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# EXPLORING ABSTINENCE, RECOVERY, IDENTITY AND PERSONHOOD IN INDIVIDUALS ENGAGING WITH ADDICTION SERVICES

Section A: How is abstinence understood in recovery from substance dependence?

Word Count: 8000

Section B: "You've just gotta think in your mind everyone has a story… I feel like my story could help somebody else."

A narrative exploration of life story and identity for users of addiction services.

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Firstly I would like to thank my incredible participants. Sharing your life history and allowing me to tell your story made this possible. I hope we can change things together.

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## Summary of the MRP

**Section A:** This review aimed to understand how abstinence is understood in recovery by those who access substance misuse services. A systematic literature review was undertaken and fourteen studies were identified. These were quality assessed using the CASP quality analysis tool. Limitations of CASP as a tool were discussed. The fourteen studies were analysed using thematic synthesis and seven themes with ten sub-themes were identified. Themes were organised along a temporal path. Future clinical and research directions were discussed, as were strengths and limitations of the paper.

**Section B:** This empirical study aimed to explore how salience in identity impacts those who engage with substance misuse services. It aimed to explore this by eliciting the narratives of participants who used services and analysing their life stories using narrative analysis. Nine participants from two services in London participated in the study. The narratives were analysed following the method of Blom and Nygren (2010). A performative narrative analysis was undertaken. An overarching narrative was produced followed by a description and interpretation of life chapters. The performance of the narrative was discussed, as were strengths and limitations of the research. The paper concluded with clinical and research implications and future directions for research.

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## Section B

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How is abstinence understood in recovery from substance dependence?

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Supervisors: Professor Margie Callanan, Dr Derek Tracy

Accurate word count: 8000

**Note:** Tabular quotations are included in the word count and so are not labelled or formatted as tables in the APA 7th style to avoid confusion.

## Abstract

**Background:**

There is not an existing review of the role of only abstinence in recovery from substance dependence. Abstinence may be an important aspect of recovery identity and may direct effective community support.

**Aims:**

To undertake a qualitative systematic literature review exploring how abstinence is understood in addiction recovery, what type of service users are consulted, and whether there are common experiences among abstinent individuals.

**Methods:**

A systematic literature search was undertaken, and an assessment tool was used to assess quality (Critical Appraisal Skills Programme; CASP). The following databases were searched: APA, Pubmed, Proquest, JSTOR, Taylor Francis, Wiley, Sage, and NIDA. Fourteen studies were evaluated and thematically synthesised.

**Results:**

Seven themes and ten sub-themes were established. These were described along a temporal path. Participants began to realise the consequences of their addiction but had to reach rock bottom before making changes. The support from others was vital but this was not the case for everybody. Friends, family, services, and employers all provided obstacles to abstinence. Participants experienced self-transformation but recognised a continued journey with opportunities to grow.

**Conclusions:**

The impact of addiction on the lives of participants and the need for total separation from addiction by remaining abstinent was highlighted. The importance of feeling identified with

other service users and communities was emphasised. Future directions could focus on identity to explore how services and communities can best support individuals.

**Key words:** Addiction, abstinence, thematic synthesis, transformation, identity

## Addiction

Addiction is the term used throughout, with the understanding that substance dependence, abuse, and addiction are used interchangeably. Addiction definitions vary depending on problem conceptualisation; whether as primarily a biological, psychological, or social problem. DSM-5's "substance use disorders" is an umbrella term explaining intense activation of the brain reward system through maladaptive means (such as substances) which leads to "normal activities being neglected" (DSM-5, 2013, p.481) and continuation of use despite use-related problems. The World Health Organisation (WHO) explains addictive disorders are characterised by distress or a preoccupation with dependence-producing substances at the expense of other rewarding behaviours (World Health Organisation [WHO], 2022). For this review, addiction is defined as the reliance on alcohol or an illegal substance resulting in detrimental impacts on an individual's life.

## Abstinence

Abstinence is here defined as non-engagement in a behaviour, voluntarily or not (Fernandez et al, 2020). The encouragement of abstinence in recovery is most emphasised by the Minnesota model (Anderson et al, 1999), which suggests that addiction is a biopsychosocial, curable disease needing treatment. According to the Minnesota Model, abstinence is vital to recovery (Morojele & Stephenson, 1992) as eradicating the cause is necessary to cure the disease. There are some proponents of harm reduction rather than total abstinence: aiming to decrease use, not stop it (Mallett, 1995). The belief is that an abstinence-only approach is punitive and unrealistic. Harm reduction is a less blaming, more accessible way of reducing substance reliance. Harm reduction models do not have abstinence as a recovery goal; instead, individuals are provided safe environments and methods to use drugs to minimise risk of overdose and/or infection.

# Recovery

## Identity

Abstinence may be necessary for some people to view themselves as being "in recovery". Here, recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMSHA, 2012). To achieve this, some individuals may believe that they need a total shift in identity. They may need to remove any substance use and thus create a total disconnect from their drug-using past. Some research suggests that group identities within addiction services allow people to move from a seemingly pejorative "addict" identity to a "recovery" identity by identifying internal traits they feel align with this changed identity (Buckingham, Frings and Albery, 2013; Frings and Albery, 2015; Hanninen and Koski-Jannes, 1999).

## Community

This shift could be achieved through recovery capital (Granfield & Cloud, 1999; Webb et al, 2020) which can be understood as a set of internal and external resources that provide optimal conditions for people to remain abstinent, including appropriate housing, supportive social networks, and self-motivation and reinforcement.

Research emphasises the importance of community support in recovery and the need for treatment services to understand the person's external world. This makes it easier to identify how the community can continue to support people after leaving services (Haroosh & Freedman, 2017). Understanding parameters people set for their identity can also help to understand who someone's community is and how community can help. Research into social networks post-recovery (Beckwith et al, 2018; Best et al, 2016) found that community engagement and engagement with groups without a substance dependence identity as the norm was associated with recovery maintenance. It may be difficult to achieve this in a social grouping where substance use is still prevalent under a harm reduction system.

## Review rationale

There is extensive research on recovery in substance abuse disorder. However, the definition of recovery, and whether recovery consists of abstinence, harm reduction, or consideration without any change in substance use remains unclear. It is also unclear how these concepts are understood by those that are adhering to them, rather than other stakeholders such as services or clinicians. A lack of understanding of the importance of abstinence could mean a limited understanding of what could be helpful. A review of the literature considering how abstinence is understood and emphasised by those in recovery allows a deeper understanding of the experience of those who have been addicted to substances. Confusion among definitions is unhelpful for those who are help-seeking and may result in a lack of help-seeking for those who need it.

The aim of this review, therefore, is to analyse existing literature aimed at understanding how abstinence within recovery is understood by those with lived experience of recovery. The review question is: "How is abstinence understood in recovery from substance dependence among working-age adults"?

Questions considered within the overall review question are:

1. How is abstinence conceptualised and understood by substance users?
2. What type of users are consulted when discussing abstinence?
3. Are there common experiences of abstinence evident in more than half of studies?

## Methods

### Search strategy

A scoping exercise was undertaken to assist with development of search terms. Relevant databases associated with psychological and social sciences were identified using the CCCU-library-search tool and are outlined in figure 1. The database search was conducted between 1st and 20th October 2022. Due to there being no existing reviews of the question, there was

no date limitation. Boolean operators and the truncation symbol (*) were used to ensure the search terms remained focused on the research question while incorporating a range of search terms (table 1).

**Table 1.**

***Search terms for systematic search.***

| Elements of research question | Relevant search terms |
|---|---|
| How is abstinence | OR sobriety OR abstention OR non-use NOT harm reduction |
| understood in recovery from substance *use | OR "drug abuse" OR "drug misuse" addict* OR dependency OR alcoholism |
| among working-age adults | NOT children NOT adolescents NOT "older adults" NOT "young" |

The database sift was completed following guidance from *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA; Page et al 2021; figure 1). After duplicates were removed, studies were screened based on title, abstract, and full text. Screening was based on meeting all inclusion and no exclusion criteria. The full list of inclusion and exclusion criteria is in table 2.

**Table 2.**

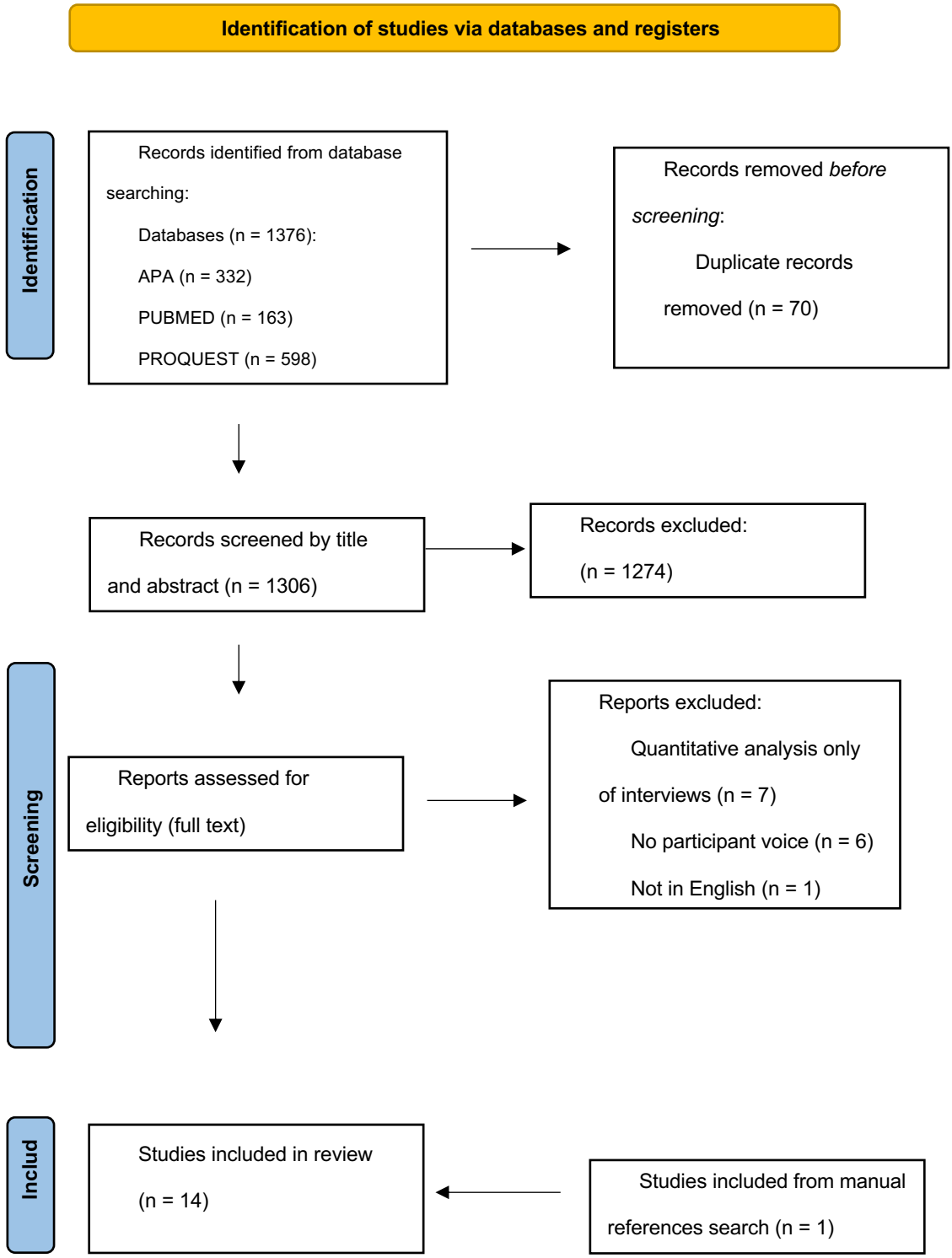
***A list of inclusion and exclusion criteria for systematic search.***

| **Inclusion criteria** | **Exclusion criteria** |
|---|---|
| Abstinent from a substance | Smoking |
| 18 - 65 | Older adults/children/adolescents |
| Qualitative | Quantitative or mixed methods |

| | |
|---|---|
| Own experience of substance dependence | No participant voice |
| | Not written in English |
| | Second-hand information |

**Figure 1.**

***PRISMA Diagram.***



**Topical boundaries**

Smoking was excluded from this review as although nicotine is an addictive substance, this question aimed to encapsulate those that would meet criteria for addiction services, which smokers would not. Studies were excluded where participants were abstinent but had never been addicted, and where participants were in recovery, but it was not made explicit that they were abstinent.

Any studies that did not use the words of those who were abstinent from substances were excluded from the research. This is because the scope of the review was to understand how abstinence was understood experientially for those who were abstinent. The viewpoints of other stakeholders such as professionals, social networks, or academics were excluded as their experience is likely to differ from those who are being directly asked about their abstinent recovery. The impact of abstinence in recovery for other stakeholders may be a relevant direction for future research.

**Thematic synthesis**

The studies were analysed using thematic synthesis. This was applied to the results and discussion sections and followed the approach set out by Thomas (2008), which codes findings line-by-line before organising these into descriptive themes. These descriptive themes are developed into analytical themes.

**Quality appraisal**

The Critical Appraisal Skills Programme (CASP; Long et al., 2020) was used as a critical tool for appraising study quality. The CASP checklists are designed to assist systematically assessing papers for their relevance, usefulness, and methodological strength. Studies are referred to throughout this review by their study number. Additionally, CASP examines researcher reflexivity and ethical considerations. The author judged studies to be of good

quality if 7 or more out of 10 items were present on the CASP checklist. A half point was awarded if the response was partial.

Table 3 gives a short summary of the fourteen studies reviewed. The CASP appraisal is outlined briefly below, with full checklists in Appendix one.

**Table 3.**

***Summary of studies included in review.***

| Study year | Study name | Authors | Participants | Summary | CASP Score |
|---|---|---|---|---|---|
| 2006 | Course of Recovery from Alcoholism | Venner, K. L.; Matzger, H.; Forcehimes, A. A.; Moos, R. H.; Feldstein, S. W.; Willenbring, M. L. and Weisner, C. | 16 USA ex-alcoholics | The transformational change that occurred in 16 ex-alcoholics who are part of AA. Understanding how this change happened and what it was. Most were already abstinent at the time of transformational change. | 7.5 (2 no, 1 partial) |
| 1990 | Alcoholic psychologists: Routes to recovery | Skorina, J. K.; Bissell, L. and de Soto, C. B. | 70 USA ex-alcoholics | Psychologists practicing or otherwise and their experience of being an alcoholic while in the job role. The journey of recognition and abstinence, how this was achieved, and what support was received. | 6.5 (2 no 3 partial) |

| | | | | | |
|---|---|---|---|---|---|
| 2013 | Therapy or threat? Inadvertent exposure to alcohol and illicit drug cues in the neighbourhoods of sober living homes (SLH) | Heslin, K. C.; Singzon, T. K.; Farmer, M.; Dobalian, A.; Tsao, J. and Hamilton, A. B. | 68 mixed substance abstinent individuals, inc. veterans, YP with dual diagnosis, SLH operators, SLH residents | People living in SLH's discussing the temptations to relapse and the motivators to remaining abstinent. An exploration into "avoidant" or "approach" ways to cope with triggers or cues for substance use – avoidant as keeping away from and approach as facing the triggers e.g. going outside at night. | 8.5 (1 no 1 partial) |
| 2021 | Familial Influences on Treatment and Substance Use Among Mothers Engaged in Prostitution | Murnan, A.; Ferber, M. F. | 15, USA, mixed substance abstinent | Interviews discussing what influences entering and staying in treatment and remaining abstinent. Families and romantic partners can directly or indirectly impact on abstinence. | 8.5 (1 no 1 partial) |

| | | | | | |
|---|---|---|---|---|---|
| 1993 | Coping Strategies of Abstainers From Alcohol Up To Three Years Post-treatment | Murphy, S. A. | 23, USA, mixed substance abstinent | There is a paradigm shift that occurs when people move into recovery. This is accompanied by a change in worldview and often with a change in identity. Women have had far more life events than men. Women are more likely to have partners who use, which impacts on their recovery. | 8.5 (1 no 1 partial) |
| 2011 | Recovery from Heroin or Alcohol Dependence: A Qualitative Recovery Experience in Glasgow | Best, D.; Gow, J.; Taylor, A., Knox, A.; & White, W. | 205, Glasgow, heroin, or alcohol | There were some differences between those recovering from heroin and those recovering from alcohol, such as heroin users seeing recovery as finite while alcohol users viewed recovery as ongoing. A positive change in identity and life having meaning were cited as useful ways of maintaining recovery. | 8.5 (1 no 1 partial) |

| | | | | | |
|---|---|---|---|---|---|
| 2012 | A Christian Faith-Based Recovery Theory: Understanding God as Sponsor | Timmons, S. M. | 10 USA African American ex-crack-cocaine or mixed substance abstinent | God as a sponsor is separate and distinct from the role of spirituality in AA. A crisis (often financial) or other "rock bottom" experience helped them to find God which has led them to remain abstinent. | 7.5 (1 no 3 partial) |
| 1983 | The Retirement Phase of Heroin Using Careers | Jorquez, J. S. | 29 USA mixed substance abstinent | People have different experiences that lead them to retire from heroin use. Some are voluntarily abstinent, some are mixed, and some are involuntarily abstinent. Some have a "naked lunch" experience which makes heroin use unattractive. Many want to become "model" citizens but some continue a criminal career even post abstinence. | 8.5 (1 no 1 partial) |

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|---|---|---|---|---|---|
| 2019 | Into the unknown: Treatment as a social arena for drug users' transition into a non-using life**.** | Robertson, I. E.; Nesvåg S. M. | 17 Norway mixed substance abstinent | A grounded theory approach to in-depth interviews of people abstinent or having made a significant reduction in use. Everything needs to change, including attitudes to the mind, body, and environment. Routine and structure are important. There is a new living of life as an abstinent person. | 9 (1 no) |
| 2020 | Sex, Drug, and HIV/AIDS: The Drug Career of an Urban Chinese Woman | Wang, X; Liu, L. | 1 China heroin abstinent | A woman fell in love young with a man from a rich family who was older. There was some misogyny and negative cultural attitudes towards women. She ran a successful club and became addicted to heroin to be thin and to socialise. When her fortunes changed, her addiction became a problem because she could no | 7.5 (2 no 1 partial) |

| | | | | | |
|---|---|---|---|---|---|
| | | | | longer afford it. She continued using until she became unwell from HIV/AIDS and with medical and psychological support was able to quit. | |
| 2019 | Native Americans resolve alcohol use disorder: 'Whatever it takes or all that it takes' | Venner, K. L.; Hagler, K; Cloud, V. and Greenfield, B. | 55 Native Americans in the USA, Alcohol abstinent | Participants spoke about motivation for stopping drinking and actions taken to stop drinking. Motivations included interpersonal, legal, and medical motivations. Actions included treatment groups and spirituality. Some engagement barriers were discussed, such as confidentiality. | 9 (2 partial) |
| 2016 | Christianity in Narratives of Recovery from Substance Abuse | Lund, P. | 21 Finland mixed substance abstinent | All participants had been in recovery for at least three years. Four story types were established: the first was one of repeated attempts at sobriety; the second was | 9 (1 no) |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | sobriety being established and then a softer version of Christianity allowing for less self-punishment; the third is a story of letting go of shame; and the fourth is a story of a life-changing connecting moment with God. All saw Christianity as instrumental to their recovery. | |
| 2020 | Parents' experiences of substance use problems, parenthood, and recovery within the 12-step movement | Heimdahl V. K. | 8 Sweden mixed substance abstinent | | Parents spoke about their motivations for abstinence and their relationship with their children. Most participants hit a “rock bottom” independent of their children. Some did not have children until after achieving abstinence. some spoke about the “addictive gene” and how they would discuss addiction with their children. They spoke about change | 9 (1 no) |

| | | | | | |
|---|---|---|---|---|---|
| | | | | (identity transformation) through abstinence. | |
| 2021 | The Road to Recovery from Addiction: A Qualitative Exploration of Motivators and Challenges to Achieving Sobriety in Recovery Housing | Parker, K. A.; Roberson, L. Ivanov, B.; Carter, R. and Riney, N. | 31 USA male mixed substance abstinent in recovery homes | People living in recovery houses discussed being able to start a new life through abstinence with the support from peers in the recovery house. They talked about having hope for the future, despite the temptations and challenges that come from the external environment, including friends. The topic of transformation was also discussed, as a turning point where people realise lifestyle changes are necessary. | 8 (2 no) |

Note: The following acronyms have been used: AA: Alcoholics Anonymous. A support group that follows 12 steps to promote and achieve abstinence

YP with dual diagnosis = young people with dual diagnosis of substance dependence and mental health difficulties

SLH = sober living homes. Housing where a condition of living there is remaining abstinent

## Results of appraisal

Only Jorquez (1983) and Venner et al (2019) considered the relationship between researcher and participant (partially). Consequently, no studies were judged to achieve all ten items. Seven studies were not deemed by the author to give a sufficiently rigorous account of data analysis. Five of the studies did not discuss ethical considerations sufficiently and four gave limited justification for the value of the research. The CASP analysis for Skorina et al (1990) relied on inference rather than explicit information which impacted the score. While the researcher drew some valuable conclusions for the role of colleagues in supporting other professionals with addiction, the study reporting was slightly weaker than other papers. However, it was included as it was the only study consisting of a single professional body (psychologists) and considering the impact that profession may have on achieving recovery.

It is also worth noting that CASP has its own limitations. Given that the centring of whiteness in research is a known issue (Camacho & Echelbarger, 2021), it is unfortunate that CASP neglected to appraise the potential impact of researcher or participant race on the research. Currently, this reflection could be applied to the CASP question regarding the relationship between researcher and participant, but only if the appraiser highlighted it. CASP questions are broad and unspecific, resulting in a reliance on the skill of the appraiser to adequately interrogate the papers.

### Description of papers' characteristics

#### *Aims*

All but one study clearly set out the aims of the research within the introduction, with research questions supported by literature. Skorina et al (1990) presents an 'issue' and it is clear from the rest of the study that this 'issue' is being explored, but it does not explicitly state an aim.

### *Methodology*

Qualitative methodology appeared appropriate for all studies. Two studies may have benefitted from a slightly different approach. Skorina et al (1990) used structured interviews where semi-structured or open may have elicited more information. However, structured interviews fit with the refined focus of their study. Parker et al (2021) could have answered their research questions with questionnaires rather than interviews. However, they balanced focused interview questions with rich responses by using semi-structured interviews.

### *Design*

Wang & Liu (2020) and Skorina et al (1990) did not describe their method of analysis and Best et al (2011), Heslin et al (2013), Murphy (1993) and Venner et al (2006) described coding and analysing interviews with varying degrees of detail. Murphy (2021) and Venner et al (2006) attributed this to a hermeneutic approach, but not a particular form of analysis, while the other two did not specify an approach or analysis. The remaining eight studies specified their analysis: Parker et al (2021) and Venner et al (2019) thematic, Heimdahl (2020) and Lund (2016) narrative, Murnan & Ferber (2021) and Jorquez (1983) inductive-content, and Timmons (2012) and Robertson & Nesvåg (2019) grounded theory.

### *Recruitment*

Recruitment strategies generally appeared appropriate, with researchers recruiting from their local services. The sample size ranged from a single case study to 205 participants. Five researchers commented on the impact their recruitment strategy may have had on their demographic spread. Three of five male-dominated studies commented on the lack of women but did not reflect on how their recruitment strategy could have exacerbated this issue.

### *Demographics*

Studies were selected on the basis that all participants were abstinent and able to share how they understood the role of abstinence in recovery. Of the fourteen studies, nine were set

in the USA, two in the UK (England and Scotland), and one each in Sweden, Norway, Finland, and China. Five samples were male-dominated. The case study was of a single woman, one study was male only, one was females only and all other studies were mixed. One study only spoke to African Americans and one study only spoke to Native Americans. Purposive sampling was utilised for these two studies. No other studies required a particular ethnic origin but were predominantly white. One researcher commented on the ethnicity of participants.

***Data collection***

Two studies specifically focused on the relationship between recovery houses and abstinence. Recovery houses are dwellings where a condition of housing is sustained abstinence. All studies attempted to understand factors and motivations in achieving abstinence, but there was variation in hypotheses and therefore interview direction depending on the focus of the study. Two studies focused on the role of religion in abstinence, two studies focused on parenthood, and the rest focused on exploring a range of factors that led to achieving and maintaining abstinence.

***Researcher bias***

No studies adequately interrogated potential researcher bias in the selection or exclusion of participants or data extraction and analysis. One study noted that there was only one researcher from the same ethnic background (Native American) as the participants and reflected on the impact this may have had. One study noted the lead researcher was Chicano but to explain why almost half of participants were Chicano, not to reflect on the potential impact (Jorquez, 1983). No other researchers reflected on any of their social graces (Burnham, 1993) and the impact of these on their research.

***Ethics***

All studies specified a semi-structured or in-depth interview format. In all studies, the material could be deemed sensitive. One study explicitly discussed ethical considerations. This study reflected on the potential distress caused by the interview and steps taken to minimise this.

## Review of the papers

### Review Methodology

The studies were analysed using thematic synthesis (Thomas, 2008). This involved in-depth reading of all studies which were coded line-by-line, creating a total of 94 codes (Appendix 2). These codes were cross-coded between studies to check for duplicates, resulting in the removal of 14 codes. This was completed manually and then imported into *NVivo* 12 software for added rigour. The studies were reread in depth and coded using NVivo's *nodes* system. These nodes were grouped together into descriptive themes and then grouped into primary and secondary themes. This left six primary analytic themes (Appendix 3). These were deemed most salient due to the number of studies they appeared in, and the number of references made to them, plus relevance to the research question.

### Results

Please see table 4 for the results of the thematic analysis. Quotes from the text exist in tables below each theme and sub-theme to enable them to be read independently. Some quotes are included in text to further elucidate interpretations. Additional quotes are in Appendix four.

**Table 4.**

***Themes and sub-themes discussed in thematic synthesis.***

| Theme | Meaning | Sub-theme(s) |
|---|---|---|

| | | |
|---|---|---|
| “Why did I want to . . . add to the tragedy?” | Realisation there was a need to change | - Sacrifice |
| “Rock bottom” | Reaching the lowest point before beginning the recovery journey | - Wanting to die<br>- An identifiable “turning point” |
| "Just say the word, I'll take you”. | Support from others encouraging the road to recovery | |
| “I did not get any support, not from my parents or from anyone. I went back to drinking.” | Being failed by those who are meant to support you | - “First comes the man, then comes the relapse.”<br>- “The confidentiality it just, gosh it wasn't there” |
| “Transformational change” | A change in self, in relationships, in priorities, in understanding. Change has been total. | - “Please mom, just do it for me.”<br>- Relationships with God<br>- “Look, temptation will come at you at all angles.” |
| “I have to be aware and beware” | A level of self-awareness that identifies individual and environmental protective factors and triggers. | - “I see myself as a different person, a new person, a better person.” |

| | | |
|---|---|---|
| | | - "Nothing is free from the memory of using." |
| "If I could just save one life, it's worth it." | A reflection on life after addiction. | |

Themes were organised along a temporal path. Prochaska & DiClemente (1983) describe a cycle of change that appeared to be present in client experiences. Participants began in a pre-contemplation phase where their substance was the all-encompassing, most important aspect of their lives. In time, they began to understand the cost of their addiction (contemplation). They had made reckless or impulsive decisions, sometimes endangering themselves or others. They began to understand they had a problem and accepted the need for change (preparation followed by action). They encountered obstacles along the way, which included the behaviour of loved ones, consequences at work and environmental pressures on sobriety. Sometimes this impacted their sobriety and lapses occurred. Despite this, they maintained a belief in the importance of abstinence and changed their lifestyles and social networks to fit this new self (maintenance).

Participants reached a point of "recovery" by changing their environment and social networks. For some participants, a "higher power" was involved. For all, the journey was deeply meaningful. Bar one study, all participants had reached abstinence. This study (Jorquez, 1983) required a minimum of two years abstinent but allowed those with occasional, controlled opioid use to be part of the study. Despite abstinence, all participants understood that while their progress was remarkable, the journey continued, and temptation and triggers may remain.

**“Why did I want to . . . add to the tragedy?”**

Participants described the negative consequences of addiction that eventually led to their total abstention. Over time, they moved into a contemplation phase where they started recognising this was not a life they wanted. In Skorina et al (1990), participants made risky choices while under the influence of alcohol, personally and professionally.

