a 'buzz', **high availability**, and **life problems**. A number of other concepts also emerged as important, specifically in relation to participants' reasons/factors for their continued/excessive use. The clearest factor that was reported by the majority of participants was **physical dependence** on a substance(s). Generally, participants continued to use so as to avoid experiencing withdrawal effects and feeling physically bad, and in order to be able to function normally:

> "...without a drink in my hand I couldn't even walk up the road...my back would be bad, my stomach, I would vomit...I would have a drink to ease it, well it would take 2 or 3 til it would be fine...without a drink in me I couldn't function at all..."

Furthermore, participants often reported using more excessively due to increasing tolerance levels as they became more dependent on their drug(s). Another reason for continued/excessive use for many participants was as an attempt to **escape from the substance misuse problem** itself, and/or the various negative consequences of it. For example, the following extract shows how a lack of employment, which occurred as a result of the substance misuse problem, resulted in more excessive use:

> "...when I lost my job it really became problematic because I had all the time in the world to drink, it really did.."

For many participants, a final factor which significantly impacted on their in their continued use of substances was various **barriers to behaviour change**, such as a lack of awareness/denial of the problem, a lack of treatment services or long waiting lists. The latter factor obviously acted as a barrier to immediate behaviour change, but also seemed to have been influential in deterring some participants from committing to behaviour change earlier. The following extract also highlights fear of experiencing withdrawal symptoms as a significant barrier to behaviour change:

> "...I basically said I'll stop tomorrow...I'll stop tomorrow for 4 years, because you know when you stop you're gonna have the shakes..."

Another apparent barrier to behaviour change for several participants was a feeling of

being unable to see a way out of the substance misuse problem:

> "...there was no way out...I could see no way out of this...I felt there was absolutely nothing I could do...I realised I was ...making everybody else's life a complete hell...I tried to make it stop but it wouldn't stop..."

Therefore, although participants may have recognised that they had a problem and accepted the need to change their behaviour, they may not have felt able to stop using due to their apparent lack of control over it.

Lapse/relapse

Many of the same concepts highlighted as reasons for initial and continued use were influential in participants experiencing a lapse/relapse. Such factors included lapsing/relapsing as a result of various **life problems** and **negative feelings**, and **high availability** (e.g. due to still mixing with users and the resultant temptation of people using in close proximity). However, several additional factors also emerged from the data that were specifically related to lapse/relapse. For some participants, a major reason for lapsing was a **failure to cope adequately with the addiction and the associated cravings**, which was often due to a lack of adequate therapy alongside substitute prescriptions:

> "...for me (I needed) counselling because last time I never had no counselling I think that's why I relapsed...they just gave me my script, that was it...I think counselling does help a lot..."

For several participants another factor influencing their lapse/relapse was the fact that **substitute prescriptions were withdrawn too quickly**, or that they were unable to cope as it was withdrawn and as a result, they used:

> "...I found that once you got below 6 ml (of subutex)... then you did start to feel it, and as addicts we cant handle pain, so the first thing that popped into my mind was...you've got to go out and score..."

Another important reason for relapse for some participants was **complacency**. Participants often falsely believed that using a small amount would not result in a full-blown relapse, or they used again because they quickly forgot about the negative effects of use. **Other** (less common) **factors** influencing relapse included a lack of effort/commitment to behaviour change, the justification of use as a reward for being clean, and self-destruction, since some participants felt that they did not deserve the

success that came with being clean/dry. An illustration of this self-destruction is given in the following extract:

> "...I got myself this beautiful brand new flat...a great job, lovely car everything, and I think I pressed the self-destruct button, I don't deserve this, cos I think a lot of drinkers feel the same, they self-destruct, why have I got this...I really do not deserve this..."

3. Negative effects of use:

Concepts

- **SUB-THEME: Physical**
  - General deterioration
  - Use-related illness/problems
  - Personal consequences

- **SUB-THEME: Emotional/psychological**
  - Negative feelings/emotions
  - Suicidal/didn't care if dead
  - General effects
  - Psychological consequences

- **SUB-THEME: Relationships**
  - General effects
  - Break-ups/loss of relationships

- **SUB-THEME: Social**
  - Isolation
  - Less socially active
  - Changing social circles

- **SUB-THEME: Practical**
  - Employment/jobs
  - Neglect practicalities
  - Lack of responsibility
  - Practical consequences

It is clear that for all participants their substance misuse resulted in numerous **negative effects.** These have been sub-categorised into **physical effects**, **emotional and psychological effects**, **social effects**, the **impact on relationships**, and the **practical impact**. Many of these negative effects were extremely serious and for several participants some of these effects clearly persisted for considerable time following abstinence:

> "...six and a half months I've been clean, and on the weekend I was getting the symptoms of heroin withdrawal...so I'm still feeling it now...the pain in my back, my chest suffers, I get palpitations in my heart from continuously smoking..."

Physical effects

In terms of **physical effects**, most participants described a **general deterioration** in their physical health/state as a result of their use. The vast majority of participants also described experiencing more specific **use-related illnesses** or **physical problems.** Common examples included weight gain or loss, collapsed veins due to needle use, alcohol-related memory problems, and withdrawal symptoms. Several participants also described the negative experience of blackouts as a result of intoxication.

A final physical factor alluded to by most participants was in terms of the **personal consequences** of their use, which essentially related to the participant's inability to look after themselves properly. For instance, many participants described a lack of self-care regarding their health, for example by not exercising/eating properly. Many participants also described a lack of hygiene or care for their appearance:

> "...my hygiene went, just everything went...I used to dress really dirty, couldn't be bothered to dress in the mornings..."

Emotional/psychological effects

The **emotional and psychological effects** of use related to a range of concepts, the most common of which was a variety of **negative feelings/emotions**, which were experienced by all of the participants. In particular, many participants reported that their using left them feeling depressed or low, with other common feelings including guilt, shame, desperation, fear, and a numbness/lack of feeling:

> "...when I was drinking ...I wouldn't have known a feeling if it'd hit me in the face I was so numb..."

For many of the participants, these negative feelings became so extreme that they reported experiencing times where they **didn't care if they died**, or were consciously **suicidal**, either experiencing suicidal thoughts or actually attempting suicide attempts:

> "...I ended up taking an overdose. I'd tried before but this time was serious...I really had given up..."

Many participants also reported more **general emotional effects** such as feeling emotionally fragile or experiencing emotional breakdowns, which was a likely consequence of the negative emotions they were experiencing. A final negative effect reported by several participants was in terms of various **psychological conditions** resulting specifically from their use, such as anxiety and panic attacks, or paranoia and psychosis.

Relationships

The vast majority of participants reported various **general negative effects** on **relationships**, such as increased family arguments, a general bad atmosphere within the family and increased worrying by the family about participants etc. Many participants also reported that their substance misuse resulted in the **break-up** or **loss of many relationships**, resulting in either a loss of support from family and friends or a loss of contact:

> "...it lost me everything...I've got two children who are in foster care. It lost me my family...none of them will speak to me..."

Social impact

The most commonly reported negative consequence was in terms of the **isolation** experienced by the majority of participants. An example of this isolation is provided in the following extract:

> "...I felt isolated, I felt...as though I was the only one who ever felt the way I felt, that nobody could understand me..."

Often this isolation was due to the users isolating themselves from others for various reasons including shame of use or hiding use. Isolation also occurred for other reasons such as loss of contact with family/friends due to their substance misuse. Some of the participants also reported that their substance misuse resulted in them being **less socially active**, or a reduced ability to mix with others, for example due to feeling

lethargic, or unable to function socially without their 'fix':

> "...socially I didn't want to go anywhere, it was excuses so I could stay in the four walls and just drink..."

Obviously, this lack of social activity is likely to be associated with the isolation experienced by participants. The final social effect reported by many participants was a **change in social circles**, as a result of their increased use. Basically, this involved an increase in contact with users and often a decrease/conscious avoidance of non-users, i.e. old friends and family. Again, it is possible that changing circles may have implications for the isolation experienced as participants became more isolated from non-users.

Practical

Finally, with regard to the **practical effects,** one of the clearest consequences of use was in terms of **employment/jobs**. Virtually all of the participants reported that their use affected their ability to work effectively, as well as increased the time that they took off work, both of which often resulted in the participants being sacked or resigning from their jobs. Furthermore, many participants described their inability to find further work or work at all during periods of very heavy use. Another difficulty that resulted from participant's heavy use was a **neglect of practicalities,** such as paying bills and saving money:

> "...I didn't pay bills, I didn't make appointments, I didn't want to get out of bed..."

It seemed that many participants **lacked a sense of responsibility**, with most participants describing themselves by using negative attributes such as being unreliable or irresponsible. Other common examples of irresponsible/negative behaviour included criminal activity including stealing, the manipulation of others, lying to or lacking respect for others, and violent/aggressive behaviours. Most of these behaviours were often reported to be an attempt to fund their habit. Often this lack of responsibility combined with a neglect of responsibilities resulted in various **practical consequences** for participants, such as financial problems, losing houses or possessions, as well as inhibiting potential life achievements:

> "...(I) wasted all that money, lost two houses, lost countless jobs...I wasted 20 years really..."

4. Process of realisation:

Concepts:

- Unaware of the problem
- Series of realisations
- Factors influencing realisation
- Clearer awareness
- Continued use despite awareness

Many of the participants reported being **unaware of their substance misuse problem** in the earlier stages of their addiction and that others around them often being aware of the problem before they were:

> "…when you're on them you don't see that, you don't see when people tell you you want to get off them, you just think 'what do you know'…"

> "…I didn't see it as a problem; it was other people around me that saw it as a problem…"

Not only were participants unaware of their escalating use and developing dependence, but many were also unaware of the increasing negative effects of their use and that these effects were a consequence of their use. For example, some participants were unaware that certain illnesses/physical problems were use-related or the symptoms of withdrawal. This lack of awareness was often reported to be due to denial of the problem or more simply to a lack of awareness, education or understanding of themselves and their addiction:

> "…I think because I had no understanding of alcohol at the time I didn't think I was alcoholic because I'd go 2 or 3 weeks without it, and then after the 2 days (bingeing) I'd get up and put my make-up on…and nobody'd know any different…its more difficult for somebody who binge drinks because there's not the education out there…"

Another factor which inhibited/delayed several participants' awareness of the problem was the fact that they had a continued supply or used continuously for a period of time, which masked the signs of their developing dependence.

Several participants described the realisation of their problem as resulting from a series of realisations, often occurring later in their addiction. As well as starting to recognise the substance misuse problem, participants also tended to experience realisations regarding the negative effects of use and the connection between these effects and the substance misuse; of the need to change their behaviour, and of the need to seek help/treatment in order to do this.

It should be noted that for some participants the initial realisation/awareness of the problem did not automatically result in a full recognition/acceptance of the problem. For several participants it was often very difficult to accept the problem and to admit it to others:

> "...I know that I'd got a problem but to sit down and actually admit it to somebody was very very hard to do..."

Due to these difficulties, it sometimes took considerable time for this acceptance to occur and so it was generally a gradual process. However, for a minority of participants, the process involved a sudden realisation of the problem. This highlights marked individual differences between people, in terms of how they experience and recognise their addiction.

A variety of **factors influencing the realisation/recognition/acceptance of the problem** and the need for behaviour change were revealed. The following extract highlights how the experience of withdrawal was an important factor in helping participants to realise their developing dependence on their substance(s) of choice:

> "...I didn't realise I had a problem until the first time I (went through withdrawal)...cos I always had (drugs)...and then I woke up one morning covered in sweat..."