In other studies “negative consequences, rather than positive driving forces” (Heimdahl, 2020) created motivation for abstinence. Participants saw their current behaviour as destructive and cited their impact on others as a core reason for abstinence.

Participants appeared to have begun to understand the consequences of their actions, thus reducing the allure of being drunk or high. They appeared to want more control over themselves, their behaviour, and their future. This may not have been the final step that led to abstention, but it was a step closer as participants begun to recognise an incongruence between their behaviour and their values or ideals.

| Quote | Study |
|---|---|
| “Impaired while working…” (psychologist) | Skorina et al (1990) |
| “I bought a house on my lunch hour while under the influence” | Skorina et al (1990) |
| “I realized my behaviour was appalling” | Heimdahl (2020) |

***Sacrifice***

While uncommon, two participants noted enjoyable aspects of drug use, potentially indicating why stopping was difficult. One participant noted “using heroin was regarded as a symbol of high socioeconomic status” (Wang & Liu, 2020) while others reflected on the

enjoyment of a "heroin high" (Jorquez, 1983). For them, abstention may remain somewhat sacrificial, or may resemble what they have lost. In both cases, any positives did not outweigh being "unable to stop" (Jorquez, 1983) or "living in hell" (Wang & Liu, 2020).

**"Rock bottom"**

To reach a point of help-seeking, people had to hit "rock bottom". It was mostly emotional or health-related problems that led people to realise the damage their addiction had caused. Emotionally, people had damaged their relationships: "told too much to casual acquaintances about an aborted child and hurt its father and others" (Skorina et al, 1990) or various aspects of their life: "dropping out of school and/or losing employment, … broken friendships, partner and/or family relationships" (Robertson & Nesvåg, 2019). For some, this had tragic consequences: "she gave birth to a baby who died quickly after three days." (Wang & Liu, 2020). Addiction took precedence and this led to consequences that could devastate participant lives. Their lifestyle was described as "chaotic" (Best et al, 2011) and often resulted in financial crises or criminal behaviour (Best et al, (2011); Timmons, 2012) to finance the addiction. Abstinence meant realising rock bottom was reached and a desire to abstain from its cause.

For others, their addiction led to dangerous threats to life such as HIV (Wang & Liu, 2020), intensive care (Parker et al, 2021), or fleeing for their life (Jorquez, 1983). Abstinence was lifesaving. The consequences of addiction were beginning to affect all aspects of participants' lives.

| Quote | Study |
| --- | --- |
| "Living in agony and fearing the life-threatening illness, Lydia, for the first time, | Wang & Liu (2020) |

| | |
|---|---|
| felt that she could no longer live like that and decided: “I have to quit!” | |

***Wanting to die***

For some, “rock bottom” was the ultimate attempt on their life. These attempts were intentional, resulting from the despair of addiction and its consequences, or unintentional. Unintentional suicide attempts stemmed from people reflecting that they were slowly “killing themselves” through addiction. Until that time, they did not consider their future.

| Quote | Study |
|---|---|
| “Looked for “one big shot to die, to be with the baby.” | Wang & Liu (2020) |
| “I had to stop. It was either that or die.” | Best et al (2011) |
| “I remember being dead in this gray place. I woke up with this guy saying, “You stupid bitch! We had to rob three drugstores to keep you alive!”” | Jorquez (1983) |

***An identifiable “turning point”.***

Reaching “rock bottom” became a “turning point” in the lives of participants where they recognised change was necessary. Some people reflected on their life direction compared to the life they wanted. These people had “had enough” of addiction which meant that moderate or minimal use could not work. Harm reduction meant relapse. For these participants, they could not use substances in a non-harmful way. One participant lost his wife to an overdose and realised his life was more important than heroin. Abstinence became their final chance at

redemption, to create a life for themselves worth living: “my last chance to do things differently compared to what I’ve done before” (Robertson & Nesvåg, 2019).

| Quote | Study |
|---|---|
| She died in my arms. … When she died and I went through the mourning, the grief, the loneliness, I found out I loved me more.” | Jorquez (1983) |
| “Hanging with these criminals, and doing these criminal things, putting myself in these situations – it will kill me.” | Heimdahl (2020) |

**"Just say the word, I'll take you”.**

Abstinence was not easy to achieve alone. Ten studies emphasised how vital support from others was. Some participants explained that their friends and family helped them enter recovery.

Other participants explained that peer support was vital for maintaining abstinence. Having people who continued to remain abstinent and empathise with the participant while giving support and advice to remain sober was incomparable. It helped participants to transform their social networks and surround themselves with people who would enhance their recovery journey rather than jeopardise it.

People offered emotional and practical support to help people maintain abstinence. Some employers were credited with offering childcare to participants while they engaged in treatment. In other cases, “people helped [her] conquer her shame” or provided positive “role models” (Best et al, 2011, Parker et al, 2021) that helped participants move into abstinence by

giving them aspirations or reminding them of their self-worth, giving them an alternate future.

| Quote | Study |
|---|---|
| "My dad said, 'we'll go through this [recovery] together." | Venner et al (2019) |
| "A key factor in sustaining their recovery was mixing with people who did not use alcohol or heroin, "keeping sober company."" | Best et al (2011) |
| "Spouses, partners, family members, friends and colleagues were identified as sources of support". | Murphy (1993) |

**"I did not get any support, not from my parents or from anyone. I went back to drinking."**

Conversely, in nine different studies, participants reflected how they had been failed by those meant to support them. For some, friends and family actively encouraged addiction. This may have been because they were addicted themselves, or because of what they gained from the participant remaining involved with drugs. Two participants described how a trusted person used their addiction to exploit them for sex work: the mother of one and partner of another. This meant that abstinence was not seen as a realistic goal. There was nobody who encouraged abstinence, led participants to believe that abstinence was achievable for them, or provided participants with alternatives to addiction and the accompanying lifestyle. How

could they when they maintained that lifestyle and, in some cases, introduced participants to it?

Some participants found that family members struggled to connect with them when they were sober and struggled to respect the boundaries that they set to maintain sobriety. In other cases, misguided attempts at second chances became leniency and meant that addiction continued without consequence. Lydia (Wang & Liu, 2020) describes police leniency that allowed her to avoid arrest repeatedly. Skorina et al (1990) describes the lack of accountability given by employers and colleagues that allowed addiction to continue. Across many studies, participants found that their family and friends were unsupportive of their attempts to remain abstinent, and this placed them in a predicament: relapse, or maintain sobriety but lose all social networks.

It seemed particularly difficult for women to remain abstinent. They were more likely to have partners selling or using drugs and more likely to be expected to return home from addiction treatment early if there was a family emergency or crisis. Four studies noted that women reported more significant life events during their recovery journey than men. Some women felt their sobriety impacted negatively on their relationships, and therefore relapse maintained equilibrium with their social network (Murnan & Ferber, 2021). The authors noted that some women used drugs to feel close to their family, as they had often grown up in homes where drug use was common.

| Quote | Study |
| --- | --- |
| "I could say that my mom human trafficked me. I mean, she's the one that introduced me to that part of life." | Murnan & Ferber (2021) |

| | |
|---|---|
| "The police officers caught her buying drugs four or five times, but every time, as soon as they realized she was pregnant, she was released immediately" | Wang & Liu (2020) |
| "Once back home, women would relapse in the presence of their family members… to assimilate back into the family norms". | Murnan & Ferber (2021) |
| "Her family reportedly cut her off for "5 or 6 years" because she set this boundary." (Not bring her alcohol or visit her drunk) | Venner et al (2019) |

**"First comes the man, then comes the relapse."**

Relationally, there were many negative influences on participants throughout their recovery journey. Sometimes these were unintentional. For example, some co-workers did not understand that people felt they needed total abstinence, so would offer them alcohol because their substance of choice was heroin (Venner et al, 2019), leading to uncomfortable situations. One participant described how heroin use was suggested for weight loss (Wang & Liu, 2020).

Women "had partners who were drinkers who encouraged them to drink" (Murphy, 1993) which would negatively influence their abstinence. Commonly used phrases like 'first comes the man, then comes the relapse'" (Murnan & Ferber, 2021) indicate the negative impact of male partners (in these studies) on maintaining abstinence. Their relationships with partners often mirrored the relational patterns in their family of origin. Relapse may have reminded them of generational patterns that made sense. Gender and power are therefore important dynamics to consider when reflecting on consequences of abstinence for different groups.

| Quote | Study |
|---|---|
| "Being around old people, places, and things. Being around my family. Stressful situations that would make me go use again." | Murnan & Ferber (2021) |

***"The confidentiality it just, gosh it wasn't there."***

Some participants were failed by services and individuals in their attempts to maintain abstinence. Some participants felt services did not fit for them and felt marginalised within the group. Having already felt marginalised by society due to their substance use, being marginalised in a support group may have been detrimental for engagement. Other participants did not feel their information was confidential, which may have indirectly impacted their abstinence by resulting in them disengaging from support groups.

Services could fail people just by their setup. In Wang & Liu, (2020), the government initiatives were ineffective and relied on a three-tiered system whereby the second and third tiers contained forced detox in a treatment centre. However, the participant would relapse as soon as she left the centre without adequate support for abstinence post-discharge.

"Few [services] allowed children to attend treatment" (Murnan & Ferber, 2021) which meant that it was difficult for parents to identify realistic treatment options and take the first steps into abstinence, an issue disproportionately affecting women. Others found that those who were meant to support them hindered their path to abstinence. One individual spoke to an employer about their drinking and was "promptly fired" (Skorina et al (1990)) while another found that "family members did not always understand the desire to be sober" (Murnan & Ferber, 2021), making abstinence harder.

| Quote | Study |
|---|---|
| "You would see your friends in AA… and then they would go back and tell everybody". | Venner et al (2019) |
| "One participant disliked a meeting because "there was just a bunch of old white men". | Venner et al (2019) |
| "National institutions did not have an efficient tool to help drug users achieve and especially maintain abstinence." | Wang & Liu (2020) |

**"Transformational change"**

This was a key word for many participants, who felt that they experienced a "transformational change" (Venner et al, 2006) in recovery. Many studies used the words "transformation" or "change" in the context of these changes being permanent. Ten studies explicitly referenced individuals experiencing "change" as a totally new sense of self. Studies described this change as a "paradigm shift" (Murphy, 1993) where participants' entire lives had transformed. At times, "the drug user" became an absolute otherness…" (Wang & Liu, 2020) when participants discussed their drug career. Participants seemed to actively try to separate themselves from that life, as if that person no longer existed.

The change allowed people to start the life that they wanted to lead. Some people found that this made it easy for their drug use to stop. "…like a switch that went out, took an injection and got nothing" (Best et al, 2011) and enabled them to shed their old environment: "They were who I identified with as the old me and old me had to die to become new me…" (Murnan & Ferber, 2021). This gave participants a resolve they had not experienced before.

This was mostly positive, but not always. For one participant, his transformational change began with tragedy: his wife's death from a heroin overdose, which allowed him to focus his energy on himself and his children.

For all participants who experienced this transformational change, abstinence was understood as a new beginning. They could repair relationships and re-enter the world. Many people desired to be "conventional citizens" (Jorquez, 1983) and felt this was their opportunity for "redemption" (Lund, 2016). It was not always easy. Participants noted that they "didn't know myself as an adult person", felt like they "haven't moved anywhere" and were "learning to live again" (Robertson & Nesvåg, 2019) by entering this new world of sobriety.

| Quote | Study |
|---|---|
| "… Suddenly experienced an event that changed his whole life in a moment." | Lund (2016) |
| "All that shit fell off, a new life began…" | Lund (2016) |
| "Up until the time she died, I believed that I needed the dope… I found out I loved me more… Her death made me realize who I was." | Jorquez (1983) |

***"Please mom, just do it for me."***

Participants in many studies noted how their relationships with their children were impacted by substances. The word "guilty" was frequently referenced when discussing their

children (Best et al, 2011; Heimdahl, 2020; Venner et al, 2019) although some had conflicting emotions about this. One participant “sometimes viewed her son as an obstacle to her ability to live the way she then wanted to” (Heimdahl, 2020). Now sober, she felt intense guilt about this as she felt it impacted on her relationship with her child.

Where guilt was not explicitly mentioned, there was still a strong sense of shame from participants about how their children may have viewed them while they were using. Participants reflected feeling that they had disappointed their children. They considered how their children had shown them that they knew about their addiction, and how this prevented them from being the parents that they wanted to be.

For others, the impacts on their children were undeniable, with some “begging” their mothers to seek treatment or giving them ultimatums: “She absolutely told me that if something didn’t change, she was done with me” (both Murnan & Ferber, 2021).

More positively, participants cited positive relationships with their children resulting from their abstention and cited their children as a reason to remain abstinent. Becoming the parent they wanted and believed their children deserved was an opportunity they could not sacrifice by relapsing.

Participants reflected on being able to put their children first now, and there was a sense of hope for those who had not yet repaired their relationship with their children that this was now a possibility. For others, missing out on “pivotal moments” (Murnan & Ferber, 2021) or losing others that they cared about jolted them into the realisation that they did not want, or possibly could not tolerate, another loss.

| Quote | Study |
| --- | --- |
| ``… children (ages 7 and 9) imitated my stagger, saying, 'Look, Mother, we're drunk.' | Skorina et al (1990) |

| | |
|---|---|
| "… some cited their improved relationships with their children as essential to sobriety maintenance." | Venner et al (2019) |
| "…Owed it to her son to seek treatment after his father died from an overdose." | Murnan & Ferber (2021) |
| "I stop and think about my baby, and I look at him. . . and I stop thinking about dope." | Jorquez (1983) |

***Relationships with God***

For some, the development of a relationship with God was a character-defining change. Having a sense of something bigger than themselves helped them to become and remain abstinent. Some felt their prayers were answered at a time of desperation.

For others, it was not the communication with God but a communication with nature and the subsequent connection with a higher power that inspired them to begin the abstinent chapter in their life. Abstaining provided other opportunities for fulfilment as substances were no longer the priority.

| Quote | Study |
|---|---|
| "I said Father God, if you would only help me out this situation I will never, ever touch a sip or taste a drink, a droplet of liquor again, I promise you" | Heimdahl (2020) |
| "… What am I doing? God did not put me here on this earth to be using heroin!" | Jorquez (1983) |

| | |
|---|---|
| For the first time I felt guilty about being a user." | |

***"Look, temptation will come at you at all angles."***

Participants explained the temptations of being offered drugs on the street and feeling nervous about going out after certain times. Others discussed their frustration when they went to AA meetings and saw people drinking straight afterwards. These people tried to remain abstinent by distancing themselves to prevent temptation.

Some participants noted the importance of testing yourself by resisting temptation to prove you had control. This seems to suggest that for some, abstinence cannot be "real" unless it has been tested. This may fit with religious ideas of being tested and resisting temptation. It may be that programmes such as 12 step that promote abstinence also implicitly or explicitly promote being tested, as they have religious undertones. It may be that to legitimise the abstinent, character defining identity shift participants need to demonstrate to themselves that they can resist when substances are easily accessible, maybe believing "cue exposure could increase one's ability to overcome craving" (Heslin et al, 2013).

This may serve to increase their self-confidence and faith in themselves that they can maintain sobriety. In other cases: "… failure to maintain her faith and sobriety made the situation even worse: she felt that she had missed her opportunity and was doomed to misery" (Lund, 2016). This can result in lasting setbacks.

| Quote | Study |
|---|---|
| "…after winning the conflict over whether or not to fix, often felt relieved and | Jorquez (1983) |

| | |
|---|---|
| joyous because they had successfully negotiated a dangerous situation". | |
| "There was people who would ask me just off the street" [if they wanted to buy drugs] | Heslin et al (2013) |

**"I have to be aware and beware."**

Becoming abstinent in recovery both predicated and resulted in a newfound self-awareness. Participants now compared themselves to those close to them to give them reasons to change, not stay the same. This was not predicated on the support they received to abstain.

Some of these experiences were described as "naked lunch" experiences (Jorquez, 1983). This is an acute self-awareness experience where people noticed the actions they were taking – often actions that did not align with their moral values – to maintain their addiction. Participants began to separate themselves from their addiction. The "naked lunch" experience allowed them to recognise aspects of themselves they had been masking or hiding. This was sometimes painful, as it came with a sense of enlightenment for what they had missed, but also provided them with direction for how to move forward.

| Quote | Study |
|---|---|
| "I seen a lot of my friends that had died from it . . . if I didn't quit I would have been in the same position as they were". | Venner et al (2019) |
| "As of right now, drug use is not an option. I don't want to die." | Parker et al (2021) |

| | |
|---|---|
| "Successful abstainers stated: "I've learned a new self – I used to be afraid of myself;" "I've learned to like myself; ""I enjoy myself;" | Murphy (1993) |
| "It hurts to start living again when you've never done it before". | Jorquez (1983) |

***"I see myself as a different person, a new person, a better person."***

Many participants had a negative self-image that they became aware of when they recognised a need for change. Abstinence allowed them to create a new, positive self-image. Lund (2016) discusses the concept of shame, suggesting that a participant was unable to articulate the word but experienced shame for many reasons, including how she had behaved and how she was treated by others. This encouraged her addiction to depress those feelings. Other participants also referred to shaming experiences.

Participants were able to 'accept themselves' and be accepted by others, which helped them on their recovery journey. Their self-image improved with the recognition by themselves and others that they were good enough. They described a feeling of contentment with who they were now. This was an active process of self-improvement.

In studies, some created a new self, whilst others returned to their "before"; a time prior to addiction. Although not mentioned explicitly, it seemed unlikely that a harm reduction approach would allow restoration of sense of self, as the substance would still be part of their lives.

| Quote | Study |
|---|---|

| | |
|---|---|
| "Once I moved and changed jobs, the picture changed. I could see how normal human beings are living..." | Lund (2016) |
| "I start to become myself again, become a person that I can like." | Robertson & Nesvåg (2019) |
| "I've come to realize that what I do is important". | Jorquez (1983) |
| "Several participants who were interviewed indicated that they felt their identity had been "spoiled" by their addiction and [wanted] to restore their sense of self." | Best et al (2011) |

***"Nothing is free from the memory of using."***

Alongside this self-awareness came a knowledge of their own triggers and how to minimise the risk of compromising abstinence. Participants acknowledged that the influence of others, stressful life events, and a lack of structure all interfered with their abstinence if allowed.

"Bill" (quoted below) recognised that he needed to maintain structure and routine to prevent the embodiment of old patterns resulting in relapse. This is echoed by many other participants describing feeling triggered by old environments or stimuli. For example, "going to the store" (Robertson & Nesvåg, 2019) or auditory stimuli such as the click of a lighter (Timmons, 2012). Participants had to fight against everyday circumstances to maintain

abstinence. The strength required to do this may have made abstinence even more meaningful to these participants, as they successfully won a daily battle.

For other participants, their triggers were indirect difficult consequences of abstention. They noted that since abstaining from alcohol, there was weight gain ("twenty-five pounds") and isolation (Murphy, 1993). It is important to note that without opportunities to create social capital with supportive, alternative social networks (Webb et al, 2020) isolation and loneliness may increase the risk of relapse. For many participants, addiction was a way to cope with the world and without it they had to develop new coping strategies. For these participants, abstention came with costs.

| Quote | Study |
|---|---|
| "There's drug dealers that follow me right out of a meeting, man…" | Parker et al (2021) |
| "More than 50 percent reported major life events during this period such as deaths of family members, divorce, being fired at work and loss of best friends" | Murphy (1993) |
| "Bill felt a strong association between unconventional daily routines and rhythms and his previous drug related life." | Robertson & Nesvåg (2019) |

**"If I could just save one life, it's worth it."**

Becoming an abstainer was a character-defining moment for many participants across studies. Rather than just a sense of self-awareness or improved self-image, their identity

became defined by their abstinence. For others, abstinence was a tool that allowed participants to define themselves on their own terms, not by their addiction.

Additionally, some participants reflected on next steps. They felt that being able to "give back" and help others was another way to delineate this new chapter. Rather than a person who put their substance above all else, they were able to support others in their journey, become role models for others who were struggling, and take on roles that made them proud.

Although only present in one study, which specifically focused on parenthood, it felt important to present the view that many participants in this study noted the "genetics" of addiction. Some parents felt due to their personal experience they were better able to identify this if it arose as an issue. Other parents felt that they were cautious not to overemphasise the risks of addiction and restrict their children from "normal" substance use. It was interesting in this study that participants seemed to consider addiction as part of their genetic code and therefore inseparable from themselves. This may strengthen their resolve to abstain, as they believe that addiction is riskier for them than others. It may also increase their pride in abstention for the same reason. They could protect themselves and their children by recognising their vulnerabilities and safeguarding against them.

| Quote | Study |
|---|---|
| "Some women described treatment as "learning a new life." | Murnan & Ferber (2021) |
| "What helped her deal with shame was receiving permission to exist." | Lund (2016) |
| "If I could just save one life, it's worth it" | Parker et al (2021) |

| | |
|---|---|
| "Changing from drug addicts to recovering addicts" | Robertson & Nesvåg (2019) |

## Discussion

The present study aimed to critically review literature on how abstinence is understood in recovery for working-age adults. It aimed to answer three questions.

**Which users are consulted when discussing abstinence?**

The fourteen studies included in the review interviewed participants from six different countries. Participants interviewed were mostly white, bar three studies. One study was half Chicano (which reflected the primary researcher's accessibility to this group), and two studies specifically recruited minority groups (Native Americans and African Americans). Of the fourteen studies, two were particularly focused on the impact of religion on recovery, two on parenthood, and two on recovery housing. The others were focused on recovery more generally. Participants used a range of substances, but the most frequently used were alcohol and heroin.

**Are there common experiences of abstinence evident in more than half of studies?**

Despite these differences, common threads were found across studies. The relationship between gender and addiction was noted in many of the studies. Female identity correlated with more significant life events, more pressures to leave recovery early and a higher possibility of romantic or familial relationships that were triggers for relapse. This may have been due to intergenerational patterns of addiction, stressful situations, or active encouragement to relapse by close social networks. Women were often lacking the networks, resources, and opportunities (recovery capital; Granfield & Cloud, 1999) to maintain abstinence. Reaching "full potential" (SAMSHA, 2012) is difficult without maintaining environments and networks that supported recovery, as participants noted (e.g. Murner &

Ferber, 2021). Community engagement, peer support groups and activities are evidenced predictors of recovery (Best & Lubman, 2012). For participants this was often through housing or peer networks, such as SLHs.

**How is abstinence conceptualised and understood by substance users?**

Most participants noted a character defining "turning point" or change that predicated their abstinence. This often occurred after a "rock bottom" event or crisis that demonstrated to them with finality that the costs of addiction outweighed the benefits of the substance and addiction needed to be eradicated from their life completely, as per the Minnesota Model (Anderson, 1999). Participants reflected on the need to reach this point of their own volition, although many noted the support of others (as in Haroosh & Freedman, 2017) as instrumental in achieving and maintaining abstinence. This would suggest that, at least for these participants, a harm reduction approach (Mallett, 1995) would be an ineffective way to maintain sobriety. Abstinence in recovery was defined in these studies as a complete separation between the individual and the substance. A new or changed identity created an individual distinct from who they were when using (Kellogg, 1993).

It is important to note, however, that these participants are already in recovery and already abstinent. Abstinence has allowed them to live their life by their values and highlight positive internal traits (Frings & Albery, 2015). Interestingly, in one study there were participants who the researchers stated still live a "deviant" (chronic unemployment or alcohol use) or "criminal" lifestyle (Jorquez, 1983). Despite this, their views did not differ from the rest of the sample regarding the importance of abstinence (in this case from heroin) for character and self-esteem, despite one being a heroin dealer. This highlights the commitment to abstinence as a concept, but future research may wish to further explore non-abstinent people who view themselves as "in recovery" to explore alternative perspectives.

**Limitations**

The author only synthesised a limited number of studies from a limited number of countries. While this was necessary for the scope of the review, it decreases generalisability across countries.

Although across the studies there were a range of ethnicities and socio-demographic statuses considered, there were still only three studies that elevated the perspectives of non-white individuals, one of which was a case study. Non-white voices are rarely prioritised in research, often due to the dominance of white researchers (Baffoe et al, 2014) and in these studies, very little space was given to considering issues of race and non-whiteness, except for one reflection in one study: "Had I been in a rehab with a white, black, other people . . . I probably might use some racial biases regarding their problem. And I'm sure they may do that to me" (Venner et al, 2019).

Additionally, this review was informed by my bias about what I found important. Without a second researcher, I selected the research question based on interest and selected final studies based on how well I felt they matched selection criteria. I coded and analysed the studies before creating themes. A different researcher may have written a different review.

**Clinical and research implications**

Participants across most studies noted the "fit" of services or support groups and the existence of peer support as vital for achieving and maintaining abstinence. This strongly suggests services and clinicians should attempt to work collaboratively with people entering services to consider how best to fit their needs and requirements. This may be related to race, age, gender, parenthood, or other characteristics not mentioned in this review. Considering social graces (Burnham, 1993) or racial differences (Rosenberg et al, 2017) and how these could impact on service accessibility and effectiveness means that, in a climate of prior disinvestment from and beginnings of reinvestment back into substance misuse services in

the UK (Black, 2021; Finch, 2021; Roscoe et al, 2021, 2022), services can maximise usefulness. Additionally, the "opioid crisis" of the USA and the UK "war on drugs" have incentivised governments in both countries to have drug recovery on the agenda (Godlee and Hurley, 2016; Lancet, 2021; Vadivelu et al, 2018). Services could use the information shared by participants in these studies to ensure they siphon government funding into the most helpful provision.

The importance of developing "recovery capital" is implicitly and explicitly noted throughout all studies. Tailoring interventions to target the aspects of recovery capital service users most require support with can individualise care and help to stabilise service users.

Unless explicitly interviewing women, only three studies had a gender balance greater than 60/40. This was reflected on by some researchers, with future directions considering amplifying the voices of abstinent women. Women and men have different pressures that may impact on their ability to remain abstinent. This is on an interpersonal level but also on a societal level. Future research may want to consider the impact of power and societal discourse on recovery for women and how this relates to their recovery journey.

Additionally, none of the researchers reflected on their own background and how this may bias them in the designing of the research, interview, analysis, and subsequent writing of the research, including quote selection. Future research would benefit from considering more heavily the impact of researcher bias on the interviews. Included within this could be their own relational networks and their own experience to substance dependence. While not necessary to explain this in detail, it may be helpful to reflect on this and note it in the research. Within this, including social discourse on a wider scale and incorporating issues of race and power would be useful when thinking about substance dependence. There is evidence of racial discrimination in legal and medical contexts relating to drugs, with Black

people having particularly negative sentencing outcomes and access to treatment (Mauer, 2011; Rehavi and Starr, 2013, 2014).

### Future directions

This paper offered a critical review of how abstinence is understood in recovery for people who are already abstinent. However, there is limited existing research on people who are earlier in the process: people who are newly abstinent, or non-abstinent but engaging with services. The fit and availability of services was highlighted as a matter of importance in the study. Of vital importance was also identity and sense of self. To the author, these two appear inextricably linked. How can a service fit without the person's identity being considered within this? How can abstinence be a viable option if somebody does not see themselves as capable of it? Detail on how this new self was created and how services helped or hindered this was beyond the scope of this review. Understanding which aspects of identity are most salient for those engaging with services and how identity fits with service provision is vital for ensuring that those who want to begin a new life of abstinence are provided with the best support to do so.

## Conclusions

The author wanted to explore how abstinence in recovery was conceptualised, who was sampled in the literature and whether there were common experiences within the literature. Abstinence in recovery was conceptualised by participants (who were all previously addicted to substances) as a life experience that improved physical and emotional wellbeing, compared to addiction which adversely affected relationships and prospects. Eventually, people understood the necessity of change. Abstinence was a way to create and maintain this change. This was a common experience throughout the literature. People consulted were ex-users, but the sample was male and white-dominated. This has important future implications for increasing the diversity of research.