The increasing negative effects of participant's using, particularly on their children was also reported to have been influential in participant's realisation that they had a substance misuse problem and the need for change. Other less common contributors included the transition to heavier drug use/increased tolerance and the impact of a clean period. Several participants also pointed out that for them it was a combination of such factors rather than a specific factor/event that influenced their realisation of the problem.

Despite earlier realisations of their problems many participants also described a **clearer**

awareness of the substance misuse problem and its negative effects, later on in their addiction. For many participants this seemed to be influenced by the passage of time, which resulted in a clearer perspective of the problem and associated events. Many participants also reported that the experience of treatment was extremely important in facilitating a clearer outlook. The following extract provides an example of the role that treatment played in facilitating the realisation of the negative effects of use on family relationships:

> "...I was starting to realise that I didn't really know my family anymore and that I must have spent longer away from them and a lot longer off my face on one thing or another...I started to notice that gradually and then it hit me full on since I've been in (treatment), I realised that I was losing touch with them..."

The previous quotation also alludes to a gradual process of realisation, which was common for many participants.

Finally it should be noted that **in spite of a realisation** of the problem and the need for behaviour change, many of the participants' **substance misuse continued for some time after this**. Although this is likely to have been influenced by a variety of factors, including the various reasons for continued use and barriers to behaviour change noted previously, several participants described a number of factors which were particularly influential including, feeling helpless/unsure of how to go about stopping their use, experiencing a lack/very little negative effects at the time therefore not fully questioning the problem; a lack of support/treatment which was needed in order to change behaviour. Also, the following extract demonstrates how some participants justified their continued use as a result of recognising that they had a problem:

> "...I went through a phase where I saw it as a problem but (was still) using because...it almost gave me the allowance to be able to use because I had a problem with it, I justified it..."

5. Behaviour change:

Concepts:

- **SUB-THEME: Types of behaviour change**
  - Serious
  - Non-serious/temporary

- **SUB-THEME: Influencing factors**
  - Realisation of problem
  - Importance of family/children
  - Negative effects of use
  - Access treatment as cannot change independently

- **SUB-THEME: Decisional balances**
  - Continued use rather than change
  - Change rather than continued use

- **SUB-THEME: Barriers**
  - Barriers to change

The theme of behaviour change is broad in the sense that it refers to any kind of behaviour change that was performed in an attempt to control/stop the substance misuse problem. It included behaviours such as independently cutting down in an attempt to control use, doing 'cold turkey' in an attempt to achieve abstinence and accessing treatment, whether it be substitute prescriptions, meetings, counselling, rehab etc. Nearly all participants described experiencing numerous/successive unsuccessful attempts to change their using (and associated) behaviour, illustrating the high degree of difficulty involved in this. The theme is sub-categorised into **types of behaviour change**, **factors influencing behaviour change**, **decisional balances involved in behaviour change**, and **barriers to behaviour change**.

Types of behaviour change

The **types of attempted behaviour change** have been divided into **serious** and **non-serious/temporary** behaviour change. Basically, serious attempts referred to a real commitment to behaviour change following a 'rock bottom'-like experience. Participants described themselves as being in a very bad state, being completely fed up with their situation and feeling it was necessary to do something to change it. This type of experience tended to occur later in addiction.

Conversely, several participants described having experienced non-serious/temporary behaviour change, which referred to a less committed attempt to change behaviour and tended to occur earlier in addiction. For example, several participants described temporary changes in their early use, for example, when they were pregnancy, having a family, or in order to support their denial. Several participants also described how substitute prescriptions were used as a security/safety net to support continued use, or

how earlier treatment experiences were treated as a respite from use rather than a serious attempt to change behaviour:

> "...for the first and second detox, it was basically a holiday from being an addict, that was all I was looking for really...just a couple of weeks where I could stay in bed and not worry about using...and then go back on to it once I'd had a bit of a rest..."

Finally, for a minority of participants, some aspects of their behaviour change were non-serious in the sense that it represented a forced change rather than a positive decision to change their behaviour. These related to an inability to use due to a lack of money or contact with a dealer, or attempting to change behaviour through coerced treatment.

Factors influencing behaviour change

In terms of the **factors influencing behaviour change**, the most common factor (reported by about half of the participants) was that behaviour change occurred following a **realisation and acceptance of the problem** and the need to change their behaviour. Understandably, this recognition of the problem was an essential factor for successful behaviour change.

Another important factor for some participants was **the importance of family/children** in motivating their behaviour change. For example, some participants reported wanting to achieve normality for the sake of their children and the fear of losing contact with their children:

> "...it was like come into rehab or my kids are going for adoption, so I think that scared me to come..."

For several participants, another major reason for behaviour change was the need for **relief from the increasing negative effects of their use**:

> "...I reached the stage where I'd had enough, I was suicidal. I could just see no way out, it was getting worse...my physical health was suffering...I lost all my friends, lost my partner, my gas was gonna be cut off...I'd reached the end of my tether..."

Many participants expressed that the need for behaviour change was influenced by a desire for some kind of normality that was free from such negative effects. Many also

reported that another reason for **accessing treatment** was influenced by the fact that they **felt unable to achieve behaviour change independently**. Some participants were unable to detox independently due physical dependence or being unable to cope without help/support.

Decisional balances

In terms of the **decisional balances involved in behaviour change**, it became apparent that at different times in their lives participants experienced various balances/choices, which had to be weighed up. These included the benefits of staying clean versus the benefits of continued use, the continued enjoyment of use versus the feeling that use was wrong/dangerous, and the difficulties of treatment versus the difficulties of continued use.

As the addiction progressed, the decisional balances generally seemed to shift from **favouring continued use rather than changing behaviour** in the early stages, to **favouring change rather than continued use** in the later stages. Regarding the former, factors such as continued enjoyment and desire for the substance tended to outweigh the negative effects of use, or any feelings of wanting to change:

> "...for me in a way I wanted to do it (change behaviour/give up) but I think I still enjoyed it too much..."

An additional factor that seemed to favour continued use was a necessity to use/drink and dependence on the substance, which again seemed to far outweigh other factors, which may have motivated the user to change their behaviour.

Participants often described a transitory period where the balance began to tip in favour of change:

> "...it got to a point where I did start to realise something's got to change. I was still enjoying it at that point but I started to realise it was wrong and it was going to lead me down a sad and sorry path."

In many cases it took some time for this shift in opinions to translate into actual behaviour change. Nevertheless, for many participants the balance seemed to tip in favour of behaviour change rather than continued use when the negatives of use began to outweigh the positives and/or reasons and factors for continued use:

"...all the shit I had to go through to carry on using, before a certain point it was ok because when I got my gear it all went away...it was worth it because you get wrecked at the end of it...then my tolerance got to such a point...I weren't getting wrecked at the end of it, I mean it was at the point I was just having gear to stop myself from feeling bad..."

More specifically, some of the participants described wanting behaviour change as a result of being completely fed up with the negative effects of their use or, of being too ill not to go to treatment and change their behaviour:

"...I was too ill not to go (to treatment)..."

In this phase, examples of various decisional balances included choosing the dignity of being clean rather than the substance, choosing to have a job rather than the substance, choosing a life rather than a life dictated by the substance, or quite simply choosing life rather than the substance and potential death:

"...to me I knew it was a matter of life or death, and I knew that was the place I'd got to go in the end...(treatment agency)"

An additional major factor that was influential in tipping the balance in favour of behaviour change rather than continued use was the changing effect of the substance(s) of choice. This went from being positive to becoming more and more negative:

"...at first (alcohol) made me able to fit in with people...once I'd had a couple I could fit in with a crowd...that changes...where I became a horrible person, I couldn't mix with people. I'd upset that many people my drinking couldn't be called social at all..."

"...at first it felt a nice warm buzz, it felt really nice...and then every morning I was waking up I felt violently sick...I felt really ill..."

Barriers to change

A final concept that emerged in relation to behaviour change was the existence of various **barriers to behaviour change**, which prevented successful change. These factors are considered within other themes (see theme 2 and potential barriers to treatment in theme 6).

6. Treatment

Concepts:

- **SUB-THEME- Positive effects**
  - Various improvements
  - Altering person/perspective/life

- **SUB-THEME: Positive/important components**
  - Common experience
  - Welcoming environment
  - Personal factors
  - Counselling/group therapy
  - Education regarding addiction
  - Education regarding services
  - Alternative therapies/activities
  - Holistic approach
  - Support
  - Treatment structure

- **SUB-THEME: Accessing/commencing treatment**
  - Accessed at rock bottom
  - Feeling nervous/scared at start
  - Expectations – unsure
  - Expectations – miracle cure
  - Potential barriers

- **SUB-THEME: Difficulties of treatment**
  - Accepting abstinence
  - Contradictions with services

- **SUB-THEME: Negative/unsuccessful treatment**
  - Negative experiences generally
  - Negative experience of substitute prescribing

Due to the sample, treatment was obviously of great importance to the participants, and this was illustrated by many of the participants who described their relief at receiving treatment. Several participants felt that they may have died if they had not have got into treatment when they did:

> "...I just wanted to die before I came in here...if I hadn't have known I was coming into the BAC I think I would have...gone completely off the rails..."

This theme has been sub-categorized into **positive effects of treatment**, **positive/important components for successful treatment**, **accessing/commencing treatment**, **difficulties of treatment**, and **negative/unsuccessful treatment**.

Positive effects of treatment

The majority of participants reported numerous **improvements relating to various factors**, one of the clearest of which was in terms of their understanding/awareness of themselves, their behaviour and their addiction. This improved understanding is described in the following extract:

> "...what it's done is to enlighten me on addiction. It's given me more confidence. I'm learning about my addiction and myself and other people...it's amazing how...things can change so much..."

Other common improvements were in terms of physical health, confidence (as alluded to in the previous quote), reducing feelings of guilt/shame, and a reduction in the feeling of isolation:

> "...its made me realise I'm not alone...when you're in active addiction it seems like everyone around you have not got a clue what you are going through..."

Another major improvement was in terms of learning coping methods, as indicated in the following extract:

> "...learning to deal with your emotions and feelings, that is the main thing because as addicts you can play on your feelings to the extent that you will go out and use just to suppress them..."

Other less common improvements were in terms of relationships, self-care, maturity, and anger management.

Another clear positive effect of treatment was an **altering of the person in terms of their life/lifestyle/perspective/identity etc.** This positive experience of treatment is

described in this extract:

> "...it gives you a chance to start again, you've got a new chance at life now to start again from scratch...I'm going back to college, getting my own place, get a job...and start again..."

As the previous example suggests, most participants reported some kind of actual and/or desired changes in their life or in their perspective of life, including a new optimism for life, and a desire to and/or actual rebuilding of their life with better/new relationships or college/job placements, etc.

Treatment was also reported to have been positive in terms of helping participants to achieve a clearer perspective of their substance misuse problem, and the negative effects of it. Often treatment was reported to have facilitated the process of realisation (see factors influencing realisation in theme 4), with the period in treatment allowing the user to see what life without the substance misuse problem could be like:

> "...I was given the alternative of trying to see what life was going to be like without alcohol, and because I was in treatment...the thought of that didn't actually terrify me..."

Positive and negative components

In order to achieve the positive effects of treatment, certain **positive components/needs** were reported to be essential **for beneficial/successful treatment**. One of the clearest components was that of **common experience**, both in terms of being around other addicts in treatment and the fact that many of the counsellors had some kind of personal experience with addiction. Some of the benefits of this common experience are described in the following examples:

> "...it's good to be with like-minded people because unless you've experienced it, it's very very difficult to understand where we're coming from..."