## References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of mental disorders (5th ed*.). https://doi.org/10.1176/appi.books.9780890425596

Anderson, D. J., McGovern, J. P., & DuPont, R. L. (1999). The origins of the Minnesota model of addiction treatment – a first person account. *Journal of Addictive Diseases*, *18*(1), 107–114. https://doi.org/10.1300/J069v18n01_10

Baffoe, M., Asimeng-Boahene, L., & Ogbuagu, B. C. (2014). Their way or no way: "Whiteness" as agent for marginalizing and silencing minority voices in academic research and publication. *European Journal of Sustainable Development, 3*(1), 13-32. https://doi.org/10.14207/ejsd.2014.v3n1p13

Beckwith, M., Best, D., Savic, M., Haslam, C., Bathish, R., Dingle, G., Mackenzie, J., Staiger, P. K. & Lubman, D. I. (2019) Social Identity Mapping in Addiction Recovery (SIM-AR): Extension and application of a visual method. *Addiction Research & Theory, 27*(6), 462-471. https://doi.org/10.1080/16066359.2018.1544623

Best, D., Beckwith, M., Haslam, C., Haslam, A. Jetten, J., Mawson E., & Lubman, D. I. (2016) Overcoming alcohol and other drug addiction as a process of social identity transition: The social identity model of recovery (SIMOR). *Addiction Research & Theory, 24*(2), 111-123. https://doi.org/10.3109/16066359.2015.1075980

Best, D., Gow, J., Taylor, A., Knox, A., & White, W. (2011). Recovery from heroin or alcohol dependence: A qualitative recovery experience in Glasgow. *Journal of Drug Issues, 41*(3), 359-377. https://doi.org/10.1177/002204261104100303

Best, D. W., & Lubman, D. I. (2012). The recovery paradigm - a model of hope and change for alcohol and drug addiction. *Australian family physician*, *41*(8), 593–597.

Black C. (2021). *Review of drugs part two: prevention, treatment, and recovery.* Department of Health and Social Care.

Buckingham, S. A., Frings, D., & Albery, I. P. (2013). Group membership and social identity in addiction recovery. *Psychology of addictive behaviours: Journal of the Society of Psychologists in Addictive Behaviours*, *27*(4), 1132–1140. https://doi.org/10.1037/a0032480

Burnham, J. (1993) Systemic supervision: The evolution of reflexivity in the context of the supervisory relationship. *Human Systems, 4,* 349- 381.

Camacho, T. C., & Echelbarger, M. (2022). Decentering Whiteness: Rethinking the instruction of undergraduate research methods within developmental science. *Infant and Child Development, 31*(1), 2272. https://doi.org/10.1002/icd.2272

Fernandez, D. P., Kuss, D.J, & Griffiths, M. D. (2020). Short-term abstinence effects across potential behavioral addictions: A systematic review. *Clinical Psychology Review, 76,* p18-28. https://doi.org/10.1016/j.cpr.2020.101828

Finch E. (2021). Drug treatment services are broken, says review. *British Medical Journal,* 374. https://doi.org/10.1136/bmj.n1828

Frings D, & Albery I. P. (2015). The social identity model of cessation maintenance: Formulation and initial evidence. *Journal of Addictive Behaviours, 44,* 35-42. https://doi.org/10.1016/j.addbeh.2014.10.023.

Godlee, F. & Hurley, R. (2016). The war on drugs has failed: Doctors should lead calls for drug policy reform. *British Medical Journal*, 355. https://doi.org/10.1136/bmj.i6067

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment.* New York University Press.

Hanninen, V. & Koski-Jannes, A. (1999). Narratives of recovery from addictive behaviours. *Addiction*, *94.* 1837-1848. https://doi.org/10.1046/j.1360-0443.1999.941218379.x

Haroosh, E. & Freedman, S. (2017). Posttraumatic growth and recovery from addiction. *European Journal of Psychotraumatology, 8*(1). https://doi.org/10.1080/20008198.2017.1369832

Heimdahl Vepsä, K. (2020). Parents' experiences of substance use problems, parenthood, and recovery within the 12-step movement. *Nordic Studies on Alcohol and Drugs, 37*(6), 576-591. https://doi.org/10.1177/1455072520941992

Heslin, K. C., Singzon, T. K., Farmer, M., Dobalian, A., Tsao, J., & Hamilton, A. B. (2013). Therapy or threat? Inadvertent exposure to alcohol and illicit drug cues in the neighbourhoods of sober

living homes. *Health and Social Care in the Community, 21*(5), 500-508. https://doi.org/10.1111/hsc.12040; 02

Jorquez, J. (1983). The retirement phase of heroin using careers. *Journal of Drug Issues, 13*(3), 343-365. https://doi.org/10.1177/002204268301300305

Kellogg, S. (1993). Identity and recovery. *Psychotherapy: Theory, Research, Practice, Training, 30*(2), 235–244. https://doi.org/10.1037/0033-3204.30.2.235

Long, H.A.; French, D. P.; & Brooks, J. M., Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences, 1*(1), 31-42. https://doi.org/10.1177/2632084320947559; 28

Lund, P. (2016). Christianity in narratives of recovery from substance use. *Pastoral Psychology, 65*(3), 351-368. https://doi.org/10.1007/s11089-016-0687-3

Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors 21*(6), 779-788. https://doi.org/10.1016/0306-4603(96)00042-1

Mauer, M. (2011). Addressing Racial Disparities in Incarceration. *The Prison Journal, 91*(3), 87-101. https://doi.org/10.1177/0032885511415227; 28

Morojele, M. K. & Stephenson, G. M. (1992). The Minnesota model in the treatment of addictions: A social psychological assessment of changes in beliefs and attributions. *Community and Applied Social Psychology, 2(1),* 25-41. https://doi.org/10.1002/casp.2450020104

Murnan, A. Ferber, M.F. (2021). Familial influences on treatment and substance use among mothers engaged in prostitution. *Family Relations, 70*(4) 1162-1177. https://doi.org/10.1111/fare.12492

Murphy, S. A. (1993). Coping strategies of abstainers from alcohol up to three years post-treatment. *Journal of Nursing Scholarship, 25*(1), 29-36. https://doi.org/10.1111/j.1547-5069.1993.tb00750.x; 02

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., et al. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *British Medical Journal.* https://doi.org/10.1136/bmj.n71.

Parker, K. A., Roberson, L., Ivanov, B., Carter, R. & Riney, N. (2021). The road to recovery from addiction: A qualitative exploration of motivators and challenges to achieving sobriety in recovery housing. *The International Journal of Health, Wellness and Society, 11*(2), 159-172. https://doi.org/10.18848/2156-8960/CGP/v11i02/159-172

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), 390–395. https://doi.org/10.1037/0022-006X.51.3.390

Rehavi, M. M. & Starr, S. B. (2013). Mandatory sentencing and racial disparity: Assessing the role of prosecutors and the effects of Booker. *The Yale Law Journal, 123*(1), 2-80.

Rehavi, M. M. & Starr, S. B. (2014). Racial disparity in federal criminal sentences. *Journal of Political Economy, 122*(6), 1320-1354. https://doi.org/10.1086/677255

Robertson, I. E. & Nesvåg, S. M. (2019). Into the unknown: Treatment as a social arena for drug users' transition into a non-using life. *Nordic Studies on Alcohol and Drugs, 36*(3), 248-266. https://doi.org/10.1177/1455072518796898

Roscoe, S., Boyd, J., Buykx, P., Gavens, L., Pryce, R., & Meier, P. (2021). The impact of disinvestment on alcohol and drug treatment delivery and outcomes: A systematic review. *BMC Public Health, 21*(1), 2140. https://doi.org/10.1186/s12889-021-12219-0

Roscoe, S., Pryce, R., Buykx, P., Gavens, L., & Meier, P. S. (2022). Is disinvestment from alcohol and drug treatment services associated with treatment access, completions and related harm? An analysis of English expenditure and outcomes data. *Drug and Alcohol review, 41*(1), 54–61. https://doi.org/10.1111/dar.13307

Rosenberg, A., Groves, A. K., & Blankenship, K. M. (2017). Comparing Black and White Drug Offenders: Implications for racial disparities in criminal justice and reentry policy and programming. *Journal of drug issues, 47*(1), 132–142. https://doi.org/10.1177/0022042616678614

Skorina, J. K., Bissell, L. & de Soto, C. B. (1990). Alcoholic psychologists: Routes to recovery. *Professional Psychology: Research and Practice, 21*, 248-251. https://doi.org/ 10.1037/0735-7028.21.4.248

Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). *SAMHSA's Working Definition of Recovery.* [Brochure]. https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

The Lancet (2021). A time of crisis for the opioid epidemic in the USA. *The Lancet,* 398(10297), 277. https://doi.org/10.1016/S0140-6736(21)01653-6

Timmons, S. M. (2012). A Christian faith-based recovery theory: Understanding God as sponsor. *Journal of Religion and Health, 51*(4), 1152-1164.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Med Research Methodology 8(*45). https://doi.org/10.1186/1471-2288-8-45

Vadivelu, N., Kai, A.M., Kodumudi, V., Sramcik, & Kaye, A. L. (2018). The Opioid Crisis: A Comprehensive Overview. *Current Pain and Headache Reports*, *22*(16). https://doi.org/10.1007/s11916-018-0670-z

Venner, K. L., Hagler, K., Cloud, V. & Greenfield, B. (2019). Native Americans resolve alcohol use disorder: "Whatever it takes or all that it takes". *Cultural Diversity and Ethnic Minority Psychology, 25*(3), 350-358. https://doi.org/10.1037/cdp0000241

Venner, K. L., Matzger, H., Forcehimes, A A., Moos, R. H., Feldstein, S. W., Willenbring, M. L. & Weisner, C. (2006). Course of recovery from alcoholism. *Alcoholism: Clinical and Experimental Research, 30*(6), 1079-1090. https://doi.org/10.1111/j.1530-0277.2006.00121.x

Wang, X. & Liu, L. (2020). Sex, Drug, and HIV/AIDS: The Drug Career of an Urban Chinese Woman. *Social Inclusion, 8*(2), 86-94. https://doi.org/10.17645/si.v8i2.2640

Webb, L.; Clayson, A.; Duda-Mikulin, E., & Cox, N. (2020). '*I'm getting the balls to say no*': Trajectories in long-term recovery from problem substance use**.** *Journal of Health Psychology, 27*(1), 69-80. https://doi.org/10.1177/1359105320941248

World Health Organisation (n.d.) *Addictive behaviour.* WHO. https://www.who.int/health-topics/addictive-behaviour#tab=tab_1. [Date accessed: 28th October 2022]

"You've just gotta think in your mind everyone has a story… I feel like my story could help somebody else."

A narrative exploration of life story and identity for users of addiction services.

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*A note on terminology:*

Participant language is used where possible. Service names with be replaced by the term "addiction service". "Addiction" and "addict" will be used to describe substance dependency as this was the preferred term when speaking to consultants and participants.

*A note on confidentiality*

All names, places, and areas were changed to protect participant confidentiality. These were changed at the point of transcription. There are two exceptions to this. The location was kept as London, as this was too large an area to identify participants and was deemed relevant for the discussion. In the appendix, the hometown of the author remains in text as this was relevant for the transcript. The appendix also details the area of London as this was needed for the report summary.

## Abstract

This study aimed to develop a life story narrative of individuals accessing addiction services. People have many aspects of identity that may change in importance throughout the lifespan. A life story narrative allows these various identities to be presented and explored.

**Method**

Nine participants (seven males, two females) were interviewed using a narrative approach. These interviews were analysed using performative narrative analysis. An overarching narrative was developed followed by an exploration of individual chapters.

**Results**

Participants had felt displaced and disconnected during childhood. Drugs masked physical or emotional pain. Eventually, use escalated, and they lost control, leading to service engagement. Services tried their best but were limited due to structural and economic factors. Participants faced stigma and discrimination.

**Conclusions**

Services can use important aspects of individual identity to better support service users and improve provision. Highlighting other aspects of identity may reduce self-stigma and increase wellbeing.



Key words:

Identity, loss, disconnected, addiction, narrative, substance

## Introduction

Primary labels shift throughout life and may be accompanied by changes in the way people view themselves and their position in the world. Addiction services are often commissioned to work to models of harm reduction or abstinence, which requires admission of substance dependence or "addiction" to create a treatment plan and not divert to other services. This may feel necessary to access support, despite how service users view themselves. Prior to this, their primary label may have been "parent" or "friend". The labels people carry may have an important influence on their understanding of their own identity. Labelling has been demonstrated to have a long-lasting stigmatising impact, even after the behaviours associated with the label are absent (Link et al, 1997).

Ashforth & Schinoff (2016) suggest identity can be understood as a combination of how an individual thinks, feels, and acts to construct a contextual concept of themselves. When socially validated, this identity is reinforced. Identity could therefore be influenced by social interaction, but also by wider societal discourse and personal life events (Singer, 2004). Throughout the lifespan, different aspects of an identity may become salient at different times, which may lead people to link their past and present to a desired future and alter the meaning made from different aspects of identity (Ashforth & Schinoff, 2016; Singer, 2004).

Alongside identity construction, a personal narrative is constructed which anchors the cognitive, cultural, and social context and can become a framework for somebody to view the world in relation to themselves (Singer, 2004). When engaging with addiction services, the dominant narrative of self-as-addict may need to be supported to justify service engagement and evidence capacity for change (Aston, 2009). Kelly et al (2018) found that individuals without formal treatment or an addiction diagnosis who had resolved problematic use did not define themselves as having a recovery identity. Although this identity may be expected of people engaging in services, alternative terminology could widen accessibility.

Other salient aspects of identity, such as race, gender, or economic status, may be ignored when considering treatment. The entire self may therefore not be considered and this may make change more difficult. An imposed narrative heavily focused on "addiction" above all else may impact recovery (McConnell, 2016). Membership of a "recovery" group allows people to reconstruct their dominant narrative through their new socio-cultural context. The importance of identity transformation in recovery was demonstrated in almost all studies discussed in the current author's literature review (section A, e.g. Heimdahl, 2020). While addiction continues to be stigmatised (Rundle et al, 2021), being able to accept support for addiction while not being defined by it may be vital for recovery.

Tajfel (1982) suggests people typically identify with members of a group. They overvalue in-group characteristics and devalue out-group characteristics. Emphasised characteristics could play a vital role for membership and thus engagement. This may also reflect dominant discourses and, therefore, be nuanced. For example, societal attitudes towards alcoholism may be more sympathetic than attitudes towards crack-cocaine or heroin (Chang et al, 2020; Meurk et al, 2014). It may increase the difficulty of declaring group membership, particularly if the likelihood is of internalised self-stigma or stigmatisation by wider society.

As seen in the author's literature review (section A), suitability and fit of treatment alongside community support is vital for recovery (e.g. Venner, 2019). Continuing to consider the impact of groups, Haroosh and Freedman (2017) emphasised the importance of community support in recovery, indicating the need for services to understand the external world of the person to identify how their community can continue to support them in recovery.

Additionally, past disinvestment from drug and alcohol services means that in the current economic and political climate, it is tantamount that service provision is efficacious. The Black report, published in 2021, discussed the impact of the current illicit drugs' market and its impact on society, including premature death, social care strain and an increased homeless population. She highlighted the need for reinvestment and improving treatment, housing support, criminal justice support, employment, and educational opportunities for those with addictions (Black, 2021). While this is progress, optimising service provision by ensuring that the services offered fit the needs of those utilising them can help to further mitigate some of the damage caused by disinvestment (212.2 million between 2014/15 and 2018/19; Roscoe et al, 2021).

## Present study

This study aimed to explore identities held salient by those in addiction services and how these identities are portrayed in a life-story narrative. The label of "addict" may be given or one people take for themselves. Any associated stigma or exclusion may impact on service engagement and group membership, and how people view and portray their own identity. This study may further illuminate some ideas about this and indicate some future service directions focusing on identity and exclusion.

**Study question:**

1. How is an identity narrative constructed, understood, and portrayed by those engaging with addiction services?

Exploratory ideas:

1. What characters are present in the narratives of individuals?
2. How do treatment options fit with the dominant narrative held by the service user?
3. How is treatment and life post-services (present and future scripts) integrated into the narrative?

4. How do individuals tell the story of their treatment options and groups? Who are the significant characters? How do they relate to these characters?

## Method

### Design

Narrative analysis allows an understanding of the stories that people construct about their identity and use to understand, organise, and explain their identity for themselves and to others (Butina, 2015). Participants are given an active role in creating their own story, thus corresponding with the author's goal to amplify voices often underrepresented in academic literature.

### Sample

There were seven men and two women in the study, ranging from 29 to 59 years old. One was Indian, one Bengali, one White-Irish and all others identified as White-British. Full demographic information collected is described in table 1.

**Table 1.**

*Participant demographic information.*

| Name | Age | Ethnicity | Education | Sex | Gender | Sexuality | Health conditions? | Occupation? | Religion? | Service length | Treatment |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Jason | 45 | Half Dutch-European | HND horticulture. Dropped out of degree. | M | M | Straight | None | Gardener/horticulturalist | Atheist | 24 years | Residential rehab; methadone script, allocated worker |
| Connor | 39 | White Irish | Fine art degree, some of psychology degree | M | M | Straight | COPD, asthma, undiagnosed – long term injuries/trauma, headaches, neck pain, chronic pain. | Bar management work | Identify with Jesus, prays, karma and energy. Religious belief "in the middle" – individualistic but belief in God. | 18 years | Counselling; antipsychotics; methadone script; allocated worker |
| Martin | 29 | White British | High school | M | M | Straight | knee conditions joints; anxiety, dyslexia, BPD/complex PTSD, GAD, manic depression, insomnia. | Online vape company customer service 1.5 years | None, raised church of England | 1.5 years | 1:1 support, Subutex script |
| Sophie | 45 | White British | Barista training | F | F | Straight | Borderline personality disorder, anxiety, depression | 5 months | Believe in God, no religion | 15 years | Used to attend groups, has had rehab, methadone script. |
| Steven | 40 | Indian | College – car apprenticeship | M | M | Straight | Had cancer, some physical | No, had worked in cars | | 20 years | 1:1 support, script |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | health impacts | | | | |
| Joyce | 59 | White British | College – childcare and education level 3 | F | F | Straight | Cryoglobulinemia vasculitis; high blood pressure; high risk of diabetes | Photocopier company – 10 years; not currently working (carpal tunnel syndrome). Voluntary work/babysitting since birth of son | Church of England upbringing; agnostic | 30 years | Script only; groups (do not attend); worker to check-in with |
| Simon | 46 | Bengali | University-dropped out | M | M | Straight | Epilepsy, psychosis | Security | | | |
| William | 48 | White British | GCSEs + MVQs + apprenticeship | M | M | Straight | None | Engineer; 20+ years; no current job | None | 11 years | Weekly sessions; monthly check-ins; groups in the past. CMHT support on and off for 11 years, homelessness charity support |
| Peter | 40 | White British | None | M | M | Straight | | Roofing on and off for 10 years, not currently working | Raised Catholic, belief in God but not religious | Nearly 20 years | Detoxes, inpatient and outpatient, groups, scripts |

## Ethics

The research was granted ethical approval by the university board and by HRA & HRCW Brighton and Sussex Research and Ethics Committee (IRAS no. 403044; Appendix 2). The British Psychological Society (BPS) Code of Ethics and Conduct (2021) was followed throughout the research.

## Recruitment

Participants were recruited from two addiction services in London. The proposal was presented at a drug dependence conference in November 2021 where site sponsors identified themselves. Staff supported recruitment by speaking to potential participants and there was a recruitment poster (Appendix 1) displayed at both sites.

## Procedures

Participants were included if they were over 18 and currently accessing addiction services. Participants were excluded if alcohol use was their primary reason for service engagement or if they had left and returned to treatment services within the past six months.

The inclusion/exclusion criteria were discussed with consultants, sponsors, and supervisors. Supervisors and consultants stated that the self-and-other stigma felt by alcohol users compared to other drug users was qualitatively different. Alcohol users may be less stigmatised due to its legality and social acceptability. Evidence suggests stigma shifts depending on substance, with intravenous heroin users the most stigmatised (UKPDC, 2012).

Additionally, the literature tends to focus on those with alcohol-use disorders or abstinent individuals. It was felt that elevating voices of those who use other substances would meaningfully contribute to the research.

Interviews took place between September and October 2022 in a clinic room in the addiction service participants attended. They ranged between 47 minutes and 1 hour 42 minutes. One participant had an additional follow-up call for clarification. None of the

participants were free from all substances: of the seven heroin users, all were on a script and two were also using street heroin. Two were crack users and of these, one was still using, and one was not using crack but was still drinking.

All participants were given an information sheet and consent form to read and sign (Appendix 3, 4). At the beginning and end of the interview, they were asked if they had any questions. The author's hypothesis was discussed at the end of the interview to avoid leading the interview.

Participants had the right to withdraw within two weeks of the interview taking place to give the author time to transcribe and analyse the interviews. They were given a £10 voucher to thank them for their time. It was made clear this was not inducement to take part. They were sent a copy of their transcript and narrative summary in April 2023.

The interview schedule (Appendix 5) was unstructured with an initial life-story question and follow-up prompts to develop the narrative and encourage richer storytelling. It broadly followed the narrative approach set out by Willig (2013) which focuses on the meaning people make from the stories they tell. All interviews were recorded, then transcribed and analysed. It was important to build trust and rapport (Kartch, 2017) so narratives were steered by participants rather than the researcher, and they were continually encouraged to share anything they found important. The researcher co-constructs the narrative, so for the purpose of authenticity the author shared their genuine reactions to the narrative as it unfolded and after the interview concluded.

The interview script followed guidance by Crossley (2000). It began with the broad question "can you tell me about your life up to this point. Start from wherever feels right. Everything is relevant so include as much detail as you think is important." Prompts such as "and then what happened" (Riessman, 1993) or "could you tell me more about that?" were used to further elicit personal narrative and exploration of life chapters, including high, low,

and turning points, periods of change, and important memories from key life stages. In line with Crossley, important people in the narrative were considered, before thinking about the future. Thought was given to personal ideology (specifically relating to drug dependence, addiction, relationships, and society) and how the personal ideology of the individual is similar or different to those that they know. These were not asked about directly but elicited through the narrative and subsequent prompts.

**Quality analysis**

The author initially undertook a bracketing interview with a colleague (Appendix 6). Bracketing interviews are tools for researchers to appraise their subjectivities and biases (Sorsa et al, 2015). For example, the political standpoint of the researcher was discussed, reflecting how this may have informed interview responses and subsequent analysis. Three supervisors had access to anonymised transcripts and recordings to assess quality, as requested by the ethics board. The researcher also kept a reflective diary (Appendix 7).

**Data analysis**

Interviews were recorded using a password-protected Dictaphone, before being transcribed and anonymised. Initial reflections of themes, codes, author questions and reflections were noted on each transcript. Analysis followed the procedure set out by Blom and Nygren (2010). This was deemed appropriate for the story type (relatively homogenous, unique but with commonalities). They outline four stages of understanding data through analysis: naïve reading (developing an initial understanding of the text), structural analysis (deconstructing and analysing through codes), comprehension (grasping the meaning of the text), and appropriation.

Each interview was added to *NVivo* where reading gave an initial naïve understanding of each story, with the understanding that there were various possible interpretations of meaning. Manually coding each story (structural analysis; Appendix 8) led to comparative

elements being established across codes. These codes were grouped into dominant and secondary codes. The codes developed an overarching narrative. From this narrative, chapters were further explored and interpreted. Although a departure from Blom and Nygren, it seemed inherently valuable to develop individual narratives to aid comprehension.

The analysis took a performative approach, which is cited as appropriate for research on identity construction as it examines what identities are at stake and how they sit relative to wider societal discourse (Parcell & Baker, 2017; Riessman, 2005). The role of the researcher alongside the narrator in the co-construction of the story is integrated into the analysis. Appropriation (enhanced understanding through discovering future possibilities) occurs throughout the discussion.

### Epistemological position

The author takes a critical realist stance. The narratives construct a version of reality that can shift throughout time and between individuals. The author becomes part of that reality through the interview process and their interpretation of the narrative. Reality is co-produced by the author and participants.

## Results

Narratives allow people to "discursively construct their own identity" (Kartch, 2017, p.2), and in doing so, create meaning for themselves and establish their position in the wider sociocultural context. Participants accepted an "addict" identity by being in services. Life story narration gave participants the opportunity to construct alternative identities and present as individuals with a myriad of traits, not just an "addict". All participants initially attempted to anchor the conversation in their addiction, which speaks to the recruitment context. When encouraged to share their entire life history, however, a rich narrative of early life, romantic relationships, imagined futures, tragedy, and hope emerged. The overarching narrative gives a collective picture followed by a chapter-by-chapter analysis.

**Overarching narrative**

The narrative begins in childhood. There are key figures that feature heavily: parents, an older sibling. Parents are emotionally unavailable in almost all cases. Sometimes they are totally absent. The main characters have grown up with single parents or spent their early years with people other than their biological parents. For some, their parent-child relationship was painful. They felt unwanted or smothered. They did not want to go home. They spent time with other children that did not want to go home, often much older. For others, their parent-child relationship was reportedly pleasant, but without emotional connection. Some noted that their parents met only their basic needs.

The recurring theme is the disconnect of the main character from those around them. They never quite felt like they fit in, and struggled to identify what made them different.

Contextual events created an environment where drug use and eventually addiction happened without them realising. For most, drug use began with friends: a way to socialise and to fit in. Some began using drugs to connect with their romantic partner who was using. Another became addicted after a medical prescription. All were experiencing physical or emotional pain and the drug was a saviour. A way to forget, fit in, carry on.

All shared key moments where addiction spiralled out of control. This could be experiencing withdrawal and thus accepting physical dependence. For others, an increase in frequency or intensity, injecting to not “waste” heroin and noticing a detrimental impact on life.

“Rock bottom” was reached where life took a downward turn. Some participants lost jobs or relationships. Others received prison sentences or cautions. Some had periods of homelessness. For many, addiction brought isolation and loneliness. Some could not share the truth of their addiction with those closest to them. Many used alone to avoid shame and to avoid sharing.

For all participants, a realisation during addiction came that influenced them to connect with services, such as experiencing withdrawals or feeling unable to stop despite negative consequences. For some, not all, this was the end of their use of street drugs. Engagement with services changed as addiction lessened or tightened its grip. For all, the losses they had experienced due to addiction led them to accept there was opportunity for a better life with support.

Despite service support, all participants noted system failures that impacted on recovery. Some spoke about the lack of funding or budget cuts that had impacted access to therapy, detox, rehab, and long-term support. Without this, relapse often felt inevitable. Some shared the stigma they had faced from those who were supposed to help them, such as GPs or chemists. Others discussed systemic loopholes that allowed them or others to continue using while claiming sobriety. Circumstantial or structural experiences may have echoed the loss and pain that already existed and perpetuated the need to continue using rather than face the bleakness of current existence.

Engaging with services often demonstrated that participants desired change. They wanted to feel worth changing for. However, this was often fraught with contextual or systemic pain or disappointment, which undermined the sense of agency and the concept of being worthy. This could be economic, stigmatisation, support, or behaviour of others, and all served as evidence they were not enough.

All participants had experienced loss, pain, rejection, and abandonment, often from those they loved most. At these times, their usage often escalated, or they relapsed. Drugs relieved physical pain. They relieved the grief for somebody they had lost, a life they wished they had, or a life they had left behind. Some used drugs to mask the need to feel whole, and to feel loved and cared for by others.

The future was hopeful for most. Many saw themselves eventually free of all substances. They saw themselves rebuilding relationships, entering, or remaining in work, and maintaining sobriety. One person was not hopeful for their future, as they felt their suffering had been too great. However, they felt a glimmer of hope that there was scope for a new beginning.

**Narrative chapters**

This is an in-depth chapter-by-chapter analysis.

***Disconnected***

Some participants described their upbringing as "uneventful" (Joyce) but noted not having the confidence or skills to build friendships, leaving them a limited feeling of belonging. They wanted to be "one of the girls" (Sophie) by smoking or drinking, although that was not their natural inclination. William reflected that he did not have the time to invest in social relationships due to caring for his mother. He "didn't know what [peers] were on about most of the time", and this distanced him. While some craved belonging and connection, William felt his mum was all the companionship he needed.

In contrast, others experienced irreparably damaging parent relationships. A common narrative thread was the discussion of parents' marital relationship and its impact, with fathers often being emotionally or physically absent. While William's father was absent, he did not feel his mother-son relationship suffered. As William's interview directly followed Steven's, whose father was also absent, the author wondered whether in both situations, their mother needed their close male presence to help with the absence of her romantic partner. Steven told a story of a mother who used him as a surrogate husband, asking him to be with her instead of going to school or out with his friends: "she used to say to me like, Oh, don't go just stay at home… because I understand it now, she was lonely". For Steven, his resentment meant he spent as little time at home as possible. Connor also avoided home, but

for different reasons. Connor felt unwanted by both his parents and had a deep-seated fear of his dad due to his drinking and mental health difficulties. Steven and Connor felt unprotected and unsupported by their parents and sought external connections.