> "...there's no way you can blag cos they've been there themselves...if you are struggling at any point there's always somebody that's that many weeks ahead of you they can offer you the advice and support..."

This common experience was reported to be beneficial in many ways, for instance in providing a more empathetic/understanding environment, where clients (and counsellors)

could positively relate to each other and draw on their own experiences to provide useful/practical advice and support. Furthermore, many participants described how the common experience of addiction was beneficial as they were not able to 'blag' treatment or conceal, for example if they were lacking motivation for treatment. This common experience was also important in reducing isolation, which was of high significance to (see social effects of use in theme 3).

Also, many participants described the benefits of being surrounded by people at different stages of their addiction, with new/relapsing addicts serving as a reminder of the negatives effects of using, and successful recovering addicts (e.g. people in aftercare) instilling hope and serving as potential role models or goals to aspire to:

> "...half of them have ended up (relapsing) in a very short time and that just reminds me of what I was like...they remind you of what it was like and you don't want to go back there because when you're feeling alright you forget how bad it was..."

Another crucial component of treatment, according to many participants was having a **welcoming/friendly/safe environment**. One participant in particular described the importance of being surrounded by genuine people after having been surrounded by so many less-than genuine people in the previous few years of addiction. Most participants also reported the positive experience of **talking about their problems and getting feedback/advice in both counselling and group therapy**.

Many participants particularly emphasised the positives of having group therapy, and some kind of feedback component:

> "...I love feedback...it helps me to look at myself...I need that for me to be able to recover...and think yeah that's ok and that needs looking at...and I feedback to other people as well, and your confidence grows..."

The previous quote also indicates how the two-way process of giving and receiving feedback can produce positive effects such as improved self-esteem and confidence. The need for some form of therapy alongside substitute prescriptions was also repeatedly reported to be important.

For many participants, **education regarding various aspects of addiction** was also an important component of positive treatment. For example, many participants referred

to the importance of learning about the disease model of addiction, or the fact that drug use could have induced their psychotic and paranoid experiences.

Also, about 50 per cent of participants indicated the need for **education regarding the availability treatment of services**, which may have been beneficial of engaging them or others earlier in their addiction:

> "...I'd never heard of the BAC...if I'd have known about it earlier I'd have probably come to it earlier..."

> "...if you can educate people earlier in their lives, before they get to middle and chronic phases of their addiction it seems that they'd have a far better chance, and we shouldn't ignore it really..."

A further treatment component that was reported to be influential in producing positive effects was the adoption of a **holistic approach**, whereby the 'whole package' of the person was addressed in treatment, rather than just the substance misuse problem:

> "...the whole programme is just brilliant basically; it's taken a complete look at your addictions, but its things you never even knew about..."

> "...it's not just the alcohol and drugs, it's about your own self-awareness and well-being..."

Participant's reported that, in addition to addressing the substance misuse problem, treatment should address various a range of things including negative behavioural patterns, ways of coping, physical and psychological/emotional problems, practical problems, social and relationship difficulties, and self-awareness.

Of similar importance to many participants was the use of **alternative therapies** in treatment, such as acupuncture or relaxation, or **alternative activities** such as exercise or fun days out. Participants reported that such therapies/activities were beneficial in numerous ways, such as increasing self-awareness, distracting them from their substance misuse problem, and providing valued time away from therapy to prevent overload. The following quotes illustrate some of the benefits of alternative therapy:

> "...they sort of break up the day...especially the relaxation...sometimes you just needed that...break. I think too much education on addiction is too much you

can take in, you need a break..."

"...obviously alcohol and drugs are the main priority, but when you've not got those what can you do, how can you look after yourself, how can you relax, take time out, not get too stressed out. So instead of getting stressed out and looking at the bottle...you've got alternatives to use to take your mind away from it...I've found it really really enlightening..."

About 50 per cent of the participants also highlighted **support** as being an integral component for successful treatment, with several participants indicating that practical support in particular was beneficial to them. **Treatment structure**, which refers to the type/style of treatment that participants considered to be beneficial, was also reported to be highly influential to recovery. In particular, many participants emphasised the benefits/need for BAC-like services, in the sense that they needed an abstinence-based, structured/intensive day care programme, over a relatively long period of time:

"...although its intensive...I could have gone...for counselling...at an hour a week but that wouldn't have been enough..."

"...the problem is that it's not something you can do in 2 weeks; you need that 14-20 weeks because you can't alter 4 years of behaviour in half an hour session a week."

Some participants also described the need for specialist therapeutic treatment rather than general help, e.g. medical assistance to detox. Several participants also referred to the need for both an individualistic and realistic style of treatment, which should be instantly/easily accessible when required. Finally, another component that was considered crucial for successful treatment was **personal factors,** such as effort, hard work and commitment. This is a fundamental component since without this; treatment cannot be effective regardless of its merits.

Accessing/commencing treatment

In terms of **accessing/commencing treatment,** it was clear that most participants did not enter treatment (in a committed way) until they reached **a rock bottom-like experience**:

"...most addicts have to wait almost rock bottom or rock bottom before they get any help..."

Some of the participants described experiencing feeling **nervous, scared or lost before or at the start of treatment**:

> "...the first time I was in treatment I was just scared stiff I didn't know what to expect, I was terrified..."

Clearly, the existence of such fear reiterates the importance of providing treatment in a welcoming/supportive environment, in order to ease the apprehension experienced by participants. A range of expectations prior to starting treatment was reported by participants (ranging from high to mixed to low), but one common feeling was being **unsure regarding what to expect** (which is also expressed in the previous quote). Another less common but seemingly important expectation was some kind of **false belief in a miracle cure**. This seems to be of importance, as treatment agencies need to be aware of it and therefore, be open and realistic with clients regarding the high level of effort required to achieve recovery, and avoid disappointment.

For many participants, there were various **potential barriers to accessing treatment**, the most common of which was a lack of services or lack of awareness of existing services. The following extract provides an example of this lack of awareness:

> "...the BAC has been open 5 or 6 years, I've lived in Burton on and off since 1979, I only live up the road...I didn't know about this place until last year...they need to publicise it more..."

Clearly, this knowledge is essential in order to engage people in treatment and therefore facilitate behaviour change. Other common barriers were long waiting lists, which potentially deterred people from accessing treatment; and personal circumstances/feelings, such as feelings of shame/pride/fear, which hindered them from asking for help/treatment.

Difficulties of treatment

Participants also described numerous **difficulties of treatment** throughout their various experiences. This was demonstrated by the fact that it took some participants a relatively long period of time before they started to feel the benefits of treatment. The clearest difficulty for nearly half of the participants was related to the need to **accept complete abstinence**:

"...all my life I've had alcohol there to look after me...to suddenly have this taken away from you is a horrifying thought and you can't actually accept it..."

Many participants described experiencing the continued desire to use some sort of substance, predominantly cannabis, while attempting to give up their substance of choice:

"...I find it hard...not smoking (cannabis)...I've smoked since I was god knows how old...I can't see (the) harm..."

Some participants suggested that another difficulty was a result of the **various contradictions they had with treatment services**; for example, some participants described receiving advice about controlled use despite wanting abstinence-based treatment. Another participant described a service that would only treat his drug problem and not his alcohol problem, whilst another individual alluded to having contradictory feelings with an agency regarding how their detoxification should be managed.

Negative/unsuccessful treatment

Most participants described some kind of general **negative/unsuccessful experience** of treatment at some stage in their addiction, such as treatment not being intensive or long enough, a lack of alternative activities or education within treatment, or long waiting lists.

"...there's people out there that have been waiting months and months and have got to the point where they've given up on...the agencies, they've given up on the support and just thought sod it and they've ended up dead. I've had 3 mates that have killed themselves through overdosing while they've been waiting to get into treatment..."

Such negative experiences served to re-emphasise the importance of some of the positive components reported to be essential for successful treatment, such as the appropriate structure of treatment.

A more specific negative experience of treatment reported by nearly half of the participants was related to **substitute prescriptions**, predominantly methadone, which participants had usually received in earlier stages of their addiction. Some of the participants viewed substitute prescriptions like methadone as negative as they could also use heroin while they were taking it. This was viewed as a 'green light' to continue their use. Several participants also referred to experiencing very bad withdrawal

symptoms from methadone and expressed a strong preference for subutex.

7. Recovery

Concepts:

- **SUB-THEME: Factors/requirements for recovery**
  - Treatment
  - Personal requirements
  - Complete abstinence
  - Other factors

- **SUB-THEME: Aids to recovery**
  - Continued use of aftercare
  - Strategies against continued use
  - Expectance/coping of cravings
  - Motivating factors
  - Holistic approach

- **SUB-THEME: Changes in recovery**
  - Rebuilding person/life

Recovery is a crucial theme, and has been sub-categorized into various **factors/requirements necessary to achieve current/future recovery**, various **aids to help/facilitate recovery**, and various **changes that occur in recovery**.

Factors/requirements for recovery

All participants reported that one of the most vital components essential for successful recovery was access to **treatment** (rather than attempting to recover independently):

> "…you just can't get away from it on your own…it doesn't matter how strong you are you can't do it on your own, its really hard work…"

> "…I needed treatment. I tried to do it myself and it just didn't work and I felt very alone doing it myself because I couldn't really talk to people about how I was feeling and how awful I felt…they've not been the same boat and they don't understand…"

The latter quote also exemplifies some of the ways in which treatment is seen to aid

recovery, for example, in terms of talking about problems in an empathetic environment and reducing isolation by being surrounded by people in similar situations.

The majority of participants also discussed the importance of various **personal requirements** that were necessary for recovery. These included being focused and committed to putting in effort and hard work; and accepting that the addiction was enduring and that there was no miracle cure. Many participants also described the need to be personally ready to change:

> "...basically you've got to be ready yourself for when you want to do it..."

An additional requirement that was deemed necessary to achieve recovery was **complete abstinence** from all substances rather than controlled use. Although several participants did find this difficult to accept, most of them still recognised the importance of abstinence in order to gain successful recovery. Participants also highlighted several **other factors** that they viewed to be important requirements for recovery, the most notable of which was the need to want to change their behaviour for themselves rather than for others. The need for a good support network and the experience of a rock bottom-like experience were also deemed important.

Aids to recovery

In terms of **aids to recovery**, one of the clearest components helping participants achieve current/future recovery was the **continued use of aftercare/counselling** post treatment:

> "...the aftercare is vital..."

> "...there's no way I can go through rehab and expect to be clean or away from drugs if I just leave (treatment) and don't do anything else, support groups are vital and I try to impress that to everybody..."

The majority of participants described how vital aftercare is or will be for them. They also highlighted the importance of having a safe environment to return to if required, which provided them with a strong sense of security.

Most participants indicated that another important component in helping their recovery was the learning and use of a range of **strategies to cope with/oppose the numerous reasons/factors for use** (as highlighted in Theme 2). This referred to a

wide range of potential strategies, for example, reducing the high availability of drugs by avoiding users; changing social circles from users to non-users to reduce temptation; using distraction to avoid boredom, and using various 'tools'/strategies learned in treatment. Many participants also reported the need for **acceptance and expectance of persistent cravings** and problems associated with addiction, and the use of **effective strategies to cope** with these:

> "...you've got to realise that you are gonna every now and then fancy something, be it drugs or alcohol. I know I have...but I've let it pass. Doing something instead of sitting and thinking on it really helps. And getting plenty of support..."

> "...the problem is with addiction is that once you've understood that its something that's always going to be there, its just something you have to learn to cope with, it's a disability..."