Sophie was desperate for parental love and comfort and did not feel she received it. She began to look for that love in romantic relationships, in her desperation to create a family. Simon's parents discussed him negatively with other family members. Simon's Bengali background increased how hurtful this was, as he lacked the sense of community prevalent in his culture, which ruptured his sense of identity and belonging. He said they "can't even be bothered to say hello." This isolation and distance from those he is meant to feel closest to is an extension of his familial experience. "I've hated him since I was a kid. To be honest, I do quite like the idea of making [my father] feel fucking regret and suffering by watching me last few years of his life".

Martin and Peter spent little time discussing their parents. Peter's narrative focused on his close sibling relationship. Martin gave precedence to a childhood health problem that directly contributed to his addiction. Martin and Peter felt they were just on the outside of what "should" have been. Peter spent time with significantly older cousins, so was in a liminal space where he felt too grown up for his peers but was too young to be fully immersed with his cousins, and Martin found "everyone knew me, I knew everyone, but I wasn't the one who like people wanted to hang out with all the time."

For all participants, relationship tensions began before their addiction and continued beyond it. Participants moved between the past and present when describing their relationship with their parents. Connor and Sophie especially felt intense pain that they had never felt the unconditional love expected from parents. Connor's dad compared him to his siblings, saying: "I just never got to really love you like that. I don't really know you." This abandonment, being in the "out-group" of familial love, was a longstanding cause of

separation from his family and contributed to him feeling unworthy of kindness. Similarly, Sophie felt her mother's allegiance to her sister left her no space: "you just don't get nothing back from her".

***Masking pain***

Participants narrated their pain differently, and not all participants acknowledged they had experienced pain. Peter, Simon, Steven, and Connor all started using drugs as "schoolkids messing about" (Simon). Steven recalled the "whole event" of using heroin, and the feeling that you were missing out on socialising if you weren't taking it. Connor recalled the aspirational nature of heroin and recounted a story of an older boy who was expelled for smoking heroin at school. Connor, laughingly, recounted the "Nirvana heads" era where heroin was cool and harmless. While this group presented their use as fun and exciting, they had all begun this story with their difficult home life and distant parents. This meant, to paraphrase Steven, that the company they kept were other children who did not want to be at home and were similarly underperforming at school: the unnoticed. Being in this group gave, in Connor's words, "a community". Your identity is shaped by being in this group, with these people, at this time.

Interestingly, the only female participants, Joyce and Sophie, began their addiction with romantic partners. Sophie was running from marriage and motherhood and met a man who introduced her to heroin. She explained that heroin "gave me everything I was looking for in life. It fulfilled me in every single way." Joyce's partner was a heroin user, and she used it so they would be "on the same level". As above, heroin gave these women connection. Sophie's entire drug history centred around romantic relationships. Heroin, crack, and alcohol allowed her to foster a semblance of connection while escaping her emotional turmoil and inner shame. Failure was often a symbol of pain for participants. Sophie believed she failed as a

mother. All except Joyce failed at maintaining loving relationships. Their pain was loneliness, and drugs filled a hole that loneliness left.

For William, crack and alcohol filled the hole left by the ultimate loss, the death of his mother. William used drugs to numb: “as a temporary plaster over a big, full, raw wound.”

Martin attempted to demonstrate his difference with his physical pain narrative. He had an opioid prescription after an operation on his joints, which became an opioid addiction. Martin’s story of drug addiction was anchored in physical pain. Despite this, a child with health problems could still indicate a child that did not feel “normal”, like the other participants.

***Losing control***

Participants initially spoke fondly of their substance, but the narrative soon shifted. The next chapter emphasised loss of control over the drug and the realisation they were addicted. Joyce felt “more confident” on heroin and crack made Sophie feel “unstoppable”. Crack “lit up [Simon’s] world”. Only Martin and William never spoke fondly of their drug use. For both, drugs were a means to an end. For the others, this gradually became the case.

All participants discussed the moment they realised they were addicted. For the heroin users, it was the first time they suffered withdrawals and realised they *needed* the drug. Steven and his friends realised gradually, too late: “But the problem with heroin is once it builds up in your system, that's when you get hooked. And we didn’t recognise “the tell-tale signs”. Connor emphasised the mind-body link, explaining the pain of withdrawals, then “you associate after [using] every pain will go away”.

For all except Jason, it was also the progression from smoking to injecting. For Martin and Peter, smoking became “wasteful” and injecting maximised the heroin. For Joyce and Sophie, injecting was the quickest (Sophie) or only available (Joyce) way to “get well”. For Simon and William, addiction was the insatiable need for crack despite their lives deteriorating day-

by-day. Connor described the "desperation" associated with the need for more crack. Relationally, Steven realised he was isolating himself from friends to avoid sharing his drugs. Jason also withdrew, explaining his only priorities were "go to work, make money, take drugs".

***Lowest point***

There is a desperate chapter where addiction has taken everything from people. They feel unworthy of love, family, health, even a home in some cases. Addiction resulted in financial hardship and relationship breakdown. During interviews, hindsight allowed participants to see what the drug had taken from them. Sophie and Joyce spent time living in "squalor" with other heroin addicts. This helped Joyce to seek support, as she saw how "rough" they looked and "thought God, I could end up looking like that". For Sophie, "nothing mattered except drugs", despite living with other heroin users in housing "you couldn't even put a dog in." Sophie's "rock bottom" arrived much later, described by her as "selling yourself for 50 pounds an hour", escorting to fund her crack and heroin addiction.

"Why is it- is it, is it that hard to kill yourself? Is it that fucking hard?" Connor died multiple times, accidentally overdosing or semi-deliberately by giving himself a "good chance" of dying. Connor described the pain of waking up, thinking "I'm useless man, I can't even top myself properly." As Connor described this, the pain in his voice was palpable. Life was so hard "it physically hurts to be alive". Connor gained no pleasure from heroin, explaining "it's not fun. This is pure script." Despite this, he still used street drugs, highlighting the difficulty of recovery despite service engagement and personal cost.

Jason and William were in similar positions, still using street drugs despite engaging with services and despite periods of abstinence. The consequences of addiction kept them in the cycle. Jason explained: "In the end the person is taking drugs to fill a void left by lack of relationships… now yes, it is a stress relief. An avoidance of, of reality – escapism."

Describing relapse, William said “you destroy all the hard work. And it’s soul destroying. You put all that effort in just to lose it all. And you can only blame yourself. Gutting.” Part of what kept William using street drugs was the disappointment in himself when he relapsed. William remained in a self-punishment cycle.

***Services***

Some participants discussed how decision-making processes had impacted their recovery. Connor explained “[the government] see us as worse than scum” while Jason reflected that rules about methadone prescriptions made by people who did not prioritise service users meant that rather than using expertise, staff “have to go along with whatever the government and politics tells them to do.” Alongside decision-making processes, cuts to funding meant older participants reflected on what used to be available compared to now. This led to guilt and shame that they did not maintain sobriety historically. They have made life harder for themselves and this added a layer of disappointment to the narrative.

Connor shared his experience of rehab being cut after two weeks due to funding. He recalled begging staff not to send him to a step-down while he was still in withdrawals but was told that funding varied by borough, and he did not have funding. Connor’s pleas: “please don't let me I'll do something stupid”, begging them for more time demonstrated again his devastation at being abandoned. This was more evidence that Connor was unwanted and undeserving of help. After twenty years of use, two weeks of detox meant Connor felt destined to fail. He was still withdrawing at discharge.

Joyce experienced direct and structural discrimination. She recounted being refused by a GP surgery despite meeting all criteria after telling them she had an opioid-substitute prescription. She recalled her pharmacy actively disrespecting her by breaching confidentiality. They announced her prescription, ensured she was last to be served and gave her script to others during the COVID-19 pandemic when imported prescriptions were

limited. Once in Scotland she needed methadone, and the nearest hospital was two hours away, with no local clinic. What about emergencies? This structural discrimination impacted Joyce once but impacts people who do not live in cities regularly. Jason was in severe pain, unable to leave the house. His prescription was stopped, leading to a vast increase in his heroin use. As Jason sees it: "The law doesn't care… they just want to protect the system, protect themselves, regardless of how it affects the users of the service."

Overall, participants noted that services do their best with what they have but this often is not enough. They do not encourage the community or camaraderie that give people fulfilment outside of addiction (Connor). They do not have the funding to meet people's needs, and they do not have the time to truly personalise care. For Martin, Sophie, and Joyce, there was frustration that services cannot effectively police drug use. Martin felt anybody using drugs should be expelled from the service, while Joyce and Sophie felt they would rather not be tempted and disengaged from groups.

***Loss***

Loss was a primary emotion experienced by all participants. Simon noted that his children had no connection with the Bengali community, partly due to his ostracization. For many, culture is an integral part of identity. Lack of cultural connection could have ramifications for sense of self. Connor's Irish identity and how this connected him to the Black Caribbean community was referred to throughout the narrative. While he did not have his family, he still had other people who centred him.

Connor's story weighed heavy with loss. He was jealous of his family's closeness while he was shunned. He lost academic attainment, noting that after he started using drugs consistently: "I was in the top class at everything and then it just went [imitates downhill slope]". Connor had a friendship group at school. Using drugs felt free and easy. Now, things had changed. He explained: "every one of my good friends are gone". Four died, three are in

prison and two are “not there anymore” through prolific drug use. Connor saw his life and the lives of those closest to him deteriorate. This was particularly painful as due to his difficulty finding a place at home and in the world, his friends were his family.

For some, the shame of their addiction meant they distanced themselves from loved ones. Jason kept friends and family distant to avoid continually hurting them. Martin withdrew from his mum because “I feel ashamed that I was such a burden to her.” Steven withdrew from all non-using friends while using and now finds it too difficult to reach out because of how unhappy he is with his life. Modified labelling theory suggests that people who know they have a negative label (“addict”) may avoid contacts that could expose this, meaning they become more withdrawn or defensive (Link & Phelan, 1987). For example, Martin, Sophie, and William all reported anxiety preventing them from entering work or socialising. Steven sadly reflected having the best time of his life in prison because he educated himself, detoxed, and made friends. The structure and routine of prison allowed him to establish his place socially. When released, the “loneliness” of his old environment left Steven unable to maintain his new habits. Steven’s narrative was self-stigmatising and self-blaming: “I've got nothing. Going to the chemist… That’s it. That's the one little activity that I've got like, it’s pathetic.”

***Hope***

Some participants, not all, were hopeful for their future. Martin, Joyce, and Sophie all hoped they would be weaned off their script. Sophie and Martin hoped they could re-join the job market and find their place in society. Although already working, Jason hoped he could progress in his chosen career (horticulture) and reconnect with friends and family. Sophie spoke specifically about her relationship with love, explaining a newfound ability to love herself and “get to know who Sophie is”.

Connor's description of hope was slightly different. His self-esteem was variable, but on a good day: "I love who I am. I think I think I think I'm I've got a great heart." He had ambitions to leave the country and run bars, saying "I'd be great at that." Despite his kind heart and generosity, he said: "I just I just feel like I'm not I just don't belong here. I just don't want to be here, you know it just hurts a lot sometimes." Despite his personality and potential, "the world is just so cold" for Connor and being in the world sometimes felt more painful than not.

William felt similarly. For him, receiving anxiety and depression diagnoses felt like he had been given "a death sentence", with "no cure". William reported wishing his suicide attempt had been successful. Sophie, conversely, said her diagnosis (she called it borderline personality disorder) helped her understand her relationship difficulties and drug-seeking behaviour and thus be kinder to herself.

**Dominant discourse**

Discourse can be understood as a system of meaning prevalent within a culture (Wolfe & Sharpe, 2022). The way society understands addiction creates the dominant discourse about it, which includes implicit and explicit rules and norms and helps form understanding about power and the self (Bailey, 2009). The dominant discourse among participants appeared to be that they were discarded members of society deserving of shame, rejection, and injustice. Connor described being sexually harassed by a family friend he stayed with. He explained "even though I was a grown arse man, I didn't think that anyone would believe me because I'm a drug addict." The self-esteem of most participants was at an all-time low. They did not feel they were viewed as equal to others. This meant they often felt anxious (Steven, Sophie, Martin) about stepping out into the world. Connor described feeling "grateful" when shown kindness and explained he was desperate to help others as "it gives me some validation that gives me some kind of sense that I was meant to be there that night", even if this places him

in danger. This need to prove worth was evident in many of the participants narratives: the need to show that there is a point in them existing.

**Performance**

Performative narrative analysis may ask why, how, and in what context a narrative was performed to attempt to explore what identities are constructed and portrayed in storytelling (Smith et al, 2011). It may wish to explore how the storyteller locates themselves relative to the audience and other characters (Smith & Sparks, 2009). During interviews, identities became apparent in narrative performance, participant self-description, and participant positioning relative to others. Martin described unfortunate circumstances that led to his addiction, circumstances seemingly beyond his control. He described himself as a "product of the American healthcare system". Martin had a zero-tolerance policy to other addicts and clearly needed to set himself apart from them, despite still being on an opioid-replacement prescription. He described himself as "clean, 100%" whereas Steven, also on an opioid-replacement, said he was "still on methadone" and therefore not yet "clean".

Joyce's description of herself and experiences placed her in a liminal space between the in-group and out-group. Joyce used her employment status, appearance, and overall respectability to demonstrate difference between her and other users, as somebody you "wouldn't know" had a drug history or a methadone prescription. As a working woman, she positioned herself differently to the "homeless girls" and said she wouldn't "frighten away" anybody in the chemist. Joyce used this to demonstrate the unfairness of being stigmatised by the chemist and her fear of being stigmatised by her community despite being able to "pass" as the same as anybody else (Goffman, 1963).

Connor used how he dresses, how he speaks, and how he treats others to separate himself from others with addiction. It seemed meaningful for Connor to demonstrate how addiction does not define him, and other aspects of his identity are more important. This meant that it

was especially painful for him when ill-treated: “How do you carry yourself? How do you- How are you with people how you conduct yourself? That's what shines out of someone really isn't it? But I always thought is it something about me was it something people don't like?” Connor was desperate to be liked but felt: “I haven't had anyone that in my life that I feel like I could connect to.” He wanted to show he deserved to be liked.

Jason noted positive aspects of his personality while accepting his addiction meant he was not living by his values. He described himself as “kind and caring”, a person who treats people “with respect” but also somebody who is “extremely unreliable um… can’t keep an appointment on time… uh never know when he’s going to be off taking drugs instead of um going to the birthday party of the person that invited him.”

## Discussion

This study aimed to explore the following:

1. What characters are present in the narratives of individuals?
2. How do individuals tell the story of their treatment options and groups? Who are the significant characters? How do they relate to these characters?
3. How is an identity narrative constructed, understood, and portrayed in service users?
4. How is treatment and life post-services (present and future scripts) integrated into the narrative?
5. How do treatment options fit with the dominant narrative held by the service user?

The first two questions are addressed in the *summary of results*. The third, fourth, and fifth are addressed in the *narrative performance*. The first two questions were explicitly discussed in the narratives. Some ideas regarding the other areas of exploration have been inferred but are the author’s interpretation of what emerged from the narratives. For the majority of participants, treatment options and services were present in their narratives but less prevalent than stories of their identity and interpersonal relationship. The researcher wondered if that

was because discussing their history allowed them to present as a whole person rather than being focused on their addiction or their treatment. The results therefore reflected what appeared most important to participants and the subsequent narrative direction of questioning taken by the researcher. What has emerged may be a basis for further exploration with structured interview questions.

**Summary of results**

Participant narratives discussed childhood, interpersonal relationships, addiction, and service journey. Participants reflected on love, loss, and regret. The main characters in all narratives were immediate family (parents, siblings, children) and romantic partners. Some included close friends as family. All participants shared how these characters influenced their recovery in different life chapters.

Identity appeared to play a major role in addiction onset. All participants felt disconnected from the world around them and drugs helped them to forget this or to fit in with those around them. Their lack of a strong identity (emphasised by their disconnect) led them to establish a social and romantic network to establish a sense of self. Substance use and eventually addiction often started in these groups. For example, Simon taking drugs with friends to fit in and then realising he was entering withdrawals, or Joyce and Sarah using heroin to match their romantic partners. For many participants, their social environment, which was also a drug-using environment, played a firm role in identity formation as a member of that group. The influence of social environment on identity was noted by Singer (2004).

Entering services gave an opportunity to reframe identity, by allowing people to restore identities previously spoiled by addiction (McIntosh & McKegany, 2000) and potentially creating recovery capital through social networks, housing, and psychological support. Individuals may find attachments to new labels which may reduce their self-and-other-

stigma, even if the “addict” label remains, which it can even after use ceases (Link & Phelan, 2001).

Participants felt that individual needs were not accounted for in treatment, and this impacted recovery. This was due to reduced provision impacted by lack of funding, but also due to the difficulty of managing different needs within a single setting. Participants who felt vulnerable to relapse could not attend groups as people who were using would offer them drugs. They could not meet other abstinent people either. Others, who enjoyed establishing a sense of community, felt they could not do this and felt lonely and isolated. Being exposed to temptation in a recovery group or a rehab step-down led to feelings of failure and were detrimental to identity and sense of self. This often led to protective disengagement. White & Cloud (2008) suggest targeting isolation with personalised recovery plans and individualised treatment is vital for resilience (thus helping to potentially resist temptation) and recovery.

**Narrative performance**

Addiction services may be potentially stigmatising as service users may see treatment engagement as highlighting their stigmatised or shameful activities (Radcliffe & Stevens, 2008). In this context, narrative performance may illuminate some of the difficulties experienced by people engaging with these services and their need to distance themselves from the dominant addiction narrative they may have felt they had carried with them over time.

Part of the need to separate the self may have been related to the fear of a spoiled identity. Stigma has five components: the labelling of salient human difference, stereotyping, creating an us/them separation, stigmatisation of “them”, and the use of “power over”, which relates to real consequences (Link & Phelan, 2001). The stigmatised out-group may attempt to stigmatise the “other”, but this cannot work unless there are meaningful consequences: the oppressed will find it impossible to oppress. Martin is attempting to separate from the out-

group by becoming a morally superior punisher, aligning himself with staff rather than service users, separating himself from the consequences of being an "addict", and becoming the oppressor rather than the oppressed, as part of the in-group rather than the out (Tajfel, 1982).

Participants moved between past and present when storytelling and discussed their past with the benefit of hindsight and personal growth. For some, the entire story remained emotionally laden, whereas for others there were particularly painful elements. For all, the painful parts were less about them and more about their impact on others. For example, Joyce expressed guilt at keeping her addiction history secret from her son and recounted memories where her addiction had interfered with her parenting without him being aware. Sophie expressed regret at parenting decisions she had made and her subsequent ruptured mother-child relationships.

Many participants had felt disconnected from others throughout their lives and strove to feel connected to others. This was most apparent during Connor's interview. At the beginning of the interview, we discussed food. Connor noted the author's heritage and shared his childhood connection to it. When discovering the author's hometown, Connor joked and demonstrated his knowledge of the area. The use of laughter and the sharing of a common identity experience helped Connor to demonstrate to the author who he was, that he cared, that we both matter. McConnell (2016) noted that a heavy addiction narrative can impact recovery. Highlighting other aspects of self as important may have been important for Connor and other participants to see themselves as having recovery potential.

Participants that saw themselves as innately good people or as having an identity worthy of love or affection also seemed more hopeful. It was not just how they were labelled by others but how they labelled themselves. For example, William said he did not like himself and was not hopeful his life would improve. Other participants acknowledged their journey

was ongoing but were proud of what they had achieved. Connor felt he had made a "mess of [his] life" but still saw a future where he could use his skills and abilities. Sophie saw that she was developing self-love and an ability to survive by herself.

**Limitations and future directions**

This study recruited from two services in London. This impacts on the generalisability of results, particularly when discussing service provision. Service provision in other parts of the country may be impacted by funding differently, and the findings may not be applicable. Additionally, all participants bar one had been engaging in services for over ten years. They may have been more likely as a cohort to see deficits in provision, as they had seen a lot of change over time without their desired outcomes. Future research may wish to interview participants in a variety of urban and rural locations at different stages of recovery.

The study only involved two women. Both women were introduced to addiction by their romantic partners, and one became a sex worker to fund her addiction. They were also two of four participants with children. The experience of women with addictions may be different to that of men (section A, Csete et al, 2016; Heimdahl, 2020), and different societal discourses and pressures may exist, including motherhood and femininity, which may have impacted on their sense of identity and recovery journey. Future research may wish to purposively sample more women to explore this.

Importantly, race and ethnicity were not fully explored in this research. Only two participants were non-white. While culture and community were discussed to some extent, racism in society, the relationship between race and poverty, or the relationship between race and law enforcement were not explored (Csete et al, 2016; Godlee, 2016). Future research may want to explore how these experiences impact on identity and addiction experiences.

Few studies have explored the identities held most salient by current service users who would not define themselves as "recovered". Having participants who were using street drugs

despite being in services provided a richer account of the struggles between identity, recovery, and service provision experienced daily by people addicted to substances. Future research may wish to explore the impact of identity on initial engagement with services, speaking to people who have not yet sought support. They may wish to recruit from populations that are harder to reach, such as the homeless population.

Future research may extend this study further by following participants longitudinally. Participants discussed their hope for the future. A longitudinal study exploring how identity and discourse impacts them reaching their treatment goals would be useful to understand more about how services can support and scaffold individuals by placing identity as paramount.

The researcher was informed by their own beliefs on the stigmatisation of addiction and the intersection between drug policy and societal treatment of drug users. Many participant narratives focused on family. The author's own relationship with their family contributed to their own feelings about the experiences participants had and this likely impacted on their interactions and subsequent co-construction of the narrative. Participants would likely have recognised a sympathetic and reassuring tone from the interviewer which may have encouraged them to speak more openly about the impact of their relationships on their identity.

Additionally, the author was mindful that they did not want to agree with the perspective that addicts should be punished for being unable to maintain sobriety, which may have impacted on the connection built with some participants compared to others. It also may have impacted on when prompts were used (based on what the author found interesting to develop a richer narrative around) which had some implications for the final narrative.

**Clinical implications**

Funding is an issue outside of service control. Despite this, interview results seemed to indicate a need for services to consider the external environment and support network of the person when treatment planning, as changing social networks and providing non-drug related life activities are shown to be paramount for recovery (Best et al, 2016; McIntosh & McKegany, 2000). They also indicated a need to understand the salient aspects of identity for individuals. If somebody was desperate for social interaction and friendship, because their identity hinged on being able to bring people together, look after others, and brighten their day (Connor and Steven), sobriety could be encouraged by giving them responsibility, such as a peer led support group.

Other participants needed to be among other abstinent people, to remind them of their progress (Sophie and Martin). An abstinent group could be useful, particularly as they lacked a social network outside of other drug users and felt lonely and isolated. Joyce, Peter, and Jason appeared to construct their identity around value they added to the world by working and contributing to society. William also used to feel this way, and his self-worth declined since he lost his job. Placing people in groups based on their values rather than their substance may be an alternative treatment option to increase engagement.

All participants expressed shame at their use, past and present. Many withdrew from friends and family or hid their use, keeping them in a cycle of shame. The increased funding ringfenced for addiction services resulting from the Black report (Black, 2021) could be utilised by services to work with the concept of shame to enable participants to achieve fulfilling relationships and build external networks to aid recovery outside of services, such as through a compassion focused therapy intervention (Gilbert, 2009). An emphasis on recovery capital and identity means funding can also be funnelled into helping service users

maintain recovery by creating and maintaining the best potential environment for success (White & Cloud, 2008).

## Conclusion

This study sought to explore the identity narratives created by individuals engaging with addiction services. It found that identity construction was a vital part of the journey through services. Above all else, participants wanted to feel worthy of love and kindness. Life history, stigma, societal discourse, and government budget cuts meant sometimes this was difficult for them to believe. Despite this, the narratives retained a thread of hope that each participant was living, or could live, a life they hoped for.

## References

Ashforth, B. E., & Schinoff, B. S. (2016). Identity under construction: How individuals come to define themselves in organizations. *Annual Review of Organizational Psychology and Organizational Behavior*, *3*(1), 111-137.

Aston S. Identities under construction: Women hailed as addicts. *Health*. 2009;13(6):611-628. doi:10.1177/1363459309341865

Bailey, L. (2005) Control and desire: The issue of identity in popular discourses of addiction. *Addiction Research & Theory*, *13*(6), 535-543. DOI: 10.1080/16066350500338195

Black C. (2021). *Review of drugs part two: prevention, treatment, and recovery.* Department of Health and Social Care.

Blom, B., & Nygren, L. (2010). Analysing written narratives: considerations on the 'code-totality problems'. *The Nordic Journal of Social Research, 1*(10), 24-43. https://doi.org/10.7577/njsr.2035

Butina, M. (2015). A Narrative Approach to Qualitative Inquiry. *American Society for Clinical Laboratory Science*, *28(3)* 190-196. DOI: https://doi.org/10.29074/ascls.28.3.190

Chang, C., Chang, K., Hou, W., Yen, C., Lin, C. & Potenza, M. (2020). Measurement invariance and psychometric properties of Perceived Stigma toward People who use Substances (PSPS) among three types of substance use disorders: Heroin, amphetamine, and alcohol. *Drug and Alcohol Dependence, 216,* 108319. https://doi.org/ 10.1016/j.drugalcdep.2020.108319

Corrigan, P. W., & Nieweglowski, K. (2018). Stigma and the public health agenda for the opioid crisis in America. *The International journal on drug policy*, *59*, 44–49. https://doi.org/10.1016/j.drugpo.2018.06.015

Crossley, M. L. (2000). *Introducing narrative psychology: Self, trauma and the construction of meaning*. Open University Press.

Csete, J., Kamarulzaman, A., Kazatchkine, M., Altice, F., Balicki, M., Buxton, J., et al. (2016). Public health and international drug policy. *Lancet (London, England)*, *387*(10026), 1427–1480. https://doi.org/10.1016/S0140-6736(16)00619-X

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15*(3), 199-208. doi:10.1192/apt.bp.107.005264

Godlee, F. & Hurley, R. (2016). The war on drugs has failed: Doctors should lead calls for drug policy reform. *British Medical Journal*, 355. https://doi.org/10.1136/bmj.i6067

Goffman, E. (1963). *Stigma. Notes on the Management of Spoiled Identity.* London: Penguin Books.

Haroosh, E. & Freedman, S. (2017). Posttraumatic growth and recovery from addiction. *European Journal of Psychotraumatology, 8*(1), 1369832. https://doi.org/10.1080/20008198.2017.1369832

Heimdahl Vepsä, K. (2020). Parents' experiences of substance use problems, parenthood, and recovery within the 12-step movement. *Nordic Studies on Alcohol and Drugs, 37*(6), 576-591. https://doi.org/10.1177/1455072520941992

Kartch, F. (2017). Narrative Interviewing. In M. Allen (Ed.). *The SAGE Encyclopaedia of Communication Research Methods* (pp. 1073-1075). SAGE Publications, Inc. https://dx.doi.org/10.4135/9781483381411.n369

Kelly, J. F., Abry, A. W., Milligan, C. M., Bergman, B. G., & Hoeppner, B. B. (2018). On being "in recovery": A national study of prevalence and correlates of adopting or not adopting a recovery identity among individuals resolving drug and alcohol problems. *Psychology of Addictive Behaviors, 32*(6), 595–604. https://doi.org/10.1037/adb0000386

Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, *27*, 363–385. http://www.jstor.org/stable/2678626

Link, B. G., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On Stigma and Its Consequences: Evidence from a Longitudinal Study of Men with Dual Diagnoses of Mental Illness and Substance Abuse. *Journal of Health and Social Behaviour, 38*(2), 177-190. https://doi.org/10.2307/2955424

McConnell, D. (2016). Narrative Self-constitution and recovery from addiction. *American Philosophical Quarterly*, 53(3), 307–322. http://www.jstor.org/stable/44982106

McIntosh, J., & McKeganey, N. (2000). Addicts' narratives of recovery from drug use: Constructing a non-addict identity. *Social Science & Medicine, 50*(10), 1501–1510. https://doi.org/10.1016/S0277-9536(99)00409-8

Meurk, C., Carter, A., Partridge, B., Lucke, J. & Hall, W. (2014). How is acceptance of the brain disease model of addiction related to Australians' attitudes towards addicted individuals and treatments for addiction? *BMC Psychiatry 14,* 373. https://doi.org/10.1186/s12888-014-0373-x

Oates, J., Carpenter, D., Fisher, M., Goodson, S., Hannah, B., Kwiatowski, R., Prutton, K., Reeves, D., & Wainwright, T. (2021). *BPS Code of Human Research Ethics*. British Psychological Society.