In terms of general coping, several participants advocated the philosophy of coping one day at a time rather than projecting too far into the future.

Another component reported to have helped or was expected to help by many of the participants to maintain their behaviour change and recovery, was termed **motivating factors**. Most participants discussed the power of support from others to motivate them in recovery. Some also found that being able to change for others, or prove themselves to others, such as close family i.e. children/parents was important. Other motivators included fear of death from resuming their use, and the potential guilt/shame associated with a relapse.

A final aid that was crucial to recovery for many participants was the adoption of a **holistic approach** to recovery. Participants emphasised the need to change 'everything', including problematic behaviours, lifestyle, social circles etc, rather than simply the substance misuse problem. The quote below provides a clear example emphasising the need for this holistic approach:

> "...you've got to be willing to change everything, your behaviour, your thought patterns, its not just about putting a drink or drug down, its about changing your life..."

The importance of a holistic approach was also illustrated in numerous interviews where

the adoption of just one strategy for behaviour change (as opposed to a range of strategies) resulted in a relapse. In view of the powerful nature of addiction, participant's emphasised that a whole range of factors need to be addressed and a wide range of strategies need to be drawn upon or used, in order to achieve recovery.

Changes in recovery

Finally, it is clear that many of the participants' experienced or were experiencing numerous **changes in their recovery**. In the same way that using seemed to produce changes in the user as a person (see changes in person in theme 1), the process of recovery seemed to restore or reverse these changes, altering the person, their lifestyle, identity and perspective etc.

Many participants also referred to the actual rebuilding of a new kind of person or lifestyle, whilst others (presumably at earlier stages in recovery) expressed the desire to rebuild their lifestyle. This rebuilding generally involved a happier life without various substances, and with a college/work placement, a new house, and/or with new /improved relationships with others:

> "...well everything's changed for me. When I first came into the centre I didn't have nothing, my kids were going up for adoption, but now I've got everything back, my kids are coming home in a few weeks, I've got a house, I've got a new boyfriend, I'm having another baby, I'm happy...whereas before I was unhappy..."

Discussion

The objective of this study was to conduct detailed qualitative research into the processes of addiction and recovery, from the point of view of recovering addicts in various stages of treatment and aftercare. An account of the interview data has been presented in terms of seven major themes, which have emerged from the Grounded Theory analysis. Within the themes, numerous important concepts and sub-themes have been highlighted. Although the themes are presented separately, there is clearly an interrelationship between them, and certain aspects within particular themes relate heavily to those contained in other themes.

The first major theme that emerged was the nature of addiction and its development. Although this was one of the smallest themes it was clearly of high importance as in

order to begin to understand recovery, one needs an understanding of addiction, and from exactly what the addict is recovering. It was clear from the analysis that participants' addiction was very powerful in nature and was often viewed as being out of their control, as it trapped or 'took hold' of them. This powerful nature seemed to lead to a preoccupation with the substance, as the problem progressively took over their lives and participants also seemed to lack any sense of choice over their addiction. It is likely that as the substance misuse problem developed, increasing tolerance and physical dependency played a major part in influencing this preoccupation.

McIntosh and McKeganey (2002) also found that once addicts became dependent, their lives became dominated by the need to feed their habit, and the necessity to obtain money became the overriding preoccupation in their lives. For the participants in their sample, living with addiction meant living a life of deceit and manipulation, in which they would do anything to get drugs, including turning to illegitimate means, such as crime, to support their habit. Similarly, in the present study it was clear that many participants lacked a sense of responsibility whilst in active addiction, highlighted by numerous reports of irresponsible/negative behaviour including criminal activity such as stealing, and the manipulation of others. As in McIntosh and McKeganey's (2002) study, such behaviours were generally conducted in an attempt to fund their habit.

In terms of how the addiction developed, it was clear that whilst the early stages were characterised by a gradual progression towards excessive use, the later stages of addiction (when participants were generally dependent or at the peak of their habit), involved much more rapid developments. These changes involved a rapid escalation in use, accompanied by a rapid deterioration of the participant, predominantly in terms of the negative effects of their use getting further out of control. Such rapid changes exemplify the powerful nature of addiction, which increasingly took control of most participants. The period between lapse and relapse was also described in similar terms, involving equally rapid changes (the issue of relapse is discussed in more detail later in the discussion).

It was clear from the study that addiction led to a significant changing of the participants as a 'person', in many ways including their life, lifestyle, identity, perspective etc. This was exemplified by participants who noted numerous differences in themselves when they were in active addiction and when they were in recovery. This finding mirrors McIntosh and Mckeganey's (2002) ideas on identity. In this study, the majority of participants referred to their identity in terms of the negative impact that their lives as addicts had on their sense of self, which was generally reported in the form of a deep

unhappiness at the person they had become. Sometimes the addicts' sense of revulsion at what they had become was associated with a belief that they had become a 'different' person during their addiction (McIntosh and McKeganey, 2002).

The second major theme to emerge from the present study was the various factors/reasons for use. Participants referred to a wide range of factors, which acted in combination rather in isolation and seemed to contribute to different stages of their participants' use, including their early use, continued/excessive use, and their use following a lapse/relapse. One of the most common factors influencing initial use was experimentation, which predominantly involved teenage experimentation with peers or with a range of different substances. This finding supports the typical findings within the literature of experimentation with softer drugs in early teens, followed by a progression to more powerful drugs and regular use in later teens/early twenties (McIntosh and McKeganey, 2002). It also seems to coincide with the existence of phases of experimentation in Waldorf's (1983) model, and the experimental phase in Frykholm's (1985) model. Within McIntosh and McKeganey's (2002) research, compliance appeared to be of a voluntary rather then imposed nature, and likewise the present study indicated that initial use was generally (although not always) a matter of choice rather than the result of force or pressure. These findings are also consistent with a number of other researchers, who recently challenged the assumption that one of the main influences on initial drug use is peer pressure (e.g. Hart and Hunt, 1997; Lloyd, 1998).

According to McIntosh and McKeganey (2002), another main reasons for participants initial drug use was curiosity; the root of the curiosity being the fact that drug taking was clearly enjoyable for those who took drugs. Similarly, in this stud, enjoyment was also highlighted as a major reason influencing both initial and continued/excessive use. Some participants also highlighted the search for a 'buzz' as a significant reason for their initial and continued use, which is again reinforced by McIntosh and McKeganey (2002), who found that participants' escalating use was often driven by a continuing desire to experiment and find new 'highs'. High availability of drugs/alcohol was influential in all stages of participants' use in the present study. High availability referred to a variety of situations, such as being in close contact with using relatives and being offered substances by them, having lots of money and therefore increasing the potential availability to various substances, or mixing in 'boozy' work/social circles. This is partially supported by McIntosh and McKeganey (2002), who found that progression to regular use, was heavily influenced by the individuals' relationships with their partners or peer group, since these relationships provided the opportunity and encouragement to use more regularly.

The present study also highlights how all of the stages of use were influenced by the occurrence of negative feelings. Using was often reasoned to be participants' way of coping with or suppressing or escaping from such feelings. The analysis revealed a range of negative feelings, including stress, loneliness, depression, boredom, and insecurity, several of which are also highlighted to be important factors in McIntosh and McKeganey's (2002) research (in relation to becoming a regular user only). In particular, within McIntosh and McKeganey's (2002) study, regular drug use was employed to help overcome feelings of personal inadequacy, particularly as an antidote to shyness or lack of confidence. Similarly, in the present study one of the clearest examples relating to negative feelings was using drugs/alcohol as a way of coping with insecurity and building confidence in order to mix better socially. McIntosh and McKeganey (2002) also found that boredom, resulting from unemployment or poor recreational facilities served to heighten the appeal of regular drug use by helping to fill a void in participant's lives (McIntosh and McKeganey, 2002). This idea is supported by the present study, where a lack of employment led to a complete preoccupation with using and therefore led to more excessive use. Another reason for more excessive use was in order to escape from the substance misuse problem itself, and/or the various negative consequences of it, such as a lack of employment. This clearly demonstrates the existence of a 'viscous cycle' of use from which it is difficult to escape. For example, it seemed that participants used more because of increasing dependence, as a result of this excessive use they lost their job, and subsequently used even more due to a preoccupation with using, because of a lack of activity/employment.

The present study also highlighted that another significant reason for use (at all of stages) was as a result of various life problems, such as bereavement, relationship problems, or work stress. As in the case of negative feelings, using was seen as a way of coping or as a means of suppressing/escaping from these life problems. McIntosh and Mckeganey (2002) found that only a small minority started to take drugs as a way of coping with problematic aspects of their lives. They did however find that once participants had encountered the pleasurable and 'therapeutic' effects of their use, it often became an important reason for more regular use. It is possible that these differences may have been influenced by the given sample (discussed later). It also emerged from the present study that various background factors, such as childhood problems might have been influential in participants' initial use, although these were considered to be more like potential contributors rather than actual causes/reasons for use.

As in McIntosh and McKeganey's (2002) study, one of the clearest factors influencing

participants' continued/excessive use was physical dependence and increasing tolerance levels, whereby increasing amounts of substance had to be taken in order to achieve the desired effect, or in many cases just to function normally and avoid withdrawal. Continued use was also reported to occur as a result of various barriers to behaviour change, although these are considered in more detail later in the discussion.

Our study revealed specific reasons/factors influencing the use that occurred following a lapse or relapse. Addiction is commonly assumed to be a chronically relapsing disorder (Gossop, 2002), and recovery commonly only occurs following a number of unsuccessful attempts. The problem of relapse was strongly emphasised in the seminal paper by Hunt et al (1971), and has subsequently been reinforced by dozens of papers including the present study.

One of the major reasons for lapsing was due to a failure to cope adequately with the addiction and the associated cravings. Participants' who had previously received substitute prescriptions (methadone and subutuex) emphasised that the problem arose due to the lack of adequate supporting therapy and the common occurrence of substitute prescriptions being withdrawn too quickly. As a result participants' often felt unable to cope as they were withdrawn and returned to their original drug use. Such a common experience has powerful implications for substitute prescribing practices.

Other clear factors that participants attributed to causing the lapse/relapse were complacency, whereby participants falsely believed that a small amount of use would not result in a full-blown relapse, and resuming use because they quickly forgot about the associated negative effects. Other (less common) factors influencing relapse included a lack of effort/commitment to behaviour change, the justification of use as a reward for being clean, and self-destruction, whereby some participants felt that they did not deserve the success that came with being clean/dry. These relapse findings seems to reinforce the importance of lapse prevention models such as that proposed by Marlatt and Gordon (1985), which advocate the use of a range of strategies to avoid relapse. In particular, lapse management strategies seem to be of considerable importance in preventing the lapse from developing into a full-blown relapse, and in combating the abstinence violation effect. Further examples of relapse prevention strategies/approaches are alluded to later in the discussion.

The third key theme to emerge from the data was the negative effects of use, which referred a wide range of unpleasant consequences, experienced by the participants. The wide range of negative consequences, related to both physical and psychological health,

the social and practical effects, and the impact on relationships. Many of these consequences were serious; sometimes persisting for a long time after the use had stopped. The occurrence of a general deterioration in physical health, and various use-related illnesses/problems is supported by both Prins (1995) and McIntosh and McKeganey (2002), although Prins (1995) suggests that a bad health situation is not always necessarily the result of drug use, since all people, including addicts, experience certain health problems. Nevertheless, McIntosh and McKeganey (2002) note that a deteriorating health is a major occupational hazard of drug use, with common physical problems for injecting users including serious vein damage, and the risk of contracting HIV or hepatitis C. Negative effects for other addicts highlighted in this study, included various alcohol-related memory problems, blackouts, weight problems, poor hygiene etc. It seems probable that many of the associated health problems are likely to have been influenced or at least exacerbated by participants not looking after themselves properly and included such things as not exercising or eating properly. A deterioration of emotional and psychological health was also clear in the interviews, with a reported increase in various negative emotions, such as feeling depressed, or experiencing a breakdown, and a variety of psychological problems, such as anxiety/panic attacks or paranoia/psychosis. As was the case in McIntosh and McKeganey's (2002) study, whether participants lived or died became a matter of complete indifference, with some becoming consciously suicidal in a similar way to those in Prins' (1995) research.