Parcell, E. S., & Baker, B. M. A. (2017). Narrative Analysis. In M. Allen (Ed.). *The SAGE Encyclopaedia of Communication Research Methods* (pp. 1069-1072). SAGE Publications, Inc. https://dx.doi.org/10.4135/9781483381411.n369

Radcliffe, P., & Stevens, A. (2008). Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatised identities. *Social science & medicine, 67*(7), 1065–1073. https://doi.org/10.1016/j.socscimed.2008.06.004

Riessman, C. K. (1993). *Narrative analysis.* SAGE Publications, Inc.

Riessman, C. K. (2005). Narrative Analysis. In: *Narrative, Memory & Everyday Life*. (pp. 1-7). University of Huddersfield, Huddersfield.

Roscoe, S., Boyd, J., Buykx, P., Gavens, L., Pryce, R., & Meier, P. (2021). The impact of disinvestment on alcohol and drug treatment delivery and outcomes: A systematic review. *BMC Public Health, 21*(1), 2140. https://doi.org/10.1186/s12889-021-12219-0

Rundle, S. M., Cunningham, J. A., & Hendershot, C. S. (2021). Implications of addiction diagnosis and addiction beliefs for public stigma: A cross-national experimental study. *Drug and alcohol review*, *40*(5), 842–846. https://doi.org/10.1111/dar.13244

Shiner M. & Winstock A. (2015). Drug use and social control: The negotiation of moral ambivalence. *Social Science and Medicine. 138,* 248-56. https://doi.org/10.1016/j.socscimed.2015.06.017.

Singer, J. A. (2004). Narrative identity and meaning making across the adult lifespan: An introduction. *Journal of Personality, 72*(3), 437–459. https://doi.org/10.1111/j.0022-3506.2004.00268.x

Smith, B., Collinson, J. A., Phoenix, C., Brown D., & Sparkes, A. (2009) Dialogue, monologue, and boundary crossing within research encounters: A performative narrative analysis. *International Journal of Sport and Exercise Psychology, 7*(3), 342-358, DOI: 10.1080/1612197X.2009.9671914

Smith, B. & Sparkes, A. C. (2009). Narrative analysis and sport and exercise psychology: Understanding lives in diverse ways. *Psychology of Sport and Exercise, 10*(2), 279-288, https://doi.org/10.1016/j.psychsport.2008.07.012.

Sorsa, M. A., Kiikkala, I., & Åstedt-Kurki, P. (2015). Bracketing as a skill in conducting unstructured qualitative interviews. *Nurse researcher*, *22*(4), 8–12. https://doi.org/10.7748/nr.22.4.8.e1317

Tajfel, H. (1982). Social Psychology of Intergroup Relations. *Annual Review of Psychology*, *33*(1), 1–39. https://doi.org/10.1146/annurev.ps.33.020182.000245

UK Drug Policy Commission (2012). Dealing with the stigma of drugs: a guide for journalists. https://www.ukdpc.org.uk/wp-content/uploads/dealing-with-the-stigma-of-drugs.pdf. [Date accessed: 2nd April 2023].

Venner, K. L., Hagler, K., Cloud, V. & Greenfield, B. (2019). Native Americans resolve alcohol use disorder: "Whatever it takes or all that it takes". *Cultural Diversity and Ethnic Minority Psychology, 25*(3), 350-358. https://doi.org/10.1037/cdp0000241

White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor, 9*(5), 22-27.

Willig, C. (2013). *Introducing Qualitative Research in Psychology*, 3rd edition. Maidenhead: Open University Press.

Wolfe, B. H., & Scharp, K. M. (2022). A (In)curable Disease? Making meaning of addiction from the perspective of people in recovery from opioid use disorder. *Health Communication,* 1-9. DOI: 10.1080/10410236.2022.2128157

## Section C – Appendices of supporting material

### Appendix 1: CASP Quality analysis

The form can be found here:

https://casp-uk.net/images/checklist/documents/CASP-Qualitative-Studies-Checklist/CASP-Qualitative-Checklist-2018_fillable_form.pdf

The information was filled out using the form, but I have converted into tables here for ease of reading. The first two questions are screening questions to help decide whether to continue. I continued with all studies.

| | Study title and author | Comments |
|---|---|---|
| 1 | Course of Recovery from Alcoholism. Venner, K. L.; Matzger, H.; Forcehimes, A. A.; Moos, R. H.; Feldstein, S. W.; Willenbring, M. L. and Weisner, C. | |
| Was there a clear statement of the aims of the research? | Yes | 3 linked but separate aims clearly set out |
| Is a qualitative methodology appropriate? | Yes | The study wanted the experience of those who |

| | | |
|---|---|---|
| | | had experienced transformation change |
| Was the research design appropriate to address the aims of the research? | Yes | Interviews with people that met criteria who were then screened for eligibility |
| Was the recruitment strategy appropriate to the aims of the research? | Yes | They did not discuss why some people chose not to take part. They did not explain why they used hermeneutic as an approach |
| Was the data collected in a way that addressed the research issue? | Yes | |
| Has the relationship between researcher and participants been adequately considered? | No | |
| Have ethical issues been taken into consideration? | No | Not discussed in the paper |
| Was the data analysis sufficiently rigorous? | Yes | |
| Is there a clear statement of findings? | Yes | |

| | | |
|---|---|---|
| How valuable is the research? | | They discussed avenues for further research including client group, client number, and making research longitudinal. They discussed implications for abstinence and recovery. |

| | Study title and author | Comments |
|---|---|---|
| 2 | Alcoholic psychologists: Routes to recovery. Skorina, J. K.; Bissell, L. and de Soto, C. B. | |
| Was there a clear statement of the aims of the research? | No | Implicitly but not explicitly. States late recognition could delay recovery and that no study of alcoholic psychologists exists. states it wants to explore the journey of alcoholic psychologists. |

| | | |
|---|---|---|
| Is a qualitative methodology appropriate? | Yes | The study wanted the experience of those who were alcoholic psychologists (now abstinent). |
| Was the research design appropriate to address the aims of the research? | Yes | They did structured interviews. Semi-structured may have elicited more information but structured did fit with the fact they wanted to understand specific things about the experience of being alcoholic in the profession - this was set out in the method but not in the aims |
| Was the recruitment strategy appropriate to the aims of the research? | Yes | The criteria were clear and allowed them to compare with other studies. this may have also been the reason for the structured interview - to compare with previous |

| | | |
|---|---|---|
| | | studies on other professionals. |
| Was the data collected in a way that addressed the research issue? | Yes | |
| Has the relationship between researcher and participants been adequately considered? | No | Not mentioned at all. |
| Have ethical issues been taken into consideration? | Can't tell | Confidentiality is mentioned but not expanded upon. |
| Was the data analysis sufficiently rigorous? | Can't tell | There is no mention of how data was analysed, themes were derived, or which quotes were extracted and why. researcher is absent from discussion |
| Is there a clear statement of findings? | Yes | |
| How valuable is the research? | | They discussed the role colleagues play in identifying and raising issues with alcoholism in the psychology profession. |

| | | |
|---|---|---|
| | | suggests some general recommendations (training and recognition with verbalisation) but nothing specific. notes that alcoholic psychologists are being failed. |

| | Study title and author | Comments |
|---|---|---|
| 3 | Therapy or threat? Inadvertent exposure to alcohol and illicit drug cues in the neighbourhoods of sober living homes (SLH). Heslin, K. C.; Singzon, T. K.; Farmer, M.; Dobalian, A.; Tsao, J. and Hamilton, A. B. | |
| Was there a clear statement of the aims of the research? | Yes | To understand how people living in SLHs resist cues and do they use |

| | | |
|---|---|---|
| | | approach or avoidance cues. |
| Is a qualitative methodology appropriate? | Yes | The study wanted the experience of those in SLHs. |
| Was the research design appropriate to address the aims of the research? | Yes | |
| Was the recruitment strategy appropriate to the aims of the research? | Yes | Clear criteria and detailed information. |
| Was the data collected in a way that addressed the research issue? | Yes | |
| Has the relationship between researcher and participants been adequately considered? | No | Not mentioned. |
| Have ethical issues been taken into consideration? | Yes | Informed consent and confidentiality discussed. |
| Was the data analysis sufficiently rigorous? | Yes/Can't tell | Discussion of how data was transcribed and analysed, use of two researchers and kappa. |
| Is there a clear statement of findings? | Yes | |

| | | |
|---|---|---|
| How valuable is the research? | | It is valuable in thinking about how approach and avoidant coping can be encouraged, how sobriety in recovery homes can be encouraged and how abstinent people can be supported. Discusses implications for minorities groups e.g. those from urban subcultures who are at risk through sexual activity. |

| | Study title and author | Comments |
|---|---|---|
| 4 | Familial Influences on Treatment and Substance Use Among Mothers Engaged in Prostitution. Murnan, A.; Ferber, M. F. | |
| Was there a clear statement of the aims of the research? | Yes | It seeks to address the influences of family members and children on women's decisions to |

| | | |
|---|---|---|
| | | enter, stay in and exit treatment and outcomes |
| Is a qualitative methodology appropriate? | Yes | The study wanted the experience of these women in their own words. |
| Was the research design appropriate to address the aims of the research? | Yes | All made clear. |
| Was the recruitment strategy appropriate to the aims of the research? | Yes | It provided clear criteria and detailed information. |
| Was the data collected in a way that addressed the research issue? | Yes | All made very clear. |
| Has the relationship between researcher and participants been adequately considered? | No | Not mentioned. |
| Have ethical issues been taken into consideration? | Yes | Very clear and thorough. |
| Was the data analysis sufficiently rigorous? | Yes | Very clear and thorough methodology. |
| Is there a clear statement of findings? | Yes | |

| | | |
|---|---|---|
| How valuable is the research? | | The discussion includes clinical implications and ways to think about the impact on women and mothers particularly. |

| | Study title and author | Comments |
|---|---|---|
| 5 | Coping Strategies of Abstainers from Alcohol Up To Three Years Post-treatment. Murphy, S. A. | |
| Was there a clear statement of the aims of the research? | Yes | The aim is to understand gender differences in processes of change and abstinence maintenance. |
| Is a qualitative methodology appropriate? | Yes | The study wanted the experience of people in their own words. |
| Was the research design appropriate to address the aims of the research? | Yes | The research design was clear in text and tabular form. |
| Was the recruitment strategy appropriate to the aims of the research? | Yes | It appears appropriate. They recruited via appropriate channels |

| | | |
|---|---|---|
| | | however this meant they only had people who drank. They may have wanted to expand to other substances |
| Was the data collected in a way that addressed the research issue? | Yes | They appeared to when specifically examining drinking habits which was the aim of the study |
| Has the relationship between researcher and participants been adequately considered? | No | Not mentioned. |
| Have ethical issues been taken into consideration? | Yes | Clear and comparative information provided. |
| Was the data analysis sufficiently rigorous? | Can't tell | The method was described but the type of analysis was not explicitly stated. |
| Is there a clear statement of findings? | Yes | |
| How valuable is the research? | | The discussion includes important points to consider when thinking about treatment and |

| | | |
|---|---|---|
| | | abstinence maintenance between genders |

| | Study title and author | Comments |
|---|---|---|
| 6 | Recovery from Heroin or Alcohol Dependence: A Qualitative Recovery Experience in Glasgow. Best, D.; Gow, J.; Taylor, A., Knox, A.; & White, W. | |
| Was there a clear statement of the aims of the research? | Yes | The recovery journeys of people through heroin or alcohol. |
| Is a qualitative methodology appropriate? | Yes | The study is building on prior work in Birmingham as well as existing theory. |
| Was the research design appropriate to address the aims of the research? | Yes | The research design was very clear in demonstrating building on previous work but integrating own questions |

| | | |
|---|---|---|
| Was the recruitment strategy appropriate to the aims of the research? | Yes | |
| Was the data collected in a way that addressed the research issue? | Yes | It focuses on experiential feedback and quotations to demonstrate points. |
| Has the relationship between researcher and participants been adequately considered? | No | Not mentioned. |
| Have ethical issues been taken into consideration? | Yes | |
| Was the data analysis sufficiently rigorous? | Yes | The method and analysis are well described. |
| Is there a clear statement of findings? | Yes | It was clear and easy to read. The only thing is there is a limited amount of information compared to the size of the sample so the results are highly condensed. |
| How valuable is the research? | | A useful discussion that links back to findings and demonstrates difference |

| | | |
|---|---|---|
| | | between alcohol and heroin users. Also signposts to quantitative study. |

| | Study title and author | Comments |
|---|---|---|
| 7 | A Christian Faith-Based Recovery Theory: Understanding God as Sponsor. Timmons, S. M. | |
| Was there a clear statement of the aims of the research? | Yes | The aim was to understand Christian-based recovery from the perspective of African Americans. It doesn't say why they chose African Americans. |
| Is a qualitative methodology appropriate? | Yes | Yes. Grounded theory to inductively explore a previously unresearched niche |
| Was the research design appropriate to address the aims of the research? | Yes | The research design was clearly described. |

| | | |
|---|---|---|
| Was the recruitment strategy appropriate to the aims of the research? | Can't tell | Yes, although it was recommended by the director of a centre which may have involved some bias, conscious or otherwise. It doesn't demonstrate why the sample needed to be purposive. |
| Was the data collected in a way that addressed the research issue? | Yes | |
| Has the relationship between researcher and participants been adequately considered? | No | Not mentioned. |
| Have ethical issues been taken into consideration? | Yes | |
| Was the data analysis sufficiently rigorous? | Yes | The method and analysis are well described. |
| Is there a clear statement of findings? | Yes | It was clear and easy to read. The only thing is there is a limited amount of information compared to the size of the sample so |

| | | |
|---|---|---|
| | | the results are highly condensed. |
| How valuable is the research? | | It loosely discusses the link with other studies. Discusses the role of God in abstinence and how this is different from AA spirituality. Not as clearly defined future direction as other studies. |

| | Study title and author | Comments |
|---|---|---|
| 8 | The Retirement Phase of Heroin Using Careers. Jorquez, J. S. | |
| Was there a clear statement of the aims of the research? | Yes | The aim was to understand abstinence in recovery for heroin users. |
| Is a qualitative methodology appropriate? | Yes | They needed the participant voice strongly after synthesising existing research to identify levels of agreement. |

| | | |
|---|---|---|
| Was the research design appropriate to address the aims of the research? | Yes | |
| Was the recruitment strategy appropriate to the aims of the research? | Yes | They used snowballing which has appeared in other qualitative studies and appears an effective recruitment strategy |
| Was the data collected in a way that addressed the research issue? | Yes | |
| Has the relationship between researcher and participants been adequately considered? | Can't tell | They noted their own Chicano background but only to acknowledge why they had a large Chicano demographic and to say that may have helped with recruitment, not to acknowledge how this may have positioned them or participants. |
| Have ethical issues been taken into consideration? | No | No ethics mentioned at all |

| | | |
|---|---|---|
| Was the data analysis sufficiently rigorous? | Yes | The method and analysis are well described. |
| Is there a clear statement of findings? | Yes | It was clear and easy to read. The only thing is there is a limited amount of information compared to the size of the sample so the results are highly condensed. |
| How valuable is the research? | | It provides information that clinicians should give to people they work with and an interesting finding about what abstinent people want, which is to be model citizens in many cases. |

| | Study title and author | Comments |
|---|---|---|
| 9 | Into the unknown: Treatment as a social arena for drug users' transition into a non-using life. | |

| | | |
|---|---|---|
| | Robertson, I. E.; Nesvåg Sverre Martin. | |
| Was there a clear statement of the aims of the research? | Yes | The aim was to explore how people make transitions in living practices when they move from users to non-users |
| Is a qualitative methodology appropriate? | Yes | |
| Was the research design appropriate to address the aims of the research? | Yes | They are clear in explaining why they are using grounded theory and why they are using a narrative approach. |
| Was the recruitment strategy appropriate to the aims of the research? | Yes | It signposts to another study for more detailed information as it was part of a longer study. |
| Was the data collected in a way that addressed the research issue? | Yes | It did briefly identify methods but also signposted to the other study. |
| Has the relationship between researcher and participants been adequately considered? | No | No mention of their background, |

| | | |
|---|---|---|
| | | epistemological position, or beliefs. |
| Have ethical issues been taken into consideration? | Yes | They discussed gaining ethical approval and consent. |
| Was the data analysis sufficiently rigorous? | Yes | The analysis is described and supplemented with examples. |
| Is there a clear statement of findings? | Yes | |
| How valuable is the research? | | It offers an insight into what happens after treatment and suggests that outcomes are relationally bound. Links the findings to theory and indicates how people in recovery can be supported. |

| | Study title and author | Comments |
|---|---|---|
| 10 | Sex, Drug, and HIV/AIDS: The Drug Career of an Urban | |

| | | |
|---|---|---|
| | Chinese Woman. Wang, X; Liu, L. | |
| Was there a clear statement of the aims of the research? | Yes | A case study life history approach looking at the intersection between gender, drug addiction and HIV/AIDS. |
| Is a qualitative methodology appropriate? | Yes | |
| Was the research design appropriate to address the aims of the research? | Yes | Yes. As a single case study a life history approach appeared appropriate. |
| Was the recruitment strategy appropriate to the aims of the research? | Yes | They were holding a group and interviewed this participant due to the complexity of her story. |
| Was the data collected in a way that addressed the research issue? | Yes | The research issue was to explore her single story - not generalisable but still useful. |
| Has the relationship between researcher and participants been adequately considered? | No | Not mentioned. |

| | | |
|---|---|---|
| Have ethical issues been taken into consideration? | No | No ethics mentioned at all. |
| Was the data analysis sufficiently rigorous? | Can't tell | Not mentioned. |
| Is there a clear statement of findings? | Yes | |
| How valuable is the research? | | It discusses how drug services can work with those with HIV/AIDs and the government to support people trying to be sober. |

| | Study title and author | Comments |
|---|---|---|
| 11 | Native Americans resolve alcohol use disorder: 'Whatever it takes or all that it takes'. Venner, K. L.; Hagler, K; Cloud, V. and Greenfield, B. | |
| Was there a clear statement of the aims of the research? | Yes | The aim was to understand the journey of people in Native American tribes out of alcoholism and into recovery |

| | | |
|---|---|---|
| Is a qualitative methodology appropriate? | Yes | |
| Was the research design appropriate to address the aims of the research? | Yes | Questionnaires were used to remove bias from eligibility screening and then qualitative analysis of interviews. |
| Was the recruitment strategy appropriate to the aims of the research? | Yes | The use of questionnaires to remove bias and recruited via appropriate channels. |
| Was the data collected in a way that addressed the research issue? | Yes | |
| Has the relationship between researcher and participants been adequately considered? | Can't tell | The ethnic background of researchers was noted but only one reflection on how this may impact the study (an increased ability to discuss spiritual aspects). |
| Have ethical issues been taken into consideration? | Yes | They noted approval was gained from university, but they did not expand on this. |

| | | |
|---|---|---|
| Was the data analysis sufficiently rigorous? | Yes | |
| Is there a clear statement of findings? | Yes | |
| How valuable is the research? | | They link back to introduction, describing aspects of the narratives shared and thinking about directions for future research. |

| | Study title and author | Comments |
|---|---|---|
| 12 | Christianity in Narratives of Recovery from Substance Abuse. Lund, P. | |
| Was there a clear statement of the aims of the research? | Yes | The study focuses on the relationship between faith and sobriety. |
| Is a qualitative methodology appropriate? | Yes | |
| Was the research design appropriate to address the aims of the research? | Yes | The study explains why they used the narrative method. |

| | | |
|---|---|---|
| Was the recruitment strategy appropriate to the aims of the research? | Yes | They mentioned the use of snowballing. They mentioned contacting faith-based organisations. They could have widened this search because they were possibly making some assumptions that being part of a faith-based organisation means people are more religious? It is unclear why they didn't do a wider search net. |
| Was the data collected in a way that addressed the research issue? | Yes | |
| Has the relationship between researcher and participants been adequately considered? | Can’t tell | |
| Have ethical issues been taken into consideration? | Yes | They mentioned informed consent being gained. |
| Was the data analysis sufficiently rigorous? | Yes | They gave a detailed description of the analysis. |

| | | |
|---|---|---|
| Is there a clear statement of findings? | Yes | |
| How valuable is the research? | | They summarised the narratives, linked back to the introduction and addressed limitations. |

| | Study title and author | Comments |
|---|---|---|
| 13 | Parents' experiences of substance use problems, parenthood, and recovery within the 12-step movement. Heimdahl V. K. | |
| Was there a clear statement of the aims of the research? | Yes | The aim was to explore how parents in the 12-step movement speak about becoming parents. |
| Is a qualitative methodology appropriate? | Yes | Yes and describes in detail in the introduction how the method is used in other ways. |
| Was the research design appropriate to address the aims of the research? | Yes | |

| | | |
|---|---|---|
| Was the recruitment strategy appropriate to the aims of the research? | Yes | Snowball sampling is described and also describes why a different method was unsuccessful. |
| Was the data collected in a way that addressed the research issue? | Yes | Criteria are reasonable and well explained. |
| Has the relationship between researcher and participants been adequately considered? | No | Not mentioned. |
| Have ethical issues been taken into consideration? | Yes | Ethics given thought and described: consent, approval, anonymity, and minimising distress |
| Was the data analysis sufficiently rigorous? | Yes | A detailed description of analysis is given. |
| Is there a clear statement of findings? | Yes | |
| How valuable is the research? | | They summarised the narratives with an emphasis on salient points. |

| | Study title and author | Comments |
|---|---|---|
| 14 | The Road to Recovery from Addiction: A | |

| | | |
|---|---|---|
| | Qualitative Exploration of Motivators and Challenges to Achieving Sobriety in Recovery Housing. Parker, K. A.; Roberson, L. Ivanov, B.; Carter, R. and Riney, N. | |
| Was there a clear statement of the aims of the research? | Yes | The study has two research questions clearly set out. |
| Is a qualitative methodology appropriate? | Yes | Yes, due to how the questions are worded - asking about motivators and challenges. could be a questionnaire (open ended) rather than interviews but the interviews were semi-structured so some rigidity to them. |
| Was the research design appropriate to address the aims of the research? | Yes | The research design used semi-structured interviews to keep focused on the interview question and analysed via thematic analysis. |

| | | |
|---|---|---|
| Was the recruitment strategy appropriate to the aims of the research? | Yes | Participants were recruited by staff. There could be some bias but it is from appropriate locations. |
| Was the data collected in a way that addressed the research issue? | Yes | It was clearly the right group for the question and the questionnaires allow for focus. |
| Has the relationship between researcher and participants been adequately considered? | No | Not mentioned. |
| Have ethical issues been taken into consideration? | Can’t tell | Their only mention is "Institutional Review Board approval was secured". It is not clear if that is for ethics. |
| Was the data analysis sufficiently rigorous? | Yes | They give a detailed description of analysis. |
| Is there a clear statement of findings? | Yes | It was clear and easy to read. The only thing is there is a limited amount of information compared to the size of the sample so the results are highly condensed. |

| | | |
|---|---|---|
| How valuable is the research? | | It summarises the narratives with implicit recommendations. |

**Appendix 2: List of codes**

These were the initial codes generated when reading and rereading the papers.

**Study 1:**

1. Dramatic, discrete
2. Abstinence = sobriety
3. Profound, significant
4. Negative cognitive/emotional antecedents
5. Physical
6. Emotional relief
7. Discrepancy between newfound ideas and old lifestyle
8. Change becomes **necessary**
9. **Transformational experience as all the support you need.**

**Skorina et al (1990):**

10. Shame – children saw drinking, colleagues, impaired practice
11. Failed by others
12. Lucky – no formal grievances
13. Negative consequence of help-seeking (denied or sacked)
14. Negative consequence of drinking (damage to relationships, health and bought a house)
15. Attending groups in work capacity = stayed for life reasons
16. Went on proviso of helping someone else

17. Had a recommendation from someone else
18. Support system is vital

**Heslin et al (2013)**

19. Willpower and self-control
20. People as temptations
21. Old activities as temptations (walking streets, having casual sex)
22. Support from others
23. Avoiding old activities
24. Length of abstinence important
25. Support system is vital

**Murnan & Ferber, 2021:**

26. Too good for family
27. Tension between family and recovery
28. Romantic relationships often abusive and often precipitate relapse
29. Better for relationship with children
30. Children as barriers
31. Support system is vital

**Murphy (1993):**

32. Relationships as barrier

33. Relationships as support
34. Identity change
35. Paradigm shift (worldview)

**Best et al, 2011:**

36. Identity shift
37. Recovery as finite vs recovery as ongoing
38. Change in state
39. Support from others
40. Role models
41. "liking" self

**Timmons, 2012:**

42. Crisis point
43. Turns to God
44. God's plan
45. Need help

**Jorquez, 1983:**

46. Suicide attempt
47. Hate myself
48. Not myself

49. Stigma – “junkie bitch”
50. Revulsion – not like them
51. Naked lunch – reassess my life
52. Rock bottom – death of loved one, blood spots over house
53. Support – or threat of support removal
54. Desire for convention

**Robertson & Nesvåg, 2019:**

55. Socially marginalised
56. Hit rock bottom
57. Need to change
58. Embodied – old routines and ways of being
59. New life, new person

**Wang & Liu, 2020:**

60. Power and money
61. Unbalanced power
62. Men as source of drugs
63. Negative influences – sex workers
64. Failed by government
65. Rock-bottom – HIV
66. Transformation
67. Old self vs. new self

68. Othering of the addict – third person

**Venner et al, 2019:**

69. Not be like others
70. Support from others
71. Death and loss
72. Negative influences
73. Racial biases – need to find a fit
74. Need to be like us
75. Treatment groups – hypocritical
76. Change in self
77. Final chance – now or never

**Lund, 2016**

78. Failed by others – lack of support
79. Third time lucky
80. Total transformational change
81. Accepting self
82. Reborn person – new and better person

**Heimdahl, 2020**

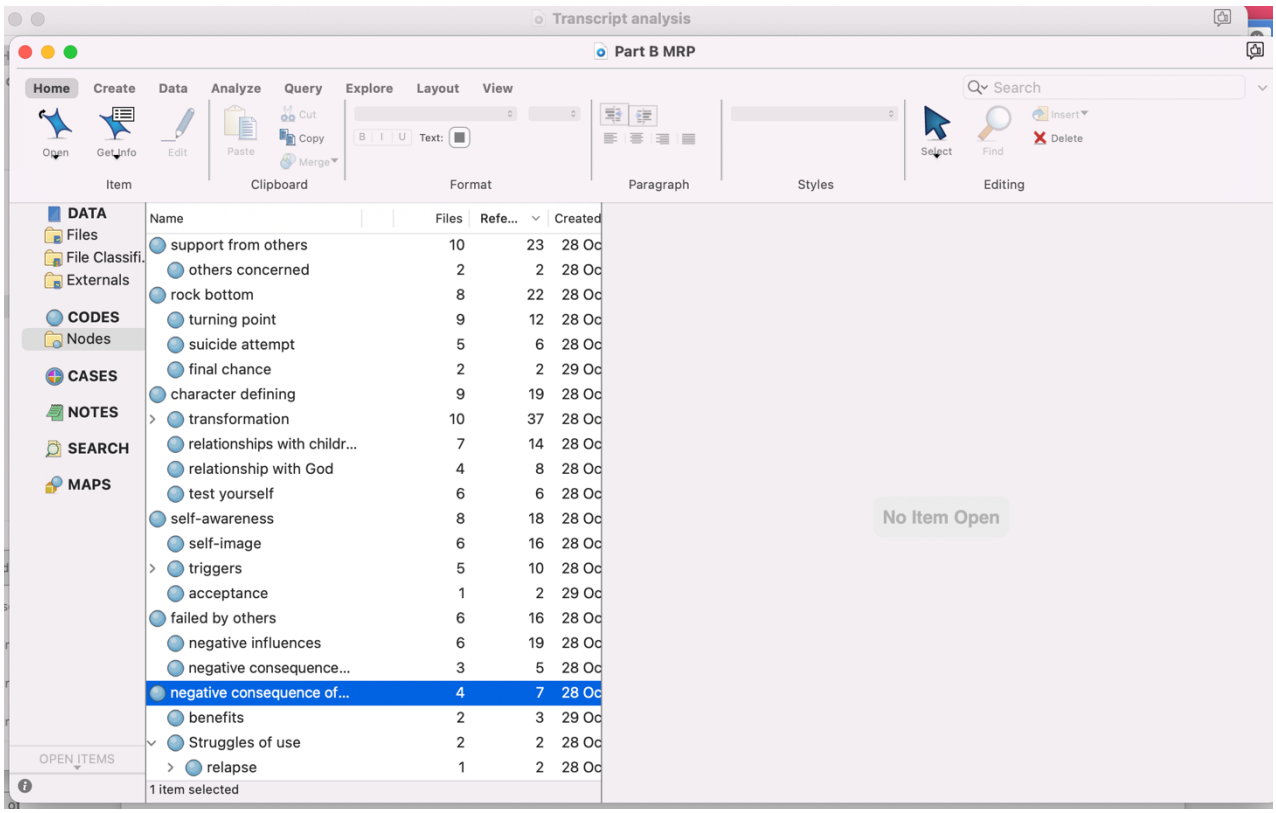
83. Insincere attempts
84. Done for yourself
85. Change in who you are
86. “let down” others – repairing
87. Drugs > anything else
88. Genetic component
89. Recognition vs overbearing

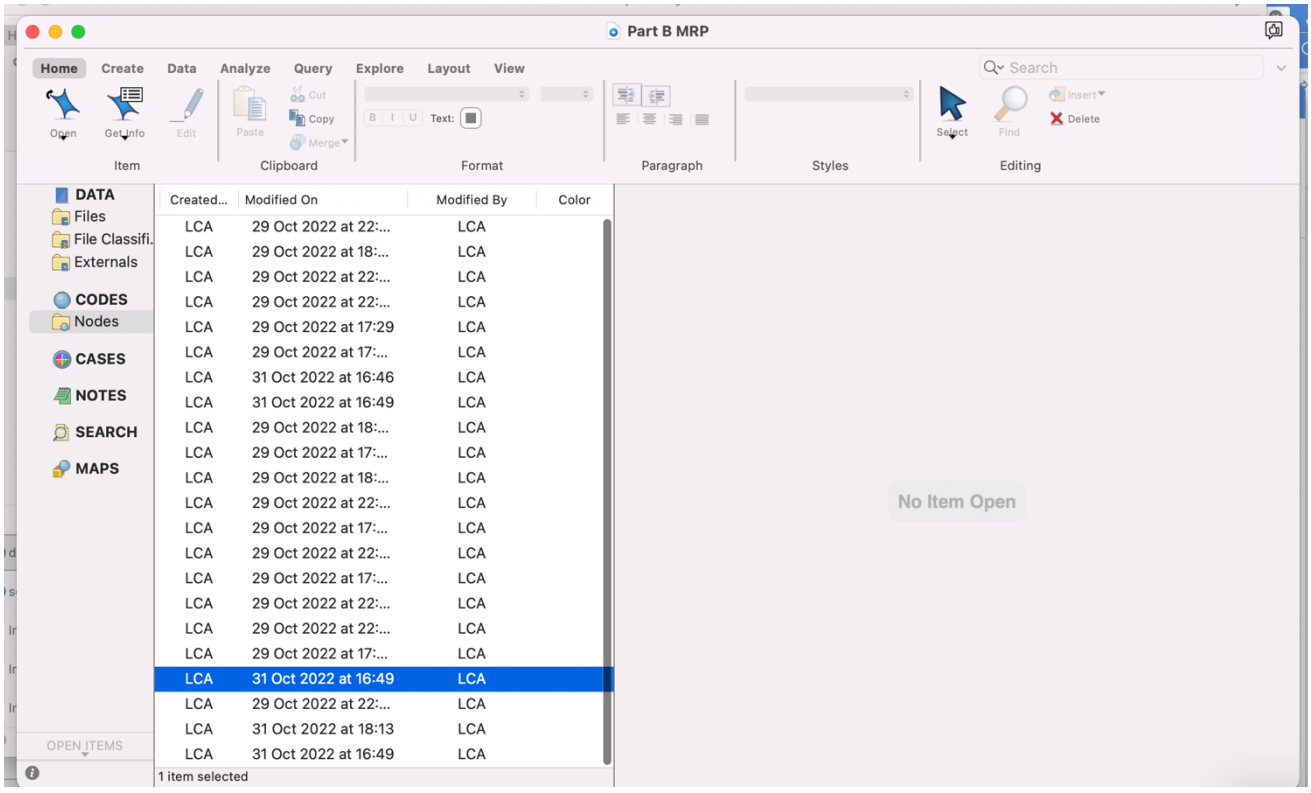
**Parker et al, 2021**

90. Sense of purpose
91. Help others
92. Newfound strength
93. Support is crucial
94. Challenge of temptation

## Appendix 3: NVivo codes and themes

The papers were added to NVivo and then coded. The codes were grouped into themes and sub-themes. These screenshots show the development of themes and sub-themes, the date this work was carried out and the number of files that have themes and sub-themes. For example, “support from others” is present in 10 papers with 23 references. The volume of papers and references meant this was a strong theme.




Part B MRP
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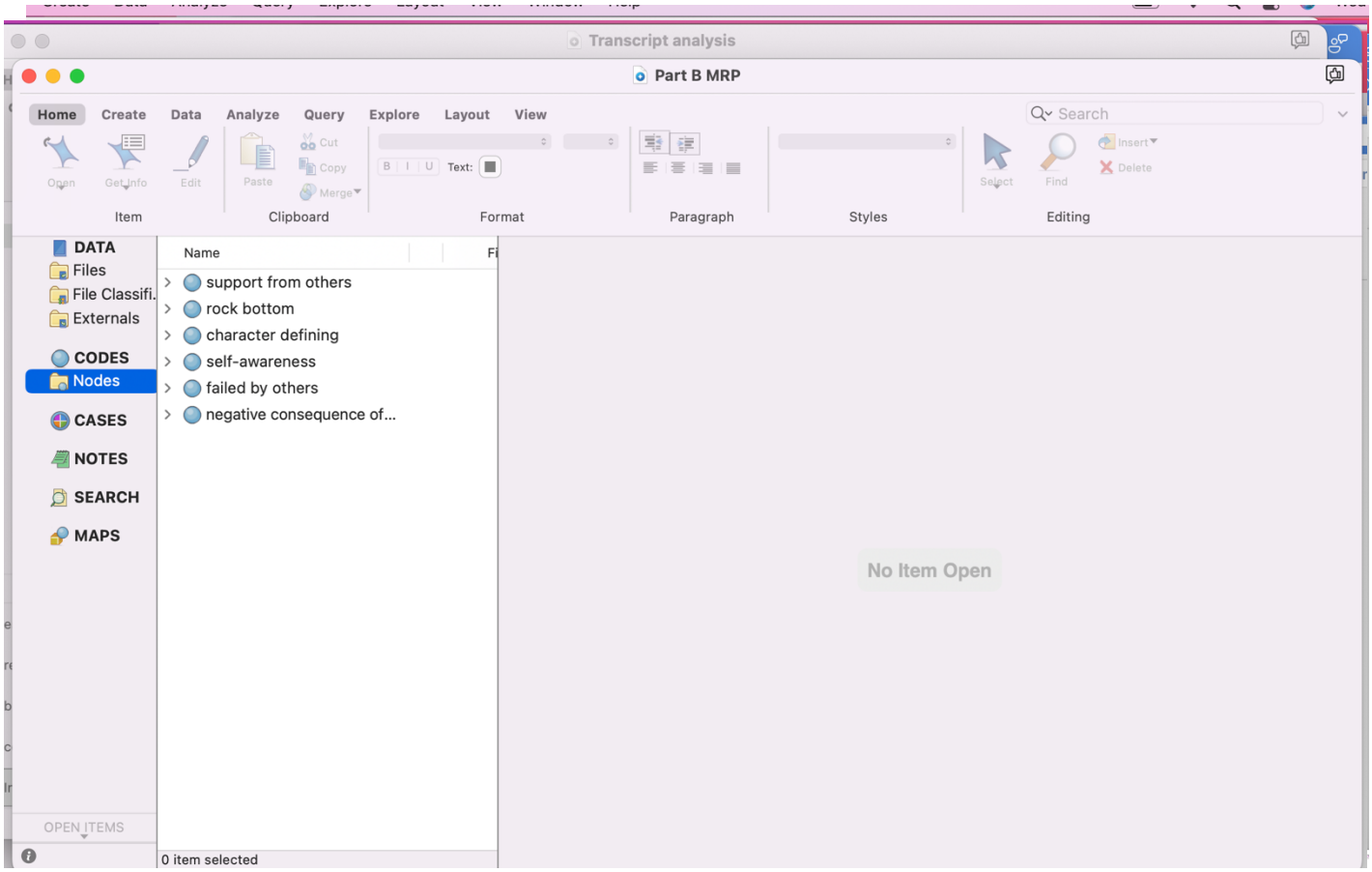
Transcript analysis
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Name
support from others
rock bottom
character defining
self-awareness
failed by others
negative consequence of...
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**Appendix 4: Additional supportive quotes**

These are additional quotes to support the themes and sub-themes.

| "Why did I want to . . . add to the tragedy?" | |
|---|---|
| Quote | Study |
| "Just looking at all the tragedy, why did I want to . . . add to the tragedy?" | 11 |

| | |
|---|---|
| “Rock bottom” | |
| Quote | Study |
| “He called me some time when I was drunk, and then he just told me that “If you don’t get your shit together, I will call the social authorities.” | 13 |
| “She became frightened after drinking so much-was shocked by seeing herself in the mirror” | 2 |
| “She was sick and miserable” | 2 |
| *Suicide attempts* | |
| Quote | Study |
| “I tried to kill myself with “reds” and “stuff’ (heroin).” | 8 |

| | |
|---|---|
| I took a suicidal turn. … I thought I had been abandoned. I drank in an insane way.” | 7 |

| | |
|---|---|
| “Turning point” | |
| **".Just say the word, I'll take you”.** | |
| Quote | Study |
| Quote | Study |
| “One spoke about how drinking had | 14 |
| “Supportive family members offered prevented him from achieving his life goals” encouragement for women’s treatment- | 4 |
| seeking.” | |
| “I needed somebody I trusted and liked and respected to tell me it was the wrong thing to do.” | 8 |
| “She [her boss] would take care of [participants children]”. | 11 |

| | |
|---|---|
| **“I did not get any support, not from my parents or from anyone. I went back to drinking.”** | |
| Study | Quote |

| | |
|---|---|
| Over half the women had partners who were drinkers who encouraged them to drink | 2 |
| Being beat on, being stressed out, being cheated on. So to deal with all them problems I turn to drugs again.… Just not happy, but not being able to leave. | 4 |

| | |
|---|---|
| *"First comes the man, then comes the relapse."* | |
| Quote | Study |
| "Being around old people, places, and things. Being around my family. Stressful situations that would make me go use again." | 4 |

| | |
|---|---|
| *"The confidentiality it just, gosh it wasn't there."* | |

| Quote | Study |
|---|---|
| “Children limited the number of accessible and feasible treatment options because few allowed children to attend treatment.” | 4 |
| “Finding the right "fit" in a meeting was important.” | 11 |
| “Denial, conspiracy of silence, or misguided protectiveness toward one's own appears to characterize psychologists at least as much as other professionals.” | 2 |

| “Transformational change” | |
|---|---|
| Quote | Study |
| “The change was total…” | 12 |
| “… identity transformation was mainly manifested through descriptions of how one has changed and become able to live a richer and more harmonious life…” | 13 |

| *"Please mom, just do it for me."* | |
|---|---|
| Quote | Study |
| "…Owed it to her son to seek treatment after his father died from an overdose." | 4 |

| *Relationships with God* | |
|---|---|
| Quote | Study |
| "I'd say, "Lord, do something with my life again! I'm sick of this life I'm in" | 8 |
| ''knowing there was something more'' and feeling like they ''existed for a reason" | 1 |

| *"Look, temptation will come at you at all angles."* | |
|---|---|
| Quote | Study |

| | |
|---|---|
| "There is no "safe endpoint" at which alcohol-dependent persons can let go of vigilance." | 5 |

| **"I have to be aware and beware."** | |
|---|---|
| Quote | Study |
| "Take responsibility/ stay committed, ask for help/stay connected, make changes in self and environment, and maintain vigilance." | 5 |
| "Asking for help staying connected was not opposite to taking responsibility, but rather recognizing one's needs." | 5 |
| "Now I feel so far away from my active addiction, but yet I'm so close because I could just lose all that in two seconds." | 6 |
| "I was lonely as well and that's how I was drinking". | 6 |
| "The revulsion of looking at the people around me and knowing "My God That's where I'm at." | 8 |

| *"I see myself as a different person, a new person, a better person."* | |
|---|---|
| Quote | Study |
| "[She was] unable to accept herself." | 12 |
| "I didn't like myself and I didn't want anyone else to like me." | 8 |
| "I was real happy that I got educated". | 11 |

| *"Nothing is free from the memory of using."* | |
|---|---|
| Quote | Study |
| "Challenges were constant for the men with the terms "everywhere," "constant," and "all the time" permeating the conversations." | 14 |

| | |
|---|---|
| "….when they experience triggers or diverse stimuli (e.g., sound of cigarette lighter, smell of beer) that provoke an intense urge to use the addicting drug." | 8 |
| "Nothing is free from the memory of using. Even just going to the store is a reminder of use." | 9 |

| **"If I could just save one life, it's worth it."** | |
|---|---|
| Quote | Study |
| "… Saw a discrepancy between their newfound values and ideals and conform their drinking and lifestyle behaviours accordingly" | 1 |

**Part B Appendix 1: Recruitment poster**

or speak to your key worker

Canterbury Christ Church University

I am Lauren Cunningham-Amos, a Trainee Clinical Psychologist who is interested in hearing your story.

## Are you currently using drug and alcohol services in West London?

If so, I would really like to hear from you over the course of two interviews and learn about your life, your identity and your journey into drug and alcohol services.

**More information available – email above or ask your worker for details**

This research has gained ethical approval from the Salomons Institute of Applied Psychology, Canterbury Christ Church University. Substance Misuse and Identity. 28/06/22 version 3.

## Part B Appendix 2: Ethical approval

*"This has been removed from the electronic copy"*

**Part B Appendix 3: Information sheet**

Salomons Institute for Applied Psychology

One Meadow Road, Tunbridge Wells, Kent TN1 2YG

www.canterbury.ac.uk/appliedpsychology

***An exploration of users of substance misuse services, the salient identities held, and the relationship between these identities, the individual, and the wider system.***

Hello. My name is Lauren, and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in my PhD study.

I also have three supervisors. They are Dr Derek Tracy, Medical Director of West London Trust; Professor Margie Callanan, Clinical Director at the Salomons Institute for Applied Psychology, Canterbury Christ Church University; and Dr James Morris, Research fellow at London Southbank University. Before you decide whether to take part, it is important that you understand why this study is being done and what it would involve for you.

Talk to others about the study if you wish.

(Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study).

**What is the purpose of the study?**

You are being asked to participate in a study about how your life experiences and how you see yourself might relate to your views on existing treatment services for substance misuse.

I am interested in understanding more about you and your experience of services.

**Why have I been invited?**

You have been invited because you are currently attending a substance misuse service for your substance misuse.

**Who can take part?**

Any individual using a substance misuse service, who after discussion with their support network and staff team, feel they would like to take part. If you are in a substance misuse service that is not primarily focused on addressing alcohol misuse, then we invite you to take part in this study.

**Who cannot take part?**

Anybody who only misuses alcohol **or** is in a service primarily focused on alcohol misuse. This is because drug services and alcohol services can be quite different in the treatment that is offered. This may impact on the stories that people share about their treatment experiences. **This does not mean that the stories of people who only use alcohol are not valuable or important:** it is just that this study is focused on treatment services for substance misuse, not alcohol misuse, and so we are inviting those who can speak to that service experience.

**Do I have to take part?**

It is up to you to decide whether to participate in the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw within one week of your interview taking place, without giving a reason. This would not affect the standard of care you receive.

**What will happen to me if I take part?**

I would like to interview you for this project. The interview is likely to last around an hour. There is the possibility that there will be a second, shorter interview to clarify some of the information gathered from the first interview.

These interviews will be audio recorded using a password protected Homder Digital Device Recorder. This is in line with sponsor **(Canterbury Christ Church)** data protection policies. I will listen to the recordings repeatedly and summarise your personal story from the information given. This will remain confidential to everybody except for me. My supervisors will read transcripts of the interviews for supervision and quality purposes. However, these transcripts will be given pseudonyms and so you will remain anonymous.

After the study is complete, participants will receive a copy of the transcript of their interview and of a summary of my analysis of their individual narrative, and then a summary of the analysis of all the narratives together. You will also receive a personal debrief sheet and the opportunity to meet for any further questions you may have. You will have two weeks after receipt of the debrief to make contact for a further meeting. This is to give you time to read through the summaries and the debrief.

**Expenses and payments**

I will be seeing you in the clinic and will try and arrange it for a time when you would be going there for your appointment anyway.

You will be given a £10 voucher to thank you for your time.

We will offer refreshments on the day and there will be an opportunity for a break, if needed.

We can accommodate virtual appointments if needed if they can take place in a private and confidential space.

**What will I be asked to do?**

I will ask you to tell me about some of your life experiences. There will be some questions about you, your life, your substance use, and your experience of services so far.

I will also ask you some demographic information (such as age, educational status, religious affiliation). Your answers to these are completely optional. This information is collected so that when I write the study, I can say how the sample is represented (such as what age ranges participants fell between or what educational background they had).

**What are the possible disadvantages and risks of taking part?**

It is possible that some of the questions may feel upsetting to you because they may remind you of times in your past. You do not have to answer any questions that you do not want to.

**What are the possible benefits of taking part?**

It might help you to understand yourself and your life's journey better. It may also help people that use substance misuse services in the future.

**What if there is a problem?**

Any complaint that you may have about the research or about the service will be addressed. There is more about this in part 2.

**Will information from or about me from taking part in the study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. There are some rare situations in which information would have to be shared with others. The details are included in Part 2. There will be some demographic information collected for me to help build the narrative, but you **will not** be identified from this information.

We will need to use information from you for this research project.

This information will include your:

- Name
- Contact details (e.g., address, phone number or email address)

I will use this information to contact you about the research.

People who do not need to know who you are will not be able to see your name or contact details. Your interview data will have a pseudonym instead.

We will keep all information about you safe and secure.

This completes part 1.

*If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.*

**Part 2 of the information sheet**

**What will happen if I don't want to carry on with the study?**

If you withdraw from the study within one week of your interview then all your information, including your interview, will be removed. After this point, it will not be possible to remove your narrative as analysis will already be underway. All personal information (name, contact details) will be removed. Demographic information (age, educational status, religious affiliation etc.) is not identifiable and so we will keep this information if you have already given it.

**What are my rights over the data?**

Your data subject rights may be limited due to the purposes of the research and that any request to exercise data subject rights will be reviewed by the sponsors Data Protection Officer.

**Concerns and Complaints**

If there are any questions or concerns, you are welcome to please email me on [redacted].

If you do not like emailing, please send an email with your phone number to the above email address and we can speak via phone.

If you have a concern about any aspect of this study, you should ask to speak to me, and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number 01227 927070. Please leave a contact number and say that the message is for me, Lauren Cunningham-Amos, and I will get back to you as soon as possible. If you remain dissatisfied and wish to complain formally, you can do this by contacting Dr Fergal Jones, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology [redacted]

If you are not satisfied with this response, you can make a complaint to the Information Commission Authority, the UK's independent body set up to uphold information rights. You can read more about this here:

**https://www.hra.nhs.uk/information-about-patients/**

**Will information from or about me from taking part in the research be kept confidential?**

Your interviews will be stored on a password-protected memory stick that only I have the password to. My supervisors (who do not work in the service) may hear small sections of the recording, but you will not be identifiable and so will be anonymous.

Your anonymised data will be kept for ten years and after this it will be disposed of securely. This is in line with the Medical Research Council. This is also in line with GDPR and DPA regulations.

The only time when I would be obliged to pass on information from you to a third party would be if, because of something you told me, I were to become concerned about you or somebody else being at risk of harm. I would not need to breach confidentiality if you told me something you did not like about your care, for example if you did not relate to your worker.

**What will happen to the results of the research study?**

I intend to publish the results of the study in a psychological journal. All your information will remain anonymous.

I will also share the results of the study with you in presentation format. You will receive this face-to-face. This can be accommodated virtually if required if it can take place in a private and confidential space.

A 'narrative analysis' approach will be used, and this means that you will be kept informed throughout as I analyse the interviews so that you can also share your own views.

**Who is sponsoring and funding the research?**

Canterbury Christ Church University.

**What are the insurance arrangements for the research?**

Professional Indemnity insurance is provided by Canterbury Christ Church University and Subsidiary companies including MEDCO (CCCU) LTD. The insurer is Royal & Sun Alliance pls.

**Who has reviewed the study?**

*All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been approved by Brighton and Sussex Research Ethics Committee and Salomons University Ethics Committee.*

**Further information and contact details**

You are welcome to ask any questions at any point during the study and will also be given a further information sheet with more detail after the interviews are completed. If there are any further questions, you are welcome to please email on lc870@canterbury.ac.uk.

If you do not like emailing, please send an email with your phone number to the above email address or use the 24-hour phone line (see previous page) to leave a message and we can speak via phone.

Version Number: 5 Date: 28th June 2022

IRAS ID: **304044**

**Part B Appendix 4: Blank consent form**


Salomons Institute for Applied Psychology

One Meadow Road, Tunbridge Wells, Kent TN1 2YG

Ethics approval number:

Version number: 5

Participant Identification number for this study:

# CONSENT FORM

Title of Project: An exploration of users of substance misuse services, the salient identities held, and the relationship between these identities, the individual, and the wider system.

Name of Researcher: Lauren Cunningham-Amos

Chief Investigator: Professor Margie Callanan

Please initial box

1. I understand that my participation is voluntary and that I am free to withdraw within one week of my interview taking place, without giving any reason and without my treatment being impacted in any way.

   ☐

2. I agree to my interviews being audio recorded for the purpose of the study.

☐

3. I agree to this recording being transcribed for the purposes of narrative analysis.

☐

4. I understand that there may be a follow-up interview that takes place to discuss some details from the first interview **within two weeks** and that I may choose not to take part in this if I wish.

☐

5. I understand that anonymised data collected during the study will be looked at by the supervisors in this study, Dr Derek Tracy, Professor Margie Callanan and Dr James Morris. I give permission for these individuals to have access to my full anonymised transcript data.

☐

6. I confirm that I have been made aware of the rules of confidentiality prior to the interview taking place.

☐

7. I agree that quotes and other information from my interview may be used in published reports of the study, but that these will protect my privacy and will not be able to identify me, so I will remain anonymous.

Yes ☐ No ☐

8. I agree for my anonymous data to be used in further research studies. OPTIONAL

Yes ☐ No ☐

9. I agree to take part in the above study.

☐

10. I confirm that I am aware that I do not have to answer any personal questions if I do not wish.

☐

11. I confirm that I am aware that the voucher I am given is to thank me for my time and not to induce me to take part.

☐

12. I consent to being contacted by:

Phone ☐

Email ☐

Post ☐

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Version Number: 5 Date: 24th June 2022

IRAS ID: **304044**

**Part B Appendix 5: Demographic questionnaire and interview schedule**

Demographics:

a. How old are you?
b. What ethnicity best defines you?
c. What is your highest educational status?
d. What is your sex?
e. What is your gender?
f. What is your sexual orientation?
g. Do you have any long-term health conditions?
h. Do you work? What has been your longest job role?
i. What (if any) is your religious affiliation?
j. How long have you been in substance misuse services?
k. How many times have you engaged with substance misuse services? * relapses
l. What treatment have you been offered?
m. Have you ever been offered any other support (e.g. third sector, charities, mental health, community support etc.)?

Version Number: 1 Date: 13th June 2022

IRAS ID: **304044**

Interview Schedule sample

Questions: life chapters, key events, significant people, future scripts, stresses and problems, personal ideologies, and life themes.

1. Can you tell me about your life up to this point? Start from wherever feels right to you. Everything is relevant, so include as much detail as you feel is important.
2. Are there any key events in your life that have led you here?
3. Who are the significant people in your life?
4. What do you see in your future?
5. What things are important to you? Has this changed throughout your life?

Example prompts:

1. Could you tell me more about that?
2. Could we just go back to *x*. If it's ok, could you tell me more about that chapter in your life?
3. Were there any other main characters involved during *x* part of the story?

Version Number: 2 Date: 13th June 2022

IRAS ID: **304044**

**Part B Appendix 6: Bracketing interview**

This bracketing interview was undertaken with a colleague. These are the questions asked and my notes from the discussion, rather than a verbatim transcript.

Bracketing interview:

Question: what motivated you to do this research project?

Question: what biases do you think you might have?

- One major motivation was that I felt there was something missing. People often want to talk to people who are better, or who are recovered. They want to know what got them to where they are now, to the "good" bit. The missing bit is the bit in the middle, where people are still using services or still aren't clear what they want. When I did my undergraduate dissertation I spoke to people who wouldn't say they were addicts because of age, because they stopped themselves. Because of how their lives were. Since then I've wanted to understand what's the difference, how you decide, what makes you call yourself that and what else do you call yourself?
- I have been aware throughout my research project, part B in particular, that my own political viewpoints have impacted on how I've entered into conversations at the research sites with clinicians, with supervisors, and with participants. e.g., funding and cuts. When participants discussed politics I was inclined to agree with them and made this clear. This may have encouraged them to discuss this more and also may have demonstrated to them that I was an advocate for them. This might have

separated me as a researcher from clinicians who may be more cautious about demonstrating their political viewpoints and may wish to remain apolitical.

- At times I felt conflicted between wanting to get across that I was on their side but not wanting to overly collude. I had an awareness that while their story was to be elevated and was important that I was only hearing one narrative. If there is no absolute truth then how did I feel about completely buying in to their view on the world? Did it matter whether I did or not? Was building the relationship more important? I felt that as long as it wasn't discriminatory it probably was better to align with them, especially because they may not have experienced this in the world, particularly not recently.
- Whose stories was I prioritising? I had to think carefully about the relationships that I formed in the room, however brief. The important part of relationship was about how you felt about people in the room and connections that I was establishing. Some people haven't felt connection in a long time.
- I was actively trying to form a connection with people and when it formed more easily, I had to be aware of that when transcribing, coding, and analysing. For example, some people's stories really struck me and I felt a lot of emotions when speaking to them. I found their stories extremely powerful. I felt this with all participants in different ways. Similarly to in daily life and in the therapy room, there are some people where you get along with them better and could see that outside of the space you may have formed a connection. In these conversations, you potentially find yourself more invested in their story and need to be mindful when thinking about what informs which quotes you select and how you immerse yourself in the data.

- I used the language that was used by participants but I was aware that some of that language may be stigmatising, e.g. people passed negative judgements on themselves and other users of their substance.
- I was aware of some discomfort during interviews e.g. when one participant was saying users that have methadone still want to get high and I had already interviewed multiple people on a methadone script. I didn't want to agree with this but didn't want to invalidate his experience and what he clearly needed to be true to help his own recovery.
- Ideas about family. I reflected on my own family relationships and how close I am to my family, particularly my parents. Hearing participants talk about the damage to their family relationships and talking about how they had been treated by their parents and people who were supposed to love them unconditionally was particularly hard for me to imagine. I couldn't identify or relate to it in any way but felt emotional imagining what it might have been like to grow up that way and to still crave that love and affection decades later.
- When writing my part a, I became painfully aware of the whiteness of research and my own judgements about the researchers not speaking about ethnicity demographics. This reflected my own experiences of university, the workplace, and the doctorate. It also highlighted to me how clearly defined my own ideas are about what is worthwhile research.
- **Things I need to hold in mind:**
    - **Noting how I feel about a participant and how that may inform how much of their story. People that are easier to form connections may inadvertently receive better care because people are more willing to advocate for them, happier to spend time with them (e.g. extending their**

**sessions) and sometimes may even place a moral superiority on them because they can relate to them or empathise more with them. I am sure I haven't done this, but I'm aware that I'm not infallible and this is important to recognise.**

- **Noting my own biases towards minorities and people of a lower social class because I know that they are often disadvantaged in research. I don't think this is something that needs to change. It is something that can be overlooked in research. I still, however, need to notice it because it's an additional layer that may impact how I interpret the stories I am hearing.**
- **My relationship with my own family and with my own partner and what I think about what I am being told about how others have been treated by their family or romantic partners. Having opinions is inevitable, and the way in which they tell the story will give some indication of how they feel about it and maybe how they are hoping I will respond. Families are complicated and relationships are complicated, and I cannot form a judgement based on the snapshot I have been given. I need to be careful of the language I use when writing, focusing on the feelings and experiences of participants rather than drawing any firm conclusions: that is not my role.**

**Part B Appendix 7: Reflective diary**

These are sample extracts. The full diary is available on request.