Another clear consequence was in terms of the effect of using on relationships, which resulted in various negative effects such as increased arguments, a bad family atmosphere, or the break-up of many relationships. A further negative consequence was the social effects, which was most notable in terms of the isolation and loneliness experienced by addicts. This isolation is likely to have been influenced by the fact that many were much less socially active when using (often due to a conscious avoidance of non-users) and the resultant change in social circles. The extreme isolation felt by participants is obviously something that needs addressing, and as this study shows, engaging in treatment can act as one means of rebuilding (non-using) social networks. Furthermore, participant's reported that meeting ex-addicts reduces isolation by combating their common belief that they were the only one in their situation. Also, the use of groups like AA/NA can provide good sources of contact for people, although one may also need to consider those addicts who do not have access to such sources, or do not wish to access them. In such cases it appears that alternative means of reducing isolation are required, with the role of the Internet becoming potentially important.

Finally, it emerged from the analysis that participants' use resulted in various practical

implications, with most of the sample being unable to work during heavy addiction. This further exacerbated their isolation, due to a lack of contact with work colleagues/friends. The importance of meaningful employment for sustained recovery was discussed by Edwards et al (1997), who suggest that it can provide a particularly useful substitution for the rewards previously found only in using drugs/alcohol. Apart from employment problems, a neglect of other practicalities, such as paying bills and keeping appointments also emerged as a problematic consequence of use, which seemed to relate to a lack of responsibility reported by many participants. As mentioned previously, this involved various irresponsible/negative behaviours, such as being unreliable, untrustworthy, deceitful, and engaging in criminal activity, most of which were conducted as a means of supporting their habit.

The fourth significant theme to be highlighted in the study relates to the process of realisation of the substance misuse problem. It was clear that many of the clients were unaware of their substance misuse problem in the earlier stages of their addiction. Not only were they unaware of their escalating use and developing dependence, but many were also unaware of the increasing negative effects of their use, and that these negative effects were a consequence of their using. The fact that many participants were unaware of the problem was often reported to be due to a denial of the problem or more simply to a lack of awareness, education or understanding of themselves and their addiction. This clearly highlights the need for increased education regarding addiction for the general public, particularly in schools. This lack of awareness is also highlighted by McIntosh and McKeganey (2002), who found that progression to regular use tended to involve an unconscious 'drift' rather than a deliberate decision. Although family and friends only occasionally informed addicts that they thought they had a problem in McIntosh and McKeganey's (2002) study, it seemed that in the present study, family and friends were generally aware of the problem long before the addicts themselves were.

For many of the participants, realisation of the problem seemed to occur as a process later on in the addiction, and it tended to be associated with a series of realisations, relating to both the substance misuse problem and the negative effects of use. Participants also described realisations relating to the need to change their behaviour and to get help/treatment in order to change such behaviour. It should be noted that for some participants initial realisation/awareness of the problem did not automatically result in a full recognition/acceptance of the problem, as for several participants it was often very difficult to accept the problem themselves and to admit it to others. Due to these difficulties, it sometimes took considerable time for this acceptance to occur and so it was generally a gradual process involving a series of realisations. However, for a minority of

participants, the process involved a sudden realisation highlighting marked individual differences between people in terms of how they experience and recognise their addiction. The presence of individual differences is reinforced by McIntosh and McKeganey (2002), who found that recognition by individuals, could take anything from a few weeks to several months, depending on the drug being used and the addicts' ability to support their habit.

The experience of withdrawal was an important factor in helping participants to realise their developing dependence on their substance(s) of choice. This is reinforced by McIntosh and McKeganey (2002) who point out that recognition usually came with the experience of withdrawal symptoms and the realisation that they needed drugs to function normally. This often came when they were deprived of them for some reasons, such as a lack of money or availability. Similarly a factor that prevented realisation of the problem was the fact that some participants had a continuous supply or used continuously for a period of time, which masked withdrawal symptoms.

The analysis also revealed that the increasing negative effects of use, particularly on children (if applicable), was also influential in determining participant's realisation that their substance misuse needed changing. This supports McIntosh and McKeganey's (2002) findings that addicts' feelings about the possible impact of their drug-use on their children were so powerful that this was often sufficient enough to make them reassess their drug use. Within the present study other less common contributors included the transition to heavier drug use/increased tolerance, and a realisation following a clean period. It was often a combination of such factors rather than one specific factor/event that influenced the realisation of the problem.

It was also clear from the study that despite realising the problem earlier many participants described having a clearer awareness of the substance misuse problem and its negative effects, at later stages of their addiction. Generally this seemed to be influenced by the passage of time, which allowed them to achieve a clearer perspective of the problem and the associated events, as well as the experience of treatment, which was significant in facilitating a clearer outlook. This highlights the importance of treatment. The analysis also revealed that many of the participants' substance misuse continued for some time after their initial realisation. Although this is likely to have been influenced by a variety of factors, including the various reasons influencing continued use and the barriers to behaviour change, a number of factors seemed to be particularly influential, including feeling helpless/unsure of how to go about stopping their use, experiencing a lack/very little negative effects at the time therefore not fully questioning

the problem, and a lack of support/treatment which was needed in order to change behaviour. Clearly, some of these factors need to be addressed to help promote behaviour change. In particular, there is the obvious but difficult need to make treatment more accessible/available to addicts, and the need to promote treatments, which support self-efficacy.

The fifth key theme evident from the results relates to behaviour change, and was broad in the sense that it referred to a wide variety of actions taken by participants to attempt to control or stop their substance misuse. As mentioned previously, virtually all participants reported numerous/successive unsuccessful attempts to change their behaviour, illustrating the high degree of difficulty involved in this. McIntosh and McKeganey (2002) believe that these failed attempts are not simply a waste of time and they play a highly significant role in the recovery process, as a period free from drug use can often clarify and highlight the extent to which addicts' identities have been damaged by drugs. Furthermore during abstinence, the addict can acquire a first-hand experience of the alternative life to which he/she might aspire.

Our analysis revealed that attempts to change could be divided into non-serious/temporary and serious types of behaviour change. Non-serious/temporary attempts referred to a less committed attempt to change behaviour. For example, several participants described temporary changes in their early use while being pregnant/having a family, or in order to support their denial, while some participants described how substitute prescriptions were used as a security/safety net to allow continued use, or how earlier treatment experiences were treated as a respite from use rather than a serious attempt to change behaviour. Another example of non-serious behaviour change was forced change rather than a positive decision to change by, for example, being forced not to use due to a lack of money or contact with a dealer, or coercion into treatment.

These types of non-serious/temporary change tended to occur earlier in an individual's addiction, unlike more serious behaviour change, which tended to occur later in addiction. These latter changes referred to a commitment to behaviour change following a 'rock bottom'-like experience. In these cases, participants described themselves as being in a 'bad state' and feeling highly depressed, 'half dead' and despondent with their situation, and feeling it was absolutely necessary to change. It was clear that serious behaviour change, in terms of making a serious attempt at accessing and 'working' treatment, was usually done when participants described themselves as being at or near rock bottom.

Although many people believe that the experience of a rock bottom-type experience is a necessary condition for successful recovery, this view has been challenged by research such as that of Biernacki (1986) and more recently McIntosh and Mckeganey (2002), who have identified two principal routes out of drug use. One route is the rock bottom type route whilst the other is exit via rational decisions. The main difference between which was having to stop in the former and wanting to stop in the latter.

Although the current study seemed to emphasise the occurrence of the rock bottom-type of experiences, this does not mean that exit via rational decisions are not significant/important. Indeed the differences in the findings may be to do with the sample, since many of the participants in the current study were still in treatment, and (unlike the other studies) only a few had been in recovery for a sustained period of time.

Moreover, in spite of the occurrence of rock bottom –type of experiences, there did seem to be evidence of more rational decisions, in the sense that participants seemed to experience various decisional balances regarding behaviour change at different times in their using life. This involved experiencing various balances/choices which had to be weighed up, for instance in terms of the benefits of staying clean versus the benefits of continued use, or the continued enjoyment of use versus the feeling that use was wrong/dangerous. It seemed that as the addiction progressed the decisional balances generally seemed to shift from favouring continued use, in the early stages, to favouring change rather than continued use, in the later stages. In terms of when the balance favoured continued use rather than change, factors such as continued enjoyment and physical dependency tended to outweigh any negative effects of use, feelings of wanting to change, or any other factors, which may serve to motivate them to change their behaviour.

Nevertheless, for many participants the balance seemed to tip in favour of behaviour change rather than continued use when the negatives of use began to outweigh the positives and reasons/factors for continued use. This finding resembles the first stage of de-addiction in Waldorf's (1963) model, where addicts are 'going through changes' and the negative effects of drug use begin to be felt. The addict then makes forced or voluntary attempts to stop, which usually end in relapse. More specifically some participants in the present study reinforced the influence of a rock bottom-type experienced and described wanting to stop using as a result of being completely fed up with the negative effects of their use or of being too ill not to go to treatment. In this phase, examples of various decisional balances included choosing the dignity of being

clean rather than the substance, choosing to have a job rather than the substance, choosing a life rather than a life dictated by the substance, or quite simply choosing life rather than the substance and potential death.

It should be noted that in many cases it took some time for this shift in opinions to translate into actual behaviour change, and it is likely that this is because some of the decisions were not as straightforward as implied, considering the vast range of reasons/factors participants described for wanting/needing to continue using. Clearly there is a conflict between the reasons/factors influencing wanting to change behaviour and the reasons/factors influencing continued/excessive use or lapse/relapse. This view is reinforced by numerous other researchers, such as Prins (1994), Biernacki (1986), and McIntosh and McKeganey (2002), who found that deciding to give up drugs was surrounded by a great deal of ambivalence, with a conflict between a desire to change and a reluctance to give up the drug. Indeed, it is argued that ambivalence is endemic to the lives of addicts and is present for a large part of their drug-using career. This view is also reinforced by the stage theorist Frykholm (1985), who argues that the first phase of de-addiction involves a period of ambivalence, where the negative effects of drug use are increasingly felt, which although results in a gradual desire to stop using drugs, is generally offset by a continuation of pleasurable effects of drugs and a physical dependency to drugs. The presence of such ambivalence clearly implies that there is a potential role for therapies such as Motivational Interviewing (Miller, 1983; Miller and Rollnick, 1991), which explores ambivalence, and aim to facilitate compliance and readiness for behaviour change.

Another major factor that seemed to be influential in tipping the balance in favour of behaviour change was the changing effect of the substance(s) of choice. These usually progressed from being positive to becoming increasingly negative. As well as cognitive and perceptual shifts, McIntosh and Mckeganey (2002) found that important changes in the pharmacological effects of drugs play a major part in the addicts' decision to stop using. It is suggested that the realisation that the drug is no longer a positive part of an addicts' life represents an important turning point; a view that is backed up by numerous researchers (Stimson and Oppenheimer, 1982; Frykholm, 1985; Prins, 1994). Despite the disagreement amongst stage theorists regarding the precise number of phases/stages involved in addiction and recovery, the presence of a specific 'turning point' is common to many models (Prins, 1994; Simpson et al, 1986; Shaffer and Jones, 1989). The fact that there seems to be a specific point where the decision to give up drugs/alcohol is taken and/or consolidated also seems to be evident in this study,

although this generally involved a gradual process rather than a specific event.

Another clear factor influencing behaviour change for some participants was the importance of significant others, such as family/children in motivating them to achieve recovery. For example, some participants reported wanting to achieve normality for the sake of their children, or deciding to change their behaviour due to the fear of losing contact with their children. The influence of significant others in the decision to stop using is reinforced in a number of studies (Waldorf, 1983; Frykholm, 1985; Simpson et al, 1986; Smart, 1994). For example, Simpson et al (1986) report that more than half of their sample stated 'family responsibilities' were important in their decision to stop, while about a third cited pressure from family members as important. McIntosh and McKeganey (2002) also indicate the potential role that significant others, particularly children, can play in recovery. Since many interviewees felt incredibly guilty about the ways in which their drug use had affected the lives of their children, children could act as a powerful catalyst for attempting to give up drugs/enter treatment.

Within the present research, another major reason for behaviour change was in order to provide relief from the increasing negative effects of use, for example, on health or relationships. Many participants expressed that the need for behaviour change was influenced by a desire for some kind of normality that was free from such negative effects. Again this finding is reinforced in other studies which show that an influential factor in the decision to stop using is deteriorating health or the fear of health problems (Waldorf, 1983; Valliant, 1983; Simpson et al, 1986), as well as the occurrence of more general negative events such as a period in prison or the overdose or death of drug-using friends/associates (Shaffer, 1992; Edwards et al 1992).

The increase in such negative effects seems to be related to the notion of 'burn out', which appears to be one of the most frequent explanations for recovery given by participants in many studies. It seems that sustaining a habit can become an exceptionally difficult and demanding task associated with many problems. This has been demonstrated in studies such as that of Frykholm (1985) and Simpson et al (1986), where addicts main reason for stopping was that they were 'tired of the life' or words to that effect. McIntosh and Mckeganey (2002) point out the similarity of the 'burn out' explanation and Winick's (1962) 'maturing out' thesis, since both are products of changes, which could be said to occur naturally with the passage of time.

However, there is not widespread agreement regarding this. For example, Vaillant (1996) does not believe there is a specific age where addicts recover, arguing that the notion of

'burnout' in middle life is a misinterpretation of the relatively smooth attrition among drug-dependent individuals. Instead, Vaillant (1996) believes that recovery seems to depend on the severity of addiction and on the individual encountering the right kind of natural healing experience. This is not an area that can be debated within the current research, as this study did not focus upon determining the final route out of addiction, as many participants were still in treatment, and only a few had been in recovery for a sustained period of time.

McIntosh and McKeganey (2002) found that a similar range of reasons/factors to those highlighted above were influential in behaviour change. However, similarly to Biernacki and Waldorf (Biernacki, 1986; Waldorf, 1983; Waldorf and Biernacki, 1981), McIntosh and McKeganey (2002) strongly believe that the factor that distinguishes apparently successful attempts from earlier attempts is related to the addicts' sense of identity, rather than any of these factors. More specifically, they argue that addicts are stimulated by a desire to restore what Goffman (1963) described as a 'spoiled identity', as they realise that they exhibit characteristics that are unacceptable to themselves and significant others. Although McIntosh and Mckeganey (2002) are not claiming that a desire to restore ones identity is sufficient for recovery on its own, they do describe it as a cognitive shift that comes close to being a necessary condition for such change to occur.

McIntosh and Mckeganey (2002) suggest that the reason/factors are seldom sufficient in themselves to promote permanent exit from drug misuse, arguing instead that their potential effect is mediated by the meaning which individuals ascribe to them and the implications these interpretations have on their sense of self. Although the issue of identity was raised in the present study (in the sense that the substance misuse produced various changes to the person, and treatment and recovery seemed to restore some of these changes), it did not appear as influential as suggested by McIntosh and McKeganey (2002). It is possible that this difference is related to the sample, since most participants in this study had not been in recovery for a sustained period and perhaps had not started to objectively evaluate their route to recovery. A far more powerful factor relating to behaviour change seemed to be the existence of various decisional balances, which were strongly emphasised by many participants.

Our analysis revealed certain barriers, which prevented behaviour change (and therefore acted as reasons/factors for continued use), such as a lack of awareness/denial of the problem, a lack of treatment services or long waiting lists, fear of experiencing withdrawal symptoms, or a feeling of being unable to see a way out of the substance

misuse problem. Obviously such factors need to be addressed if addicts are to be encouraged to engage in behaviour change sooner. In particular, the feeling of being unable to see a way out of the substance misuse problem meant that even though participants may have recognised that they had a problem and accepted the need to change their behaviour, they may have seen no way of stopping. The need to believe that change is feasible is highlighted as an important factor in producing successful behaviour change by McIntosh and Mckeganey (2002), who argue that it was not enough for addicts to desire a new identity and life, but they also needed to believe that this was feasible. Without this, any inclination to alter behaviour would simply disappear. Since addicts must believe that they have the power to change their behaviour, the enhancement of self-efficacy seems to be of considerable importance, and as mentioned previously the role of skilled therapists can be particularly important in this respect (Edwards, 2000). The importance of taking positive actions to promote behaviour change is supported by Prins (1995), who argues that although the decision to change/stop using may be a decisive moment/turning point, very often it is not enough on its own, and therefore the decision needs to be backed up by steps to implement it.

The sixth major theme that emerged from the analysis related to treatment. This was clearly very important in the sense that all participants considered it to be a vital factor in achieving recovery. In the current study, all participants had accessed treatment at some stage and felt unable to achieve recovery independently. Many were unable to detox independently due to physical dependence or were simply unable to cope with behaviour change without external help/support. This finding supports Frykholm's (1985) treatment phase, in which it is proposed that the addict perceives a need for 'external control and support' and so seeks help.

Within this study, treatment was clearly central to recovery and in many ways the themes of treatment and recovery are interchangeable/commonly linked together. However, rather than forming a concept within the theme of recovery, treatment formed a theme of its own, since it was deemed so important and clearly encompassed so many factors. The reported relief that starting their treatment provided illustrated the importance of treatment for these participants.

Various treatment experiences were reported to produce a range of positive effects in terms of drug/alcohol use, physical health, confidence levels, isolation, coping methods etc., as well as an altering of the person in terms of their life, lifestyle, perspective, identity, and facilitating a clearer realisation/awareness of the substance misuse problem. These findings relating to the positive effects of treatment are reinforced by

other research (Edwards, 2000). According to Edwards et al (1997), although treatment is one of a number of interactive influences that can play a part in recovery, it can be particularly useful, for example, in terms of nudging a person towards a more constructive way of thinking (as demonstrated in the current study), enhancing self-efficacy, or helping with the choice of an appropriate goal. Although 'maturing out' has traditionally been applied solely to the process by which some addicts give up drugs 'naturally' (Winick, 1962; Biernacki, 1986; Prins, 1994), McIntosh and Mckeganey (2002) believe that this is too narrow a view of the processes involved. They argue that it is possible for the 'maturing process' to apply as much to those who overcome their addiction with the assistance of treatment, since it is the decision to stop that is important, and whether this occurs with or without treatment is of secondary importance (McIntosh and Mckeganey, 2002).

According to Edwards' (2000), research demonstrates that a range of competently applied treatments with different theoretical underpinnings are likely to give roughly the same kinds of success rates. This obviously makes it is somewhat difficult to establish which aspects of treatment are particularly effective. However, it is possible that the present study may shed some light on this issue, as it emerged that the positive effects of treatment seemed to occur as a result of various positive components/needs, which were reported to be essential for beneficial/successful treatment. One of the clearest components was that of common experience, both in terms of being around other addicts in treatment and the fact that many of the counsellors having had some kind of personal experience with addiction. Common experience was reported to be beneficial in providing a more empathetic/understanding environment, where clients (and counsellors) could positively relate to each other and provide more useful/practical advice as they could all draw from their own experiences. Common experiences was also important since participants were not able to 'blag' treatment or conceal what was going on, as well as serving to reduce isolation. This is clearly of significance considering the fact that isolation/loneliness was so commonly experienced by participants.

Furthermore, many participants described the benefits of being surrounded by people at different stages of their addiction, with new/relapsing addicts serving as a reminder of the negatives effects of using, and successful recovering addicts (e.g. people in aftercare) providing hope and serving as potential role models or goals to aspire to. The various benefits of common experience are supported by McIntosh and McKeganey (2002), who found that talking to other recovering addicts had three main advantages. Firstly, recovering addicts understood first hand what the individuals were going through, and were able to relate and emphasise better; secondly, they had credibility, since they

had been there themselves and were knowledgeable; and thirdly, successful recovering addicts gave inspiration to those not so far along to sustain the hope that they could succeed.

Another crucial component of treatment that emerged was having a welcoming, and friendly and safe environment. This idea is supported by McBride (2002) who stresses the importance of making services approachable, not only geographically, but also socially and personally. McBride argued that the ambience of an agency/setting can have a marked impact on the treatment experience. Ideally, the setting should be informal and comfortable, with assessments conducted in a quiet and uninterrupted environment. Interviewers should display skills, such as empathy and warmth. Considering that one of the difficulties of treatment (highlighted in the present study) was that participants often felt nervous, scared, lost and unsure of what to expect at the start of treatment, the presence of a welcoming/supportive environment is especially important in helping to ease some of the apprehension experienced.

Education also emerged as a crucial component of treatment, both in terms of the various aspects of addiction, and regarding the availability of treatment services. Some participants felt that earlier education may have been beneficial in engaging them or others earlier in their addiction.

Participants also described how treatment provided them with the benefits of talking about problems and getting feedback/advice in both counselling and group therapy. Much of the emphasis was placed on the positives of group therapy. The group environment seemed to provide a situation in which participants could get intimately involved, through the two-way process of feedback. Participants strongly advocated the process of both receiving and giving advice and opinions. Often this setting seemed to enhance confidence and self-esteem, as well as reduce isolation (e.g. through bonding with peers). McIntosh and McKeganey's (2002) research supports the positives of therapy, in particular counselling. In the present study views regarding counselling were generally positive, with participants once again highlighting the value of being able to talk to others about the stresses and strains involved in trying to recover from addiction.

The need for some kind of therapy alongside substitute prescriptions was also reported to be very important for many participants in this study, illustrated by reports of relapse being a result of receiving a 'script' but not having any counselling. Participants found it unsurprising that such an approach may result in relapse, since by giving a substitute prescription often only the physical dependence is addressed, and there is an obvious

failure to address other potential problems, which may be contributing to the substance misuse. Furthermore, it is difficult to see how recovery may be maintained if there is a failure to teach/provide any advice regarding how to deal with the addiction in the long term, and manage potential cravings.

A further treatment component that was reported to be influential in producing positive effects was the adoption of a holistic approach, whereby the 'whole package' of the person was addressed in treatment, and not simply the substance misuse problem. The range of targets included behaviours, coping methods, physical and psychological/emotional problems, practical problems, social and relationship difficulties, and self-awareness. Similarly, within the recovery theme, a crucial aid to recovery seemed to be the adoption of a holistic approach, whereby all problematic aspects of the participants' lives needed addressing, such as problematic behaviours, lifestyle, circles etc, rather than just the substance misuse problem.