Reflective diary – MRP

**December 2020**

I had the research fair last month and it was much harder than expected finding somebody with a background or an interest in substance misuse. I almost gave up and went for a study that was preselected. I had to remember though, I've wanted to do this piece of research since I was 20 and always told myself that when I did the doctorate that I would do it. If I gave up now, I don't know when I'd next be able to do it. I'm wondering if this reflects what the state of substance misuse services are like – if there aren't any people interested in a university, how many people are in the field?

I've found that I'm doing a proposal to even get a supervisor. During the Christmas holidays I'm messaging people on LinkedIn that I've never met and trying to make connections through the internet. I wonder if people tend to only research in areas they work in or have contacts in because it's so much easier. Again, is that why substance misuse services are so under researched?

**November 2021**

I presented my research today at a London conference for substance abuse and mental health. Everybody was so keen on the idea! They all seemed really keen to help and support. They all asked questions and commented on how important it was. It makes it even more frustrating that I've been having a nightmare with my proposal being passed because it seems

like whenever I talk to clinicians, they think it's great and it's frustrating this cannot be enough evidence that it's a study worth doing!

**February 2022**

I passed university ethics straight away! The excitement has been very short-lived because I've gone to recruit to be told I must do NHS ethics. It feels like I'm falling at every hurdle right now and I can't imagine this study ever getting off the ground.

**March 2022**

An absolutely terrible meeting with the third site I was hoping to recruit from. The first two were really supportive and friendly. This one was rude and dismissive. She rolled her eyes at me while I was talking, while sighing. She could not have made it clearer that she did not want me to recruit from her site. I felt like I needed to defend my project and myself to her throughout the whole meeting. It made me really angry. It was almost as if she wanted me to beg her. I was really grateful for my supervisor being there, so I knew I wasn't exaggerating it.

**August 2022**

My two services are happy to take part and help with recruitment, which is great. I have visited one in person, and it was good to shadow a group and a review to gain some insight into the kind of work they do. I also was appreciative of my clinical supervisor telling the third site "thanks, but no thanks". It was nice to know he was fighting my corner and that he felt we didn't need to suck up to people to get things done. Recruitment is a worry – things seem to be moving extremely slowly.

**September – November 2022**

I have loved completing interviews. This has by far been my favourite part of the process. It has been fascinating hearing people's lives and stories. As I was listening, I was already able to think about themes and draw links between the experiences of different people. It is nearly impossible to condense people's lives into an hour, but the stories I have heard are so rich and so full. I hope the people that participated gained something from sharing their stories. They were so powerful, and it's made me really excited to see what comes out of them – but desperately sad at times. It's showed me how early the seeds of addiction can start and how much of a shift someone's life can take.

Interview 1 reflections:

I was nervous going into my first one. It was face0to-0face so I felt more comfortable but was worried he wouldn't turn up. He seemed keen to take part on the phone. He was on time. I found that the lack of initial interview structure left us both a bit unsure. After the interview, I felt it had gone well and was already building a narrative in my mind.

Interview 2:

They came early. I wasn't sure who it was when I went into the waiting room and someone else in there waiting to be seen said I had a lovely smile. I didn't know if this set a slightly odd tone. I enjoyed this interview a lot. There were some things I wanted to probe more but I was aware how much of their time they had dedicated. I didn't have a benchmark for interview length yet. I liked the settling in time at the start of the interview and the moments of connection established through mutual interests.

Interview 3:

This interview was via phone and there was a three-week gap between my first interviews and this one. I noticed that I was more confident with my questioning but the interview was more stilted. I wonder if this was because we hadn't met and I couldn't see their face. I wondered if there was a similar feeling to when we had online lectures vs face-to-face. There was a sense that I was just missing something. Sometimes I picked up on a slightly sarcastic tone or a way of explaining e.g. when he said "let me break it down for you" that I found irritating. Maybe this wouldn't have been the case in person?

Interview 4:

Interestingly, this was also via phone but was a totally different experience. I felt a connection with this interviewee and the power of her story despite being via phone. Like the pervious participant, I really wanted to know what they looked like. I felt like I didn't have a full picture of them without also seeing their face. I built a picture of this person in my mind, of both of them actually.

Interview 5:

We had to rearrange this interview a couple of times and this meant I wasn't sure how committed the participant was to the interview, especially because they had time limits on how much they can speak. I found parts of the interview really poignant (like their reflections on having fond memories of prison). However, I felt that although they got into the interview, this was the first interview where I felt that the interview produced more sad feelings than positivity. *edit* I came back to this later because they reached out to me to thank me for the voucher and I think actually the interview did allow them some cathartic release. I hope it also helped them to see what they could achieve and feel motivated for this.

Interview 6:

This interview was interesting because the participant hadn't used street drugs in 30+ years. They had a different perspective to the others because of their age and because of their life experience.

Interview 7:

This was a really strange interview. It felt quite chaotic and it was meant to be face-to-face but they changed it to phone call at the last minute. I kept getting the feeling that we weren't on the same page and there were times when he would respond in a way that led me to feel that I had said or done the wrong thing. It was only after the interview that I was told he was psychotic. I wonder whether that would have made a difference if I'd known before? Would I have not done the interview in the same way and would I have not done it via phone? Does that say anything about my own biases or did I only consider this because of the way the interview played out?

Interview 8:

This person was allegedly really nervous about interviewing so I was mindful to try and be as warm and reassuring as possible. That said, I definitely felt that I had to work harder in this interview to elicit the narrative. It felt like I had to ask a lot more questions an do a lot more paraphrasing than with other participants. It was interesting to hypothesise about this. It could have been simply nerves. I think it might also have been because this man's self-esteem was at a point where he didn't think his story was worth telling. He couldn't tell what was valuable to share because he didn't think anything was, so needed lots of guidance.

Interview 9:

This was a surprise, last-minute interview after all of the others had finished. It was nice to think of this as my final interview and go into it with a sense of ending and closure. The interview was also via phone at the request of the participant and while transcribing there were moments of frustration as they were outside for some of it, which affected sound quality. I definitely felt relieved it was my last transcription, but I also remember a sense of completeness at having done nine solid interviews.

**November 2022**

I contacted one of my participants (probably one of the two I enjoyed speaking to the most, although I'm probably not supposed to say that). He was my second interview and was so friendly and helpful. We also laughed in the interview, but he shared some chapters of his life that were so difficult and powerful that I felt honoured to share in it, as I did with all the participants. It was also face-to-face, so even though a couple of the others stick in my mind, they felt more like they were with strangers as they were faceless. We spoke again for a brief demographic conversation, and we ended up speaking for 25 minutes as he had really been struggling. It was hard to stay in role as a researcher and I ended up not having boundaries with my time (eating into a lecture). He said that he would put off sourcing drugs to speak to me and I felt this extremely uncomfortable dilemma – do I want to encourage him to source drugs? Is it realistic to assume that he will not or that I could make any difference to that? Is it worse for him to start withdrawing? I felt that I made the right decision (supported by my supervisor), but I did wonder whether I had made the right choice. Later, he sent me a long text message that was highly complimentary of me as a professional, and I suppose as a person. It made me feel sad. Why did he message me that at half 6? He followed up saying he was "dopey". When he was high, did he feel especially lonely? Did he reach out because he

felt understood by me in a way he didn't by his parents? Had I overstepped and had I created a difficult situation? Did I need to raise it?

When we next spoke after the weekend, he raised it himself and explained he had also spoken to his worker about me. I felt much better when I knew this – it meant he hadn't been harbouring any secret feelings. They were also lovely words, and it was nice to be able to appreciate them without being concerned about boundaries. We had a conversation about me calling from a private number (due to it being my personal phone) and a conversation about the healing power of his narrative interview that felt very contained. The participant shared that he had felt a connection by being in a room with someone who he could share aspects of his life with and know that they cared. This, to me, was symbolic of the life story of a man who has only ever wanted to be held in mind and considered and has never felt like he has been. It was nice to know that I was that person for a brief time, and he had the support of the drug and alcohol service to continue.

**April 2023**

Coming to the end of my MRP and writing edits. going through my transcripts again looking for a title and checking if there were any quotes that could better represent my data. I'm feeling drawn to a particular transcript again. This transcript is such a powerful story because of the way it mixes humour with sadness. Every joke is layered with sadness because of what it really means or represents. I just read a section about the world feeling so hard and horrible at 21 and still feeling the same at 29. 20+ years of addiction is a long time and for your life to have not gotten any better in that time feels so sad. On rereading for the third or fourth time it becomes more and more apparent that although there did seem to be hope in the

tone and the performance of the narrative, underneath the words is a feeling that things are too late for him.

**Part B Appendix 8: Annotated transcript**

*"This has been removed from the electronic copy"*

**Part B Appendix 9: Narrative summary (example)**

An example of the narrative summary sent to participant 2 (Connor).

Connor

Connor had a difficult childhood. His biological parents gave him away to his grandmother and godmother and "took him back" when he turned five. He later learned they convinced her she could not cope with two children, although she had a son after him. Connor always felt separate from his family. He always felt unwanted, neglected, and abandoned. They would go on holiday without him. Connor's father was a big drinker and his mum would make them sleep in the same room. Connor would avoid going home and would spend time drinking, taking drugs, and messing around with his friends.

Connor's heroin use escalated when he experienced a traumatic incident that impacted his emotional wellbeing. Connor recounted experiences with services that had been detrimental for his recovery. One example was being given herbal teas when experiencing withdrawal. Another was attending rehab and being discharged while in withdrawal due to lack of funding for his borough.

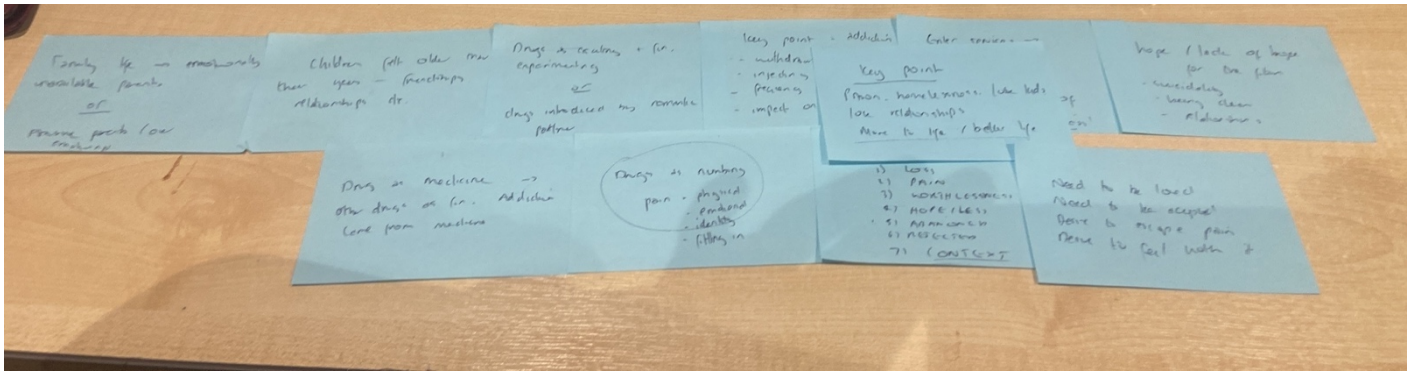
Connor has a lot of anger and pain inside due to his upbringing and family relationships. His romantic relationships have not worked out, his most recent because she did not understand he was a heroin user. Connor has had a period of homelessness due to a breakdown in family relationships. All Connor has ever wanted is to be loved unconditionally

and fought for. Connor's heroin use is to numb the emotional pain that he feels. He now uses heroin as "medicine", to stave off withdrawals.

Connor wants to feel connected to people. He wants to establish relationships. He prides himself on his honesty and loyalty, but he hates that he seeks the approval of others. Connor wants to carry himself well and remain well-spoken and polite. Integrity is highly important to him. Connor wants to be understood and he wants to be treated as a human being deserving of kindness.

Connor feels he has made a mess of his life but hopes that there is a future for him where he can find people who treat him as he deserves. He is devastated that isn't his family, but has found some level of forgiveness, and acknowledges the pain he has caused them through his addiction. He wants to be clean but feels the world is too cold and painful to be sober in.

**Part B Appendix 10: Developed narrative**



This is a visual representation of the narrative developed.

Family life -> emotionally unavailable parents

**Or**

Abusive parents/over emotional

-

Children felt older than their years: friendships, relationships etc.

-

Drugs as exciting + fun, experimenting.

**Or**

Drugs introduced by romantic partner.

-

**Key point: addiction:**

- Withdrawal
- Injecting
- Frequency of use
- Impact on life

**key point:**

- Prison, homelessness, lose kids, lose relationships.

-

Enter services:

- Groups
- Detox/rehab
- Heroin scripts
- Support/lack of
- PRISON
- HOMELESSNESS

-

Hope/lack of hope for the future

- Suicidality
- Keeping “clean”
- Relationships

Drug as medicine ->

Other drugs as fun

Addiction came from

Drug as numbing ->

Pain: physical

Emotional

**MUST MENTION:**

1. Loss
2. Pain
3. Worthlessness
4. Hopeless
5. Abandoned
6. Rejected
7. Context

- Need to be loved.
- Need to be accepted.

**Part B Appendix 11: Reflections on analysis**

My own personal reflections on analysis while transcribing and analysing interviews.

Interview 3: Martin

- Interesting that he says cannabis is harmless because it is legal in 25 states yet he was prescribed opioids legally and that spiralled into heroin addiction when it was stopped.
- Dissonance between what is allowed and what isn't.
- So conditional in his regard which may echo what he has experienced in his life.

Interview 4: Sophie

- "And it was during this time that I met this guy, Seb, and he was one of my clients."
- Considered coding something about where she meets men or the context of how she meets men e.g. first one aged 16 looking for a first love, second one when she ran away from home overwhelmed with guilt, third one when she'd run out of money and was hanging out with strangers, fourth one in a brothel, fifth one driver to and from brothel.
- Unsure whether that was judgemental, unsure whether it was helpful to say or helpful to build as part of her narrative.
- Wonder if it was my own feeling looking at her story.

- In and out group in terms of love

- In and out of the addiction
- Somebody has brought them to the drug and been open to it.
- Hole they need to fill and the belief this will do it.
- Services – becomes a “here is where you have a chance to pull away” but it doesn’t fit.
- They want it to but it doesn’t. becomes part of a new struggle
- Dissonance: carries struggle but carries hope
- Interview 3: martin – his identity becomes different to those he is seeing in the group
- They were in pain, wanted something for that, a friend had an answer
- Conscious connection looks different, mechanism is the same
- Story 3: never used to demonstrate understanding and see it is a different pain . it is used as a need to separate from the “dregs”. They have agency they are not using. I had no agency and yet look what I have done. Didn’t see it coming.
- In a lot of other spaces they will not feel superior. This is the group where I do. I can decide I am not like them rather than people thinking they are not or do not want to be like me. In the group it’s like they are holding up a mirror saying we are similar. Does not feel hopeful.

- The group that are helped may be the opposite for the ones that are not helped. It’s too much for the ones that are hanging on.
- The power of the group but not for all the members. Challenges for those that are needed but don’t want to be there. What do they offer each other?

- Narratives: individual story with their history etc.

- That exists in a system – societal, political. Purports to decouple them from the addiction but it is only a system that can do that. The context of the whole narrative is what creates their story and what creates their story is the societal and political discourse at the time. Manage to decouple from the addiction you're still in the same system.
- Nothing disappears. They have to carve a different path in the same system.
- **Social system = right around you, political system = funding, how they talk about you**
- **Living in communities that do not give a context for how to be in the world**

- **The need for connection. The need for somebody to give you a non-judgmental and**
- **A group can't be unconditional because it doesn't have a sole person**
- **Lots of therapy conditions that interfere, lots of group conditions that interfere.**
- **The need for someone to care and be proud and support you and not tied up in pain**
- **Missing an unconditional relationship and that becomes the key pathway to hope**

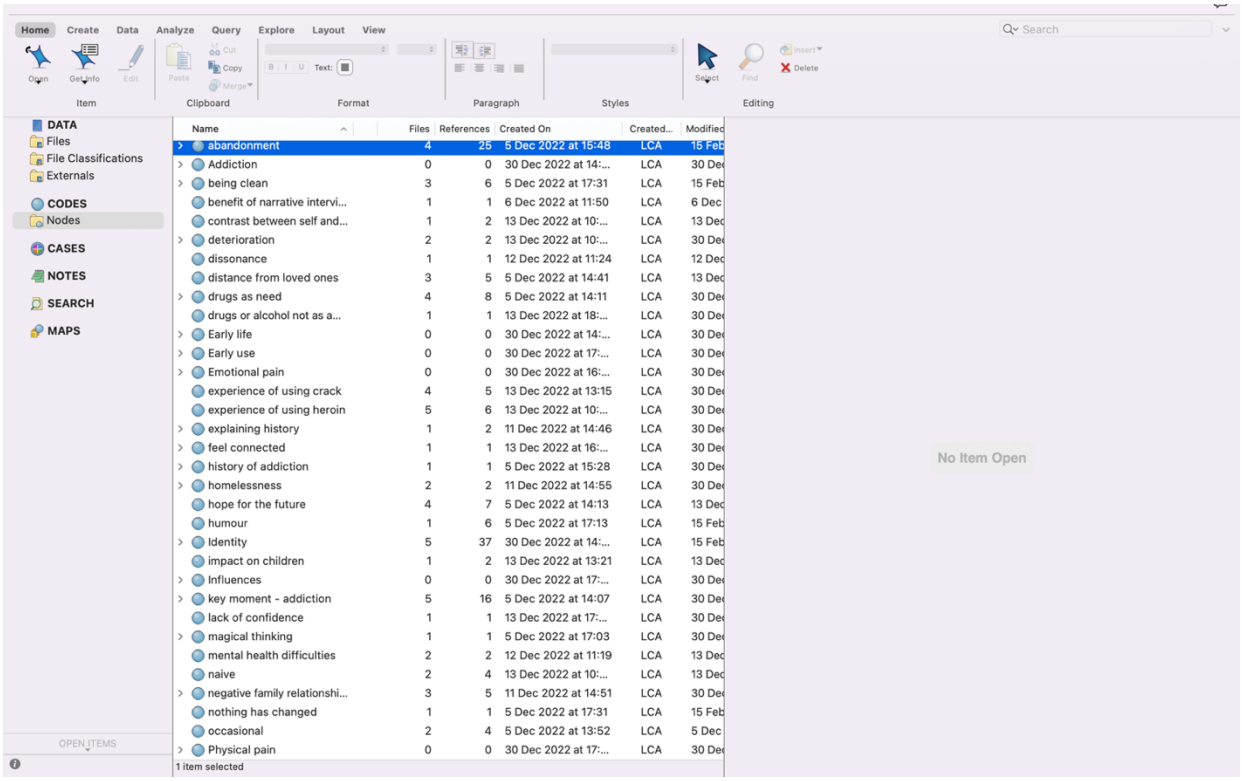
- May have a paragraph about reflexivity in the methodology which talks about what I did and how I held it in mind throughout the research process

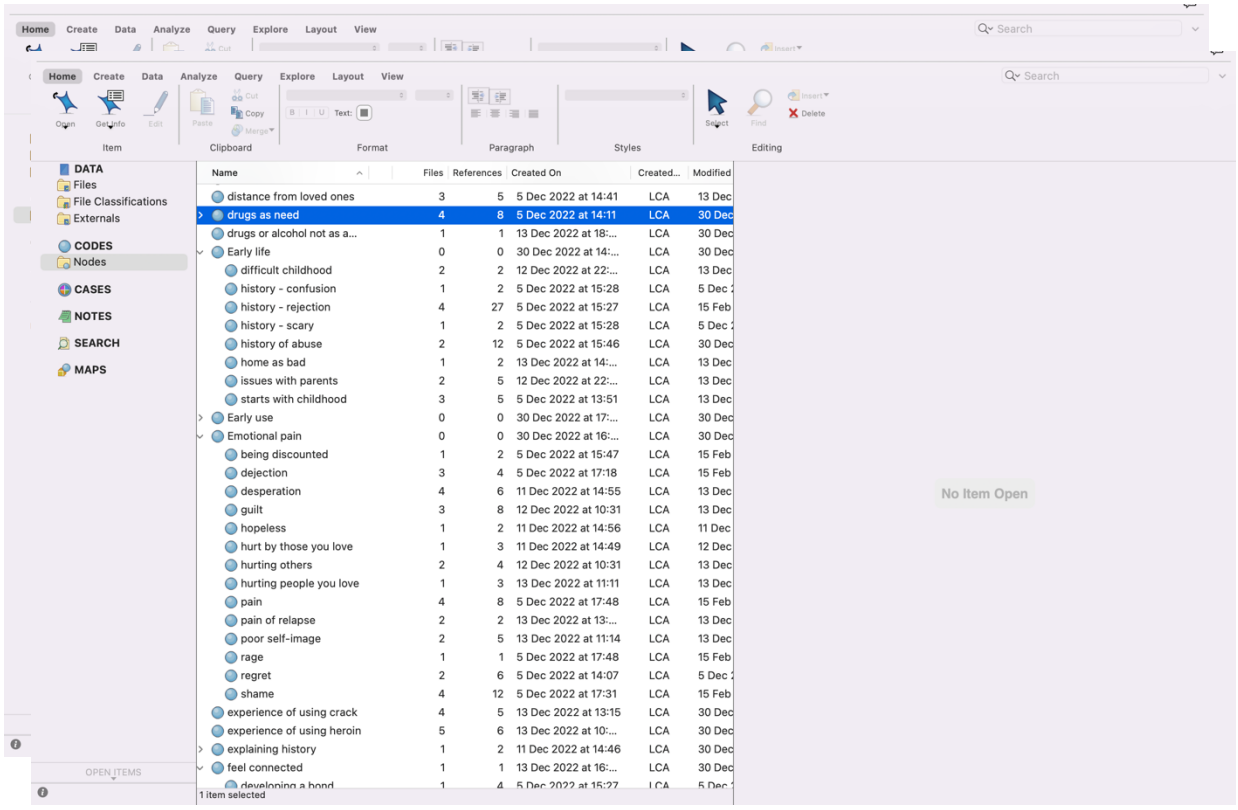
- Could have the loss element of the story and explain it doesn't always look the same but is about the loss and what that means

- Contextual or systemic pain or disappointment which undermines sense of agency of being something worthy – stigma, funding, rejection

- Could be in the desperate, abandoned, isolated, desolate part of the story. It takes things away from you because you feel you are not worthy, and you are not enough. They come from circumstantial or structural experiences e.g. not paying bills and lose flat, escorting, marital breakdown, homelessness. Echoes of what starts things off in the first place.