The use of alternative therapies in treatment, such as acupuncture or relaxation, or alternative activities such as exercise or fun days out was also supported. Participants reported that such therapies/activities were beneficial in numerous ways such as increasing self-awareness, distracting the participant from their substance misuse problem, and providing valued time away from therapy to prevent overload. The use of alternative activities is reinforced in Marlatt and Gordon's (1985) relapse prevention model, where one strategy employed to try and prevent relapse involves encouraging clients to pursue non-drinking (although it could be equally applied to drugs) recreational activities previously enjoyed before the substance misuse problem. In addition, it is suggested that cognitive-behavioural skills training approaches, such as relaxation (as mentioned above) can help clients achieve a greater lifestyle balance. Furthermore, helping the client to increase positive activities, such as exercise or yoga can also improve mood, health and coping, as well as increase self-efficacy, through acquiring new skills from new activities (Larmier, Palmer and Marlatt, 1999).

An additional component that was considered integral to successful treatment was good support networks. Practical support in particular was beneficial to some participants, which is perhaps unsurprising considering the amount of practical consequences that occurred for participants as a result of their substance misuse problem. The particular structure of treatment was also crucial to some participants, who emphasised the benefits/need for BAC-like services, in the sense that it provided an abstinence-based, structured/intensive day care programme, over a relatively long period of time. It is however, likely that their views regarding what constituted beneficial treatment had been

influenced by their contact and relative success with such services. Nevertheless, it was clear that for this sample at least, this type of treatment was considered to be what they needed for recovery.

Some participants described the need for specialist treatment rather than general help, e.g. medical assistance to detox, with several participants referring to the need for both an individualistic and realistic style of treatment, which should be instantly/easily accessible when required.

The final component that was considered necessary for successful treatment was personal factors, such as effort, hard work and commitment. This seems to be a fundamental component since without the effort and commitment of the individual treatment cannot be effective no matter how good it may be.

In relation to commencing treatment, participants reported a range of expectations (from high to mixed to low), although one common feeling experienced by most was a feeling of being unsure regarding what to expect. Another less common but seemingly important expectation was some kind of false belief in a 'miracle cure'. This appears to be something that treatment agencies need to consider with new clients so they can be realistic with them regarding the high level of effort required to achieve recovery, and therefore avoid disappointment. This is reinforced by Marlatt and Gordon (1985), who believe counteracting misconceptions to be an important part of relapse prevention.

Our analysis revealed a number of potential barriers to accessing treatment, the most common of which being a lack of services or lack of awareness of existing services. Other common barriers included long waiting lists, which potentially deterred people from accessing treatment, or personal circumstances/feelings, such as feelings of shame/pride/fear, which stood in the way of asking for help/treatment. Such barriers need to be addressed to attempt to engage clients in treatment sooner.

The data also revealed numerous difficulties that participants' experienced through their experiences in treatment. The clearest difficulty was in the need to accept complete abstinence. Many participants described experiencing continued desire to use some sort of substance, most commonly cannabis, while attempting to give up their substance of choice. Generally however, participants did concede that the acceptance of complete abstinence was an important requirement for recovery. Another difficulty experienced in treatment was related to various contradictions participants had with treatment services, for example, when receiving advice about controlled use despite wanting abstinence-

based treatment, engaging in a service that would only treat a client's drug problem and not the alcohol problem, or having contradictory feelings with an agency regarding how the detoxification should be managed.

Most participants also described some kind of negative/unsuccessful experience of treatment at some stage in their addiction, including treatment not being intensive/long enough, and a lack of alternative activities or education within treatment. Clearly such negative experiences served to re-emphasise some of the positive components reported to be essential for successful treatment, for example in terms of the structure of treatment. A specific negative experience of treatment was related to substitute prescriptions, and in particular methadone, which participants had usually received in earlier stages of their addiction. Some of the participants viewed substitute prescriptions such as methadone as negative in the sense that they were able to use heroin on top, and was therefore viewed as a 'green light' to continue using. Several participants also referred to experiencing extreme withdrawal from methadone, and expressed a preference for subutex (buprenorphine) rather than methadone.

Similarly negative views of methadone were expressed by some of the interviewees in McIntosh and McKeganey's (2002) study, although a significant proportion saw methadone as a wonder drug that had saved them from the depths of their addiction. Although a controversial issue, research evidence does indicate that methadone can make a positive contribution in reducing risk behaviour and assisting recovery (e.g. Ball and Ross, 1991). Nevertheless, McIntosh and McKeganey (2002) suggest that our understanding of the role of methadone is relatively undeveloped, and therefore there is a need for further research, for example, examining the long-term impact of methadone on the length of a drug-using career. Due to a large void in the literature, another important area of research would examine drug addicts' own views of methadone, as well as subutex.

The final theme to emerge from the analysis of the data was recovery. This was obviously one of the most crucial themes. Due to the nature of the sample (who were selected from a treatment agency), treatment was obviously one of the most important requirements of recovery (as discussed above). However, a number of other important factors also emerged as important, including various personal requirements, such as being focused and committed to putting in effort and hard work, being personally ready to change, and accepting that the addiction was enduring and that there was co miracle cure. The need for such personal requirements is reinforced by Edwards (2000), who suggests in particular, that addicts need to be motivated (and specific treatments like

Motivational Interviewing are useful here), as well as ready to change (a view strongly influenced by Prochaska and DiClemente's model).

Another factor, which emerged as an important requirement for recovery, was the need to accept abstinence. This idea supports Edwards et al (1997), who argue that recovery from severe dependence almost inevitably involves acceptance of an abstinence goal. Our analysis also revealed various other factors required to achieve recovery including the need to have hit rock bottom (which is discussed previously), and the need for a good support network. Edwards (2000) reinforces this, stressing the importance of establishing a personal micro-environment that supports abstinence. For many individuals, groups like AA/NA can provide such an environment.

The present analysis also indicated the need for addicts to change their behaviour for themselves rather than others. McIntosh and McKeganey (2002) also found that substantial numbers of subjects expressed that drug use could only be stopped successfully if it was done 'for yourself'. According to McIntosh and Mckeganey (2002), 'doing it for yourself' represents a clear reference to identity, as many participants felt that success would be unlikely if they sought to stop for the sake of others: success would only come if you did it for yourself, i.e. for the sake of your own identity. McIntosh and Mckeganey (2002) note that one of the problems with stopping for reasons other than the self, is that the drug is frequently considered more powerful than a range of very good reasons for stopping, and so the only realistic prospect of overcoming this power comes when the drug-using identity is being rejected.

The present study revealed that a range of other factors also seemed to be influential in motivating participants in their recovery, including the fear of death from resuming their use, the potential guilt/shame associated with a relapse, as well as the support of significant others, and the positive effects of their change on others (e.g. family, children). As mentioned previously, the importance of significant others in behaviour change, is reinforced by numerous other researchers.

The present interviews also revealed various aids, which had helped or were helping participants to achieve or sustain their abstinence/recovery. One of the factors considered to be of most value was the continued use of post-treatment aftercare/counselling, and the importance/security of having a safe environment to return to if required. Similarly, McIntosh and McKeganey (2002) found that their interviewees valued the ability to drop into a facility or contact someone without prior arrangement, since challenges to their recovery could occur at any time. Another highly

important component assisting recovery was the learning and use of a range of strategies to combat/oppose the numerous factors/reasons for use. These strategies were either learned through treatment or over time by experience, and included strategies such as reducing high availability of drugs/alcohol by avoiding users; changing social circles from users to non-users to reduce temptation; using distraction to avoid boredom, which may trigger use.

The need to use such strategies is reinforced by Edwards (2000), who suggests that successful recovery involves avoiding relapse, and this can be done through learning various psychological skills, e.g. through Cognitive Behavioural Therapy (CBT). Similarly, in relapse prevention models such as that of Marlatt and Gordon's (1985), one of the goals is to teach the clients to anticipate the possibility of relapse and to recognise and cope with high-risk situations. Once high-risk situations have been identified, various strategies can be used to lessen the risks, such as learning more effective coping strategies, or if this is not possible, taking evasive action, such as leaving the situation when cues/triggers for use are identified (Larmier et al, 1999).

The present study identified that a particularly important strategy was to be the acceptance and expectancy of cravings and other problems associated with addiction. This preparation helped participants to avoid panicking when they experienced them, and they could arm themselves with effective ways to cope with them. According to Larmier et al (1999), an important aspect of Marlatt and Gordon's (1985) relapse prevention model, is to teach clients to anticipate and accept cravings as a 'normal' conditioned response to an external stimulus, rather than seeing the urge as an indication of his/her desire to use. The model describes the use of various urge-management techniques, which can be adopted to deal with such cravings.

Finally, our study found that many participants experienced or were experiencing numerous changes in their recovery. In the same way that using seemed to produce changes in the user as a person, the process of recovery seemed to begin to restore these changes, altering the person, in terms of their lifestyle, identity and perspective etc. Many participants referred to the actual rebuilding of a new kind of person and lifestyle, whilst others (presumably at earlier stages in recovery) expressed the desire to rebuild their lifestyle. These desires or actual changes generally involved a happier life without various substances, and with a college/work place, a new house, and/or new/improving relationships with others.

Again, this finding seems to resemble the work of McIntosh and McKeganey (2002), and

their spoiled identity theory. However, they do point out that this restoration cannot be achieved by the simple act of the individual declaring that he/she has stopped using drugs, since it has to be built and constantly reinforced against a variety of often-powerful opposing forces. Similarly, in relation to alcohol misuse, Edwards et al (1997) suggest that although specific factors may influence or precipitate change, sobriety is usually best conceived as something built and secured over time, rather than achieved on a particular day. Recovery is most likely to be held onto in the longer term when the sober state is felt to be rewarding, with prime rewards being those that can come from a loving relationship, the discovery of a capacity for altruism, meaningful employment, hobbies, or further education and so on.

It is clear that numerous interesting themes have emerged from the Grounded Theory analysis of the interview data, much of which is supported by other findings in the field. Although the themes are presented separately, there is clearly an interrelationship between them. Some themes clearly overlap. From an examination of these interrelationships, a basic model has been developed from the study.

Overall, the substance misuse problem was clearly very powerful in nature, and after a gradual progression from participants' initial use, often resulted in a complete preoccupation with using. This led to a range of negative effects, which seemed to get rapidly out of control as their use spiralled out of control. Despite experiencing such negative effects, a wide range of factors/reasons seemed to promote or maintain participants' continued use of substances. As the addiction developed, participants seemed to gradually develop a realisation of the substance misuse problem and the need to change their behaviour. This was influenced by various factors, including an increase in the negative effects of use. This increase also seemed to be influential in tipping the balance in favour of behaviour change, over continued use, as the negatives of use seemed to outweigh the reasons/factors influencing continued use. However, behaviour change often led to relapse, which was also influenced by numerous factors or reasons. One of the most important factors in promoting successful behaviour change and recovery was clearly treatment, which seemed to produce a range of positive effects. Additional factors were also important in promoting behaviour change. Overall, a combination of many factors seemed particularly important in initially achieving abstinence, and in allowing recovery to be maintained in the longer term.

Clearly, many of the concepts described above have been reinforced by various pieces of research, most notably the work of McIntosh and McKeganey (2002). Their work however, emphasised the role of identity far more than revealed in the present study.

Within the current study, although it was clear that addiction produced changes in the person including their identity, and recovery allowed some of these changes to be rebuilt, it did not appear to be as central to the participant. However, it is possible that the differences in emphasis may be related to the differences in the sample, since many of the participants in this study were still in treatment, and only a few had been in recovery over the longer term. All participants in McIntosh and McKeganey's sample had been in recovery for at least six months. Further investigation of participants later in their recovery may prove a useful area of future research, to further explore the issues surrounding addiction and later stages of recovery.

Despite the differences in emphasis, this study resembles that of McIntosh and McKeganey (2002), in the sense that it does not focus solely on the process of recovery, but also analyses the various processes involved in addiction, the aim being to provide a complete picture of the processes involved. There is no doubt from this and other studies that the issues involved in addiction and recovery are extremely complex, and as a result it is argued that the best approach to attempting to understand them is to consider carefully all of the different factors involved in both addiction and recovery. For example, it is of little use to examine whether behaviour change will be successful, if one has no understanding of the factors, which promote continued use in an individual's life.

When carrying out a qualitative study of this nature, there are several important issues, which need to be considered. When conducting interviews, particularly on topics as sensitive as addiction and recovery, it is essential that trust is established early in the interview and that a good rapport with the participant is established. To assist this, participants were reminded of their anonymity in the research, and the interviews were conducted as informally as possible, on a one-to-one basis to ensure that a 'natural' or conversational style of interview developed. Since the study covers a sensitive subject certain ethical considerations needed to be addressed, since it was possible that the interview might raise particularly upsetting or uncomfortable emotions for the participants. In order to avoid potential problems, participants were reminded that they did not have to answer any questions that they were uncomfortable with, and that they were free to pause or terminate the interview at any time.

As a result, the interviews were extremely successful in the sense that for the most part participants seemed to be at ease during the interviews, and were generally very happy to be involved in the research. Participants were recruited from a drug and alcohol agency, and no incentives were offered to take part in the research. The accounts therefore were taken to be truthful and accurate, since participants were accessed

through reliable sources, had agreed to participate in the study and realistically participants were unlikely to gain anything from being untruthful.

The interviews were recorded for several reasons. Firstly, this avoided the need to make extensive notes during the interview, which allowed the interviewer to give participants their full attention in order to maintain rapport and to follow up any interesting areas not already stipulated within the interview guidelines. Secondly, this avoided the potential difficulties of relying on the interviewers' memory, since memory can often be a selective and inaccurate. Finally, this allowed for subsequent transcription verbatim, which provided a rich source of data on which to conduct the analysis. Generally, the digital recorders provided high quality recordings, which were imperative for successful transcription and analysis of the data.

In the study, semi-structured interviews were conducted in order to gain a detailed picture of participants' experiences of addiction and what is needed to achieve recovery. According to Smith (2001), this method provides much more flexibility than the more conventional structured interview, questionnaire or survey, as the respondent gives a fuller picture and the researcher is free to follow up interesting avenues that emerge in the interview. Smith (2001) also describes the 'natural' fit that exists between semi-structured interviewing and qualitative analysis. By employing qualitative analysis an attempt is made to capture the richness of the emerging themes rather than reducing the responses to quantitative categories, and wasting the opportunity provided by the detail of the verbatim interview data (Smith, 2001). Qualitative methods were therefore employed to analyse the data using Grounded Theory analysis.

According to Strauss and Corbin (1990), Grounded Theory analysis is different from other methods in the sense that it allows the generation of theory that closely approximates the reality it represents, rather than the testing of theory. The inductive nature of this method assumes an openness and flexibility of approach, which is advantageous since it allows the researcher to follow the leads gained from the data (Charmaz, 2001). This approach can also help the analyst break through the biases and assumptions that can be brought to or developed during the research process (Strauss and Corbin, 1990). This was especially important considering the lack of research within the substance misuse field exploring the views of addicts themselves, and including these views in the planning and delivery of services. Attention needs to be paid to the given topic.

Although the process of transcribing the semi-structured interviews for analysis was labour intensive and arduous, it was deemed necessary in order to achieve sources of

data that were detailed and rich enough to successfully conduct the analysis on, particularly since the study was a pilot. However, for future research it may be useful to consider the adoption of the method, such as that described and used by the ADF group (Velleman and Templeton, 2003). Rather than transcribing the interview data verbatim, the ADF group has refined what they describe as a far more economical and effective method, which involves writing detailed reports of the interviews, summarizing the key points and providing examples and verbatim quotations. It is these detailed reports that are then analysed using Grounded Theory or Framework techniques (Velleman and Templeton, 2003).

The results of this study cannot be generalised to all recovering addicts for a number of reasons. Firstly, the research formed a pilot study, which contained a small sample of fifteen participants from a specific treatment programme. Secondly, the treatment that participants in the sample had received is likely to have influenced their experiences in some way. Thirdly, as noted by Vaillant (1996), clinical samples such as that used in this study are likely to be biased for the following reasons: they are more likely to include addicts co-morbid for other disorders; they are more likely to over-sample the chronically relapsing addicts; they are more likely to focus attention on treatment failures and mentally ill than on natural processes of healing; and finally, addicts who have achieved abstinence often no longer attend clinics. As a result of these considerations, Vaillant (1996) advocates the study of community rather than clinical samples. Nevertheless, in spite of these difficulties, there is no doubt that this study has provided a valuable insight into a research area, which has often failed to take account of the views of the actual individuals in question. A number of interesting themes, processes and interactions have emerged, which suggests great value in continuing or extending this study further.

This study has provided important information – from clients themselves - on processes in treatment which are important for long-term abstinence and recovery from addiction. This sort of research is extremely rare, which is really quite astonishing given the many millions of pounds that are poured into drug and alcohol treatment in this country and further afield. If we are to improve the way that treatment is delivered and thereby reduce the problems that drugs and alcohol can cause to individuals, their families and friends, and communities we need to carry out such research on a much larger scale. This sort of qualitative approach needs to adopted in individual studies with clients from a wide range of treatment services and interventions, and further analyses then done across the various studies (treatment services/interventions). This will allow us to enhance our understanding of specific forms of treatment service/intervention, as well as make more generalised statements about treatment and recovery per se. This work will

facilitate the planning and delivery of future services. Needless to say, we also need to carry out research with people who have recovered from a substance misuse problem without recourse to a treatment service.

Without doubt, more effort should be made to conduct research which focuses on directly eliciting the views of those who have experienced addiction.

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Appendix A: Standardised Guidelines for Interview Layout

- We are interviewing people who have experienced a substance misuse problem as part of a research program aimed at improving our understanding of addiction.
- In particular we are interested in hearing your views about the factors involved in the development of the addiction, and the factors involved in achieving recovery, and the potential role of addiction within this.
- We also hope to develop personal stories out of the interviews if you are interested.
- I have several areas I wish to cover, and obviously if there is anything you wish to comment on please feel free.
    - drug/alcohol using history
    - transition to regular use
    - peak of habit/lifestyle
    - recognition of the problem
    - past experiences of giving up
    - experiences at treatment/BAC
- The research is completely confidential so feel free to say what you wish

Appendix B: Consent Form

We are conducting research focusing on the nature of addiction, the process of recovery and how treatment fits in with this.

Your thoughts and experiences are very important. They will help us to understand different factors involved in the problems and the ways to help people deal with these problems.

Everything you say is entirely confidential.

I would like to tape record our conversation so I can transcribe the material at a later date to help with my analysis. Your name will not be associated with either the audio tape or the transcript – they will be assigned a code. All quotations from the transcripts will be totally anonymous, unless you state otherwise.

If you choose not to answer any questions, that is completely fine. You are free to terminate your participation at any time.

Please sign below if you are happy to participate in this research study.

Participant's signature...............................

Date............................

Appendix C: Interview Outline

Views of clients on:

Nature of addiction

Process of recovery

How treatment fits in

Drug/alcohol using history

- We want to know a little bit about your past, not just about drinks and drugs, but also any other problems you may have, or have had.
    - When you started using?
    - What substances?
    - Why it started?
    - Who with where?

- How drug/alcohol history developed?
    - What substances used?
    - Substance of choice now?
    - How much were you using?

- What effects did X have on you?
    - How did it make you feel?
    - Did it change?

Transition

- When did your use become regular/a problem?

    e.g. smoking to injecting

- Why did you use change?

- What effect did this have on your life?

Peak of habit/lifestyle

- How would you describe yourself at the peak of your habit? How was it affecting you?
    - Physical health
    - Mental health
    - Emotional health

- Family and friends
- Jobs
- Criminal activities

- How did you fund your habit?

- Who were you mostly spending your time with?

Recognition of the problem

- When did you realise that you had a problem?

- How did it make you feel?
    - what made you realise?
    - Were you worried?

- Did your use change when you realised you had a problem? How?

- How long was it before you attempted to do something about it?
    - what made you?
    - What did you do?
    - Why do you think it took so long?

- Past experiences/attempts = not just seeking treatment but anything you did

    - why did you do it?
    - What did you want?
    - What did you expect?
    - What did it involve?
    - How did/do you feel about it?
    - What was good/not so helpful?
    - Did these opinions change over time?

- What effects did these attempts have on you?
    - what did you learn?
    - How did this impact on all areas of your life?

      UP TO BAC

- How did you end up at the BAC. Why did you end up at the BAC?

- What did you expect?

- What happened when you got here, and how did you feel then?
  - pre-treatment
  - induction
  - practicalities
  - moving on
  - aftercare
  - how did you feel?
  - What effect was this having in you?
  - What changes were occurring in you then?

- General views on treatment and recovery?
- What is needed to go from being a chaotic user to achieving abstinence?
- What is the most important thing needed for recovery?
- Some people argue recovery comes from within and it is possible to achieve on your own (natural recovery), and treatment only facilitates this. Would you agree?

Appendix D: A Table of themes, concepts and sub-themes to emerge from the results

Category	Concept	Sub-category
Nature and development of addiction	Powerful nature Preoccupation with using Gradual progression Rapid changes-peak Rapid changes-to relapse	
Reasons/factors for use	Experimentation High availability Enjoyment Negative feelings Life problems Background factors	Initial
	Physical dependence Escapism from SM problem Barriers to change	Continued/excessive use
	Fail to cope with cravings Withdraw scripts too fast Complacency Other factors	Lapse/relapse
Negative effects of use	General deterioration Use-related illness/problem Personal consequences	Physical
	Negative feelings/emotion Suicidal/didn't care if dead General effects Psychological effects	Emotional/psychological
	General effects Loose relationship/contact	Relationships
	Isolation Less-socially active Changing social circles	Social
	Employment/jobs Neglect of practicalities Lack of responsibility Practical consequences	Practical

Process of realisation	Unaware of the problem Series of realisations Factors in realisations Clearer awareness Cont use despite awareness	
Behaviour change	Serious Non-serious/temporary Realisation of problem Importance of family/children Negative effects of use Treatment-cannot change alone Cont use rather than change Change rather than cont use Barriers to change	Types Influencing factors Decisional balances Barriers
Treatment	Various improvements Altering person/perspective Common experience Welcoming environment Counselling/group therapy Education re addiction Education re services Alternative therapies/activities Holistic approach Support Treatment structure Personal factors Accessed at rock bottom Feeling nervous at start Expectations-unsure Expectations-miracle cure Potential barriers Accepting abstinence Contradictions with services Negative experiences generally Negative experience of script	Positive effects Positive/important components Accessing/commencing treatment Difficulties of treatment Negative/unsuccessful treatment
Recovery	Treatment Personal requirements	Factors/requirements for recovery

	Complete abstinence	
	Other factors	
	Continued use of aftercare	Aids to recovery
	Strategies against cont use	
	Expectance/coping of cravings	
	Motivating factors	
	Rebuilding person/life	Changes in recovery