# Part B Appendix 12: NVivo screenshots to demonstrate theme development

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drugs as need 4 8 5 Dec 2022 at 14:11 LCA 30 Dec
drugs or alcohol not as a... 1 1 13 Dec 2022 at 18:... LCA 30 Dec
Early life 0 0 30 Dec 2022 at 14:... LCA 30 Dec
difficult childhood 2 2 12 Dec 2022 at 22:... LCA 13 Dec
history - confusion 1 2 5 Dec 2022 at 15:28 LCA 5 Dec
history - rejection 4 27 5 Dec 2022 at 15:27 LCA 15 Feb
history - scary 1 2 5 Dec 2022 at 15:28 LCA 5 Dec
history of abuse 2 12 5 Dec 2022 at 15:46 LCA 30 Dec
home as bad 1 2 13 Dec 2022 at 14:... LCA 13 Dec
issues with parents 2 5 12 Dec 2022 at 22:... LCA 13 Dec
starts with childhood 3 5 5 Dec 2022 at 13:51 LCA 13 Dec
Early use 0 0 30 Dec 2022 at 17:... LCA 30 Dec
Emotional pain 0 0 30 Dec 2022 at 16:... LCA 30 Dec
being discounted 1 2 5 Dec 2022 at 15:47 LCA 15 Feb
dejection 3 4 5 Dec 2022 at 17:18 LCA 15 Feb
desperation 4 6 11 Dec 2022 at 14:55 LCA 13 Dec
guilt 3 8 12 Dec 2022 at 10:31 LCA 13 Dec
hopeless 1 2 11 Dec 2022 at 14:56 LCA 11 Dec
hurt by those you love 1 3 11 Dec 2022 at 14:49 LCA 12 Dec
hurting others 2 4 12 Dec 2022 at 10:31 LCA 13 Dec
hurting people you love 1 3 13 Dec 2022 at 11:11 LCA 13 Dec
pain 4 8 5 Dec 2022 at 17:48 LCA 15 Feb
pain of relapse 2 2 13 Dec 2022 at 13:... LCA 13 Dec
poor self-image 2 5 13 Dec 2022 at 11:14 LCA 13 Dec
rage 1 1 5 Dec 2022 at 17:48 LCA 15 Feb
regret 2 6 5 Dec 2022 at 14:07 LCA 5 Dec
shame 4 12 5 Dec 2022 at 17:31 LCA 15 Feb
experience of using crack 4 5 13 Dec 2022 at 13:15 LCA 30 Dec
experience of using heroin 5 6 13 Dec 2022 at 10:... LCA 30 Dec
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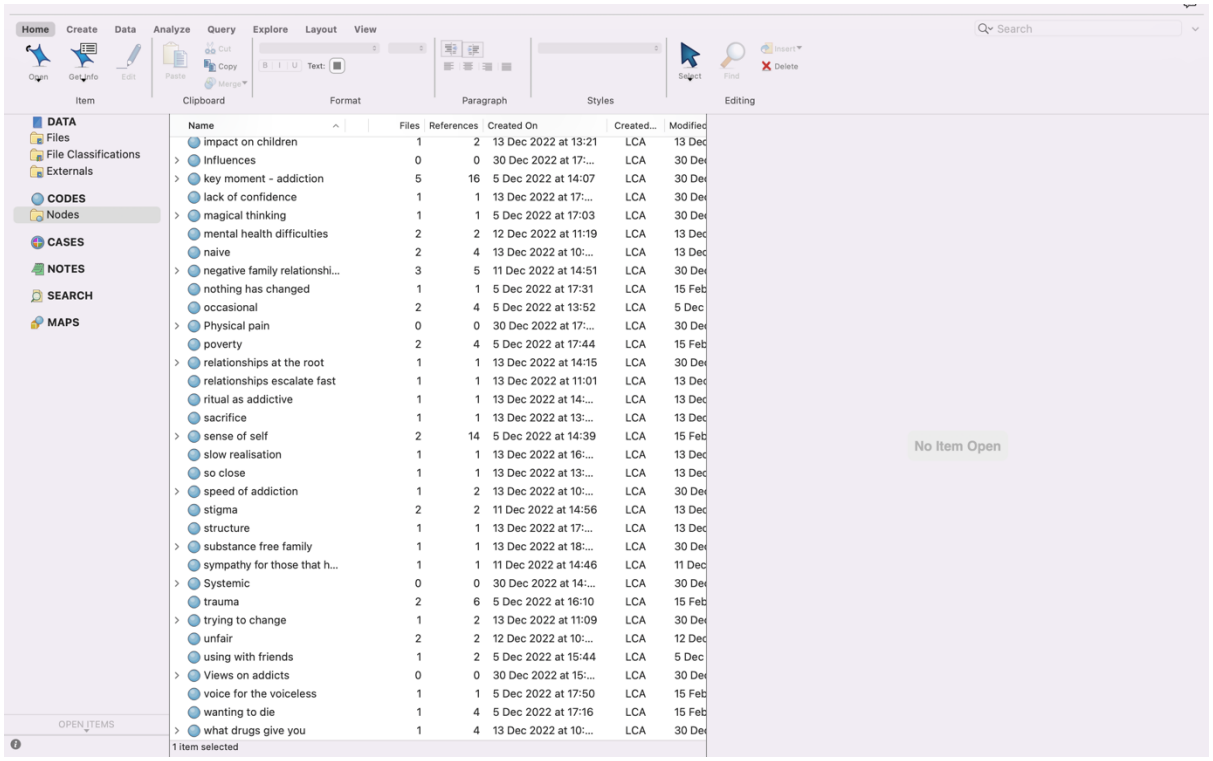
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Influences 0 0 30 Dec 2022 at 17:... LCA 30 Dec
key moment - addiction 5 16 5 Dec 2022 at 14:07 LCA 30 Dec
lack of confidence 1 1 13 Dec 2022 at 17:... LCA 30 Dec
magical thinking 1 1 5 Dec 2022 at 17:03 LCA 30 Dec
mental health difficulties 2 2 12 Dec 2022 at 11:19 LCA 13 Dec
naive 2 4 13 Dec 2022 at 10:... LCA 13 Dec
negative family relationshi... 3 5 11 Dec 2022 at 14:51 LCA 30 Dec
nothing has changed 1 1 5 Dec 2022 at 17:31 LCA 15 Feb
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ritual as addictive 1 1 13 Dec 2022 at 14:... LCA 13 Dec
sacrifice 1 1 13 Dec 2022 at 13:... LCA 13 Dec
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stigma 2 2 11 Dec 2022 at 14:56 LCA 13 Dec
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Views on addicts 0 0 30 Dec 2022 at 15:... LCA 30 Dec
voice for the voiceless 1 1 5 Dec 2022 at 17:50 LCA 15 Feb
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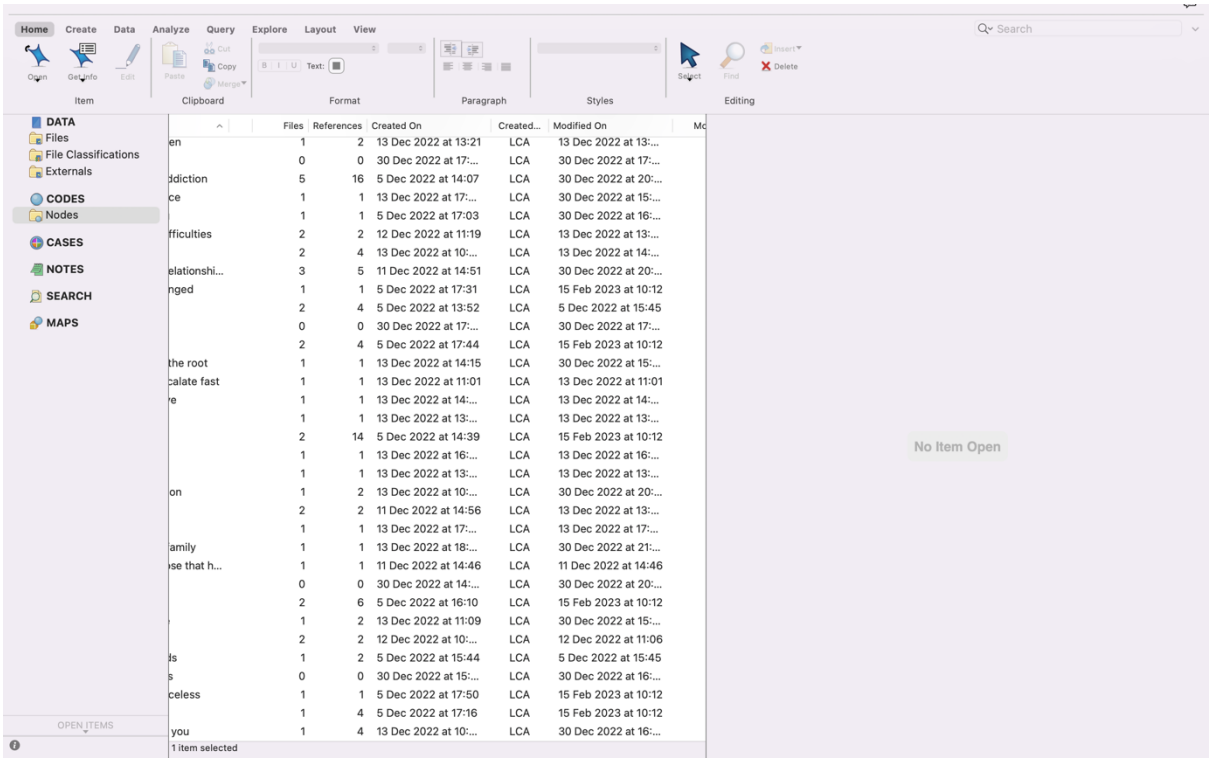
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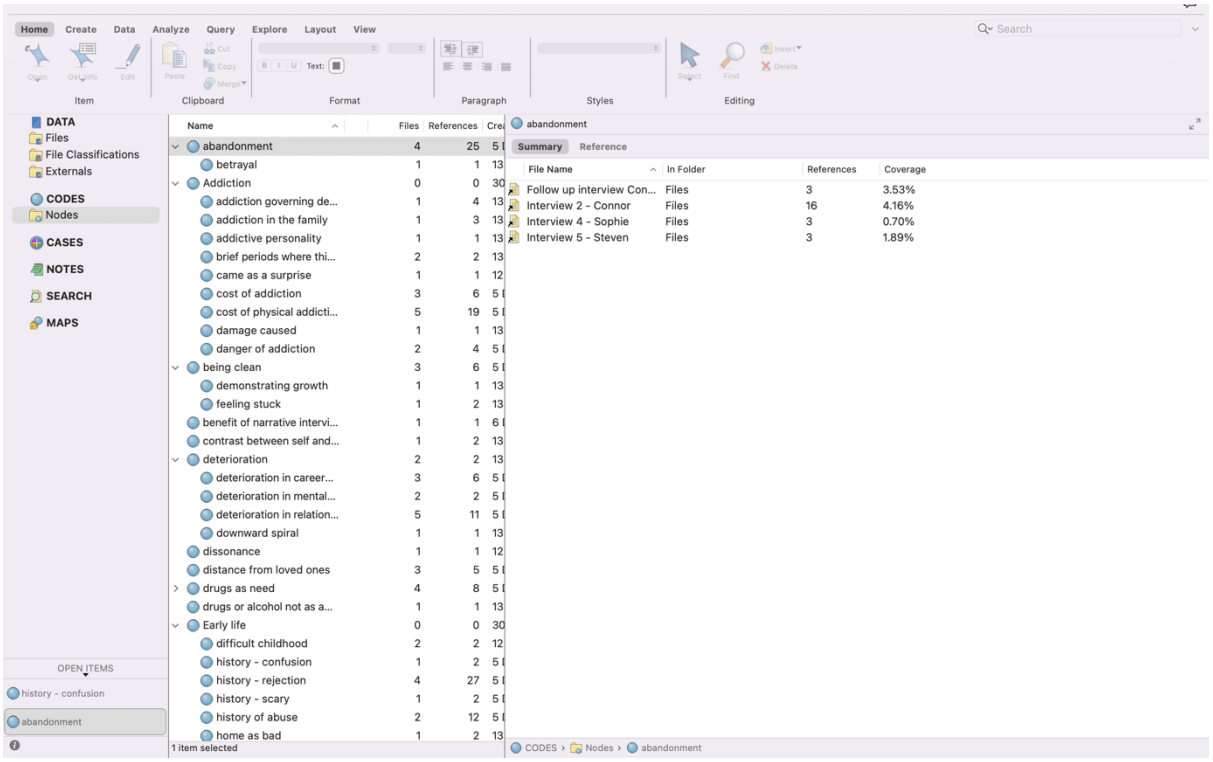
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addiction in the family 1 3
addictive personality 1 1
brief periods where thi... 2 2
came as a surprise 1 1
cost of addiction 3 6
cost of physical addicti... 5 19
damage caused 1 1
danger of addiction 2 4
being clean 3 6
demonstrating growth 1 1
feeling stuck 1 2
benefit of narrative intervi... 1 1
contrast between self and... 1 2
deterioration 2 2
deterioration in career... 3 6
deterioration in mental... 2 2
deterioration in relation... 5 11
downward spiral 1 1
dissonance 1 1
distance from loved ones 3 5
drugs as need 4 8
drugs or alcohol not as a... 1 1
Early life 0 0
difficult childhood 2 2
history - confusion 1 2
history - rejection 4 27
history - scary 1 2
history of abuse 2 12
home as bad 1 2
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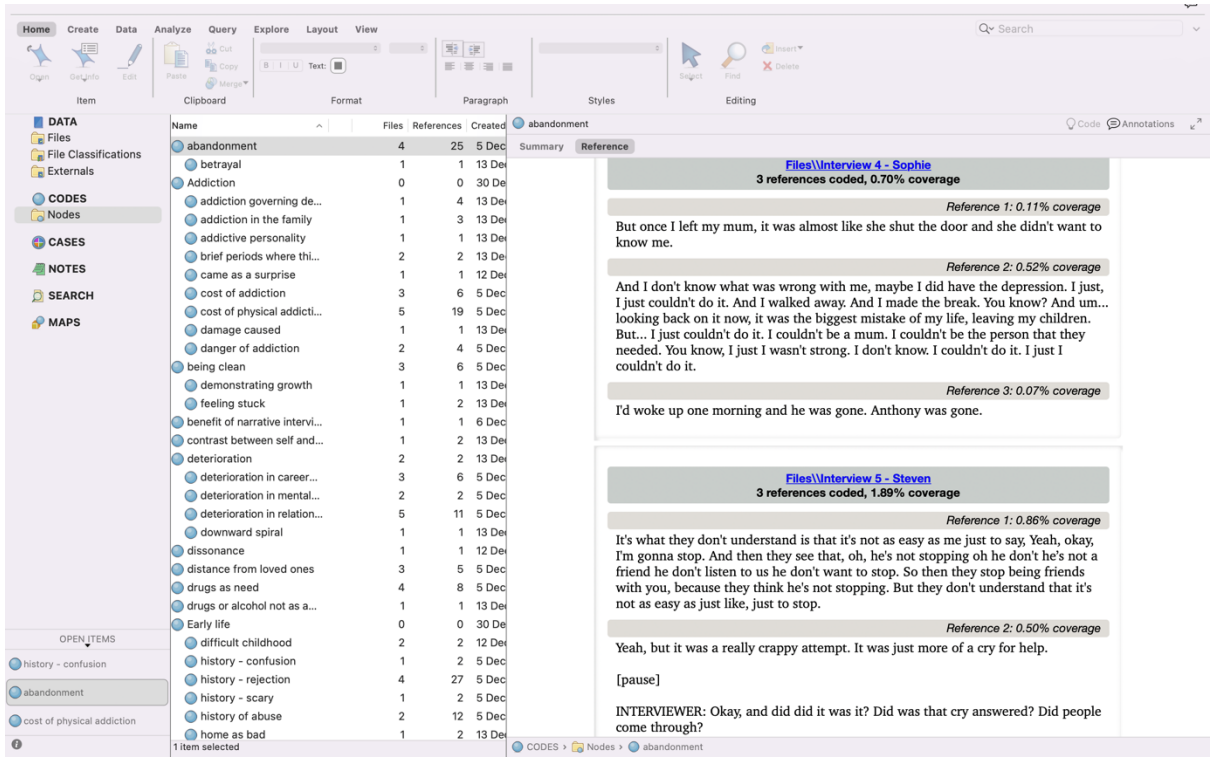
history - confusion
abandonment
abandonment
Summary Reference
File Name In Folder References Coverage
Follow up interview Con... Files 3 3.53%
Interview 2 - Connor Files 16 4.16%
Interview 4 - Sophie Files 3 0.70%
Interview 5 - Steven Files 3 1.89%
CODES › Nodes › abandonment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addiction governing de... 1 4 13 De
addiction in the family 1 3 13 De
addictive personality 1 1 13 De
brief periods where thi... 2 2 13 De
came as a surprise 1 1 12 De
cost of addiction 3 6 5 Dec
cost of physical addicti... 5 19 5 Dec
damage caused 1 1 13 De
danger of addiction 2 4 5 Dec
being clean 3 6 5 Dec
demonstrating growth 1 1 13 De
feeling stuck 1 2 13 De
benefit of narrative intervi... 1 1 6 Dec
contrast between self and... 1 2 13 De
deterioration 2 2 13 De
deterioration in career... 3 6 5 Dec
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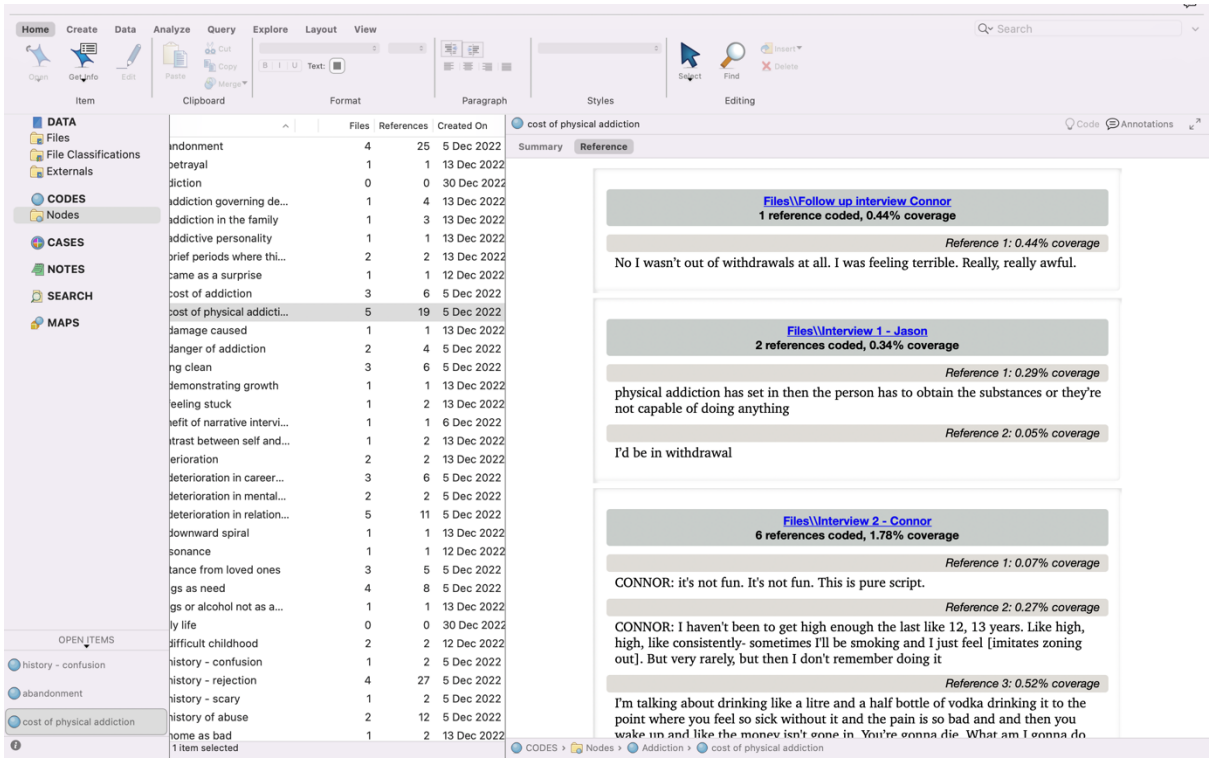
deterioration in relation... 5 11 5 Dec
downward spiral 1 1 13 De
dissonance 1 1 12 De
distance from loved ones 3 5 5 Dec
drugs as need 4 8 5 Dec
drugs or alcohol not as a... 1 1 13 De
Early life 0 0 30 De
difficult childhood 2 2 12 De
history - confusion 1 2 5 Dec
history - rejection 4 27 5 Dec
history - scary 1 2 5 Dec
history of abuse 2 12 5 Dec
home as bad 1 2 13 De
1 item selected
OPEN ITEMS
history - confusion
abandonment
cost of physical addiction
abandonment
Summary Reference
Code Annotations
Files\\Interview 4 - Sophie
3 references coded, 0.70% coverage
Reference 1: 0.11% coverage
But once I left my mum, it was almost like she shut the door and she didn't want to know me.
Reference 2: 0.52% coverage
And I don't know what was wrong with me, maybe I did have the depression. I just, I just couldn't do it. And I walked away. And I made the break. You know? And um... looking back on it now, it was the biggest mistake of my life, leaving my children. But... I just couldn't do it. I couldn't be a mum. I couldn't be the person that they needed. You know, I just I wasn't strong. I don't know. I couldn't do it. I just I couldn't do it.
Reference 3: 0.07% coverage
I'd woke up one morning and he was gone. Anthony was gone.
Files\\Interview 5 - Steven
3 references coded, 1.89% coverage
Reference 1: 0.86% coverage
It's what they don't understand is that it's not as easy as me just to say, Yeah, okay, I'm gonna stop. And then they see that, oh, he's not stopping oh he don't he's not a friend he don't listen to us he don't want to stop. So then they stop being friends with you, because they think he's not stopping. But they don't understand that it's not as easy as just like, just to stop.
Reference 2: 0.50% coverage
Yeah, but it was a really crappy attempt. It was just more of a cry for help.
[pause]
INTERVIEWER: Okay, and did did it was it? Did was that cry answered? Did people come through?
CODES › Nodes › abandonment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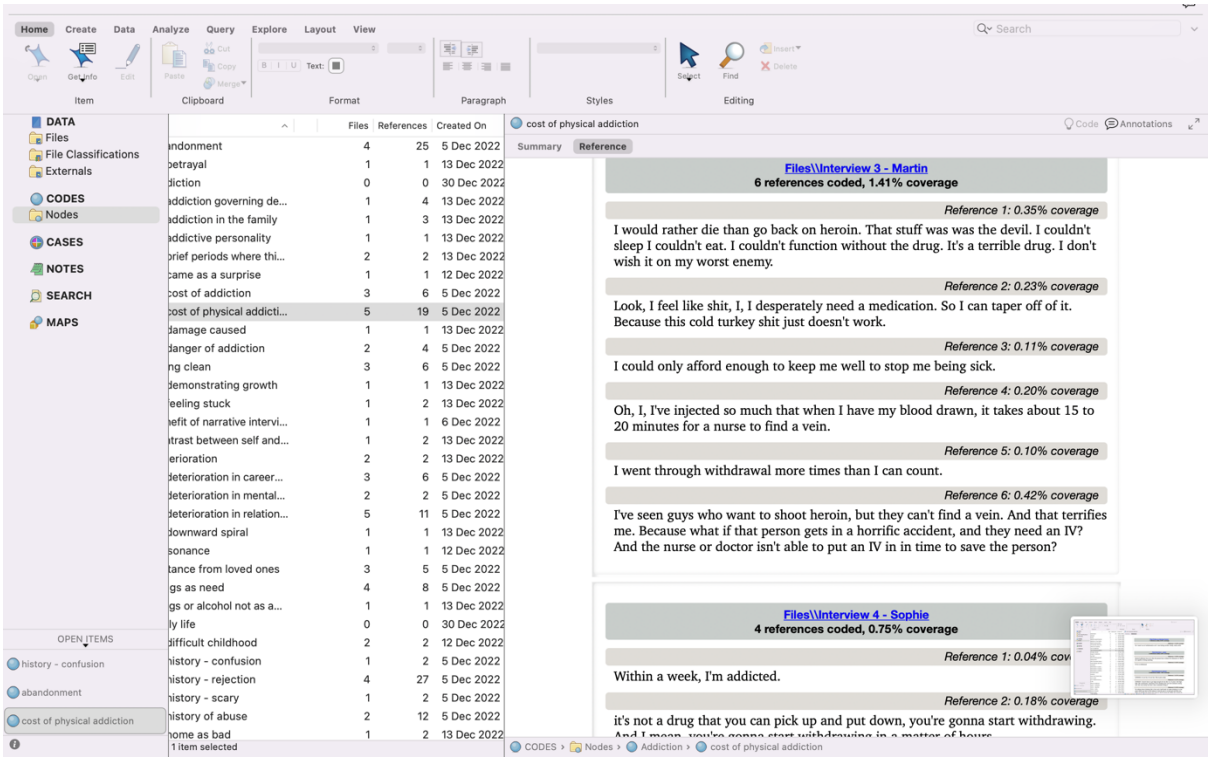
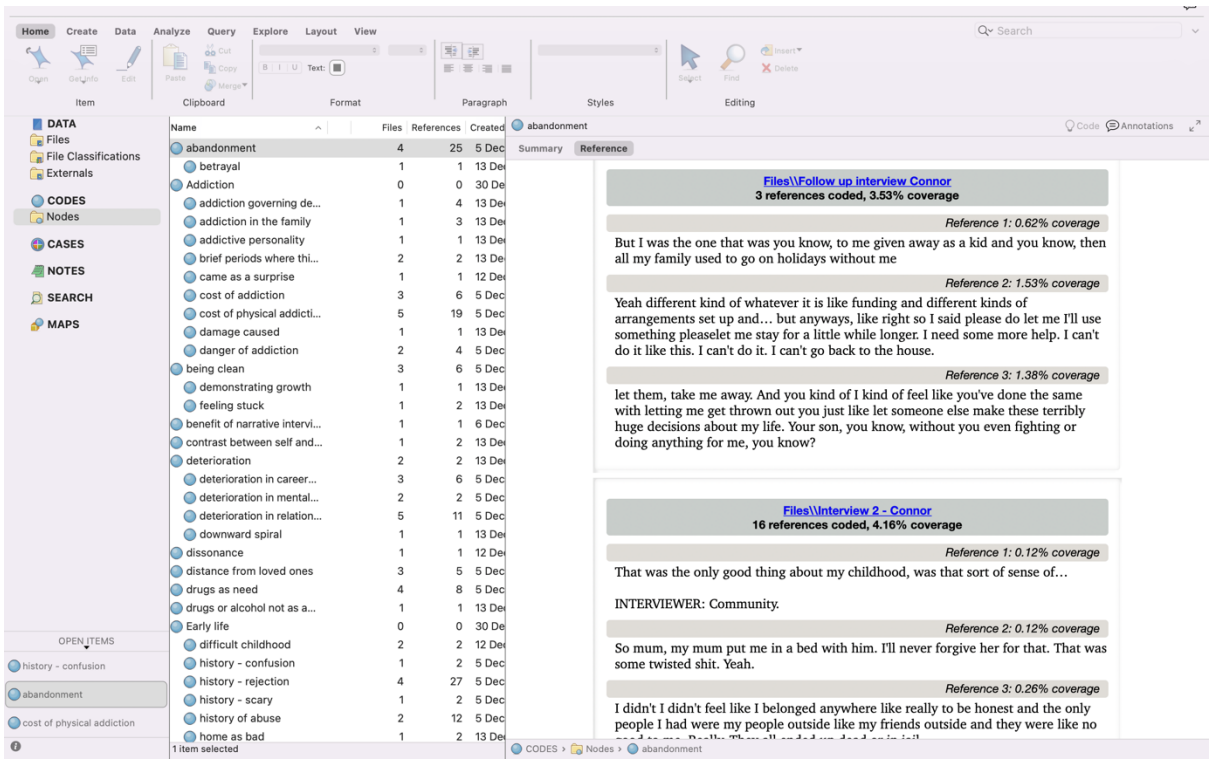
ddictive personality 1 1 13 Dec 2022
rief periods where thi... 2 2 13 Dec 2022
ame as a surprise 1 1 12 Dec 2022
ost of addiction 3 6 5 Dec 2022
ost of physical addicti... 5 19 5 Dec 2022
damage caused 1 1 13 Dec 2022
danger of addiction 2 4 5 Dec 2022
ng clean 3 6 5 Dec 2022
demonstrating growth 1 1 13 Dec 2022
eeling stuck 1 2 13 Dec 2022
efit of narrative intervi... 1 1 6 Dec 2022
trast between self and... 1 2 13 Dec 2022
erioration 2 2 13 Dec 2022
deterioration in career... 3 6 5 Dec 2022
deterioration in mental... 2 2 5 Dec 2022
deterioration in relation... 5 11 5 Dec 2022
downward spiral 1 1 13 Dec 2022
sonance 1 1 12 Dec 2022
tance from loved ones 3 5 5 Dec 2022
gs as need 4 8 5 Dec 2022
gs or alcohol not as a... 1 1 13 Dec 2022
ly life 0 0 30 Dec 2022
difficult childhood 2 2 12 Dec 2022
history - confusion 1 2 5 Dec 2022
history - rejection 4 27 5 Dec 2022
history - scary 1 2 5 Dec 2022
history of abuse 2 12 5 Dec 2022
home as bad 1 2 13 Dec 2022
1 item selected
OPEN ITEMS
history - confusion
abandonment
cost of physical addiction
cost of physical addiction
Code Annotations
Summary Reference
Files\\Follow up interview Connor
1 reference coded, 0.44% coverage
Reference 1: 0.44% coverage
No I wasn't out of withdrawals at all. I was feeling terrible. Really, really awful.
Files\\Interview 1 - Jason
2 references coded, 0.34% coverage
Reference 1: 0.29% coverage
physical addiction has set in then the person has to obtain the substances or they're not capable of doing anything
Reference 2: 0.05% coverage
I'd be in withdrawal
Files\\Interview 2 - Connor
6 references coded, 1.78% coverage
Reference 1: 0.07% coverage
CONNOR: it's not fun. It's not fun. This is pure script.
Reference 2: 0.27% coverage
CONNOR: I haven't been to get high enough the last like 12, 13 years. Like high, high, like consistently- sometimes I'll be smoking and I just feel [imitates zoning out]. But very rarely, but then I don't remember doing it
Reference 3: 0.52% coverage
I'm talking about drinking like a litre and a half bottle of vodka drinking it to the point where you feel so sick without it and the pain is so bad and and then you
CODES › Nodes › Addiction › cost of physical addiction


Home Create Data Analyze Query Explore Layout View
DATA
Files
File Classifications
Externals
CODES
Nodes
CASES
NOTES
SEARCH
MAPS
cost of physical addiction
Summary Reference
Files\\Interview 3 - Martin
6 references coded, 1.41% coverage
Reference 1: 0.35% coverage
I would rather die than go back on heroin. That stuff was was the devil. I couldn't sleep I couldn't eat. I couldn't function without the drug. It's a terrible drug. I don't wish it on my worst enemy.
Reference 2: 0.23% coverage
Look, I feel like shit, I, I desperately need a medication. So I can taper off of it. Because this cold turkey shit just doesn't work.
Reference 3: 0.11% coverage
I could only afford enough to keep me well to stop me being sick.
Reference 4: 0.20% coverage
Oh, I, I've injected so much that when I have my blood drawn, it takes about 15 to 20 minutes for a nurse to find a vein.
Reference 5: 0.10% coverage
I went through withdrawal more times than I can count.
Reference 6: 0.42% coverage
I've seen guys who want to shoot heroin, but they can't find a vein. And that terrifies me. Because what if that person gets in a horrific accident, and they need an IV? And the nurse or doctor isn't able to put an IV in in time to save the person?
Files\\Interview 4 - Sophie
4 references coded, 0.75% coverage
Reference 1: 0.04% cov
Within a week, I'm addicted.
Reference 2: 0.18% coverage
it's not a drug that you can pick up and put down, you're gonna start withdrawing.
OPEN ITEMS
history - confusion
abandonment
cost of physical addiction
1 item selected
CODES › Nodes › Addiction › cost of physical addiction


Home Create Data Analyze Query Explore Layout View
DATA
Files
File Classifications
Externals
CODES
Nodes
CASES
NOTES
SEARCH
MAPS
abandonment
Summary Reference
Files\\Follow up interview Connor
3 references coded, 3.53% coverage
Reference 1: 0.62% coverage
But I was the one that was you know, to me given away as a kid and you know, then all my family used to go on holidays without me
Reference 2: 1.53% coverage
Yeah different kind of whatever it is like funding and different kinds of arrangements set up and… but anyways, like right so I said please do let me I'll use something pleaselet me stay for a little while longer. I need some more help. I can't do it like this. I can't do it. I can't go back to the house.
Reference 3: 1.38% coverage
let them, take me away. And you kind of I kind of feel like you've done the same with letting me get thrown out you just like let someone else make these terribly huge decisions about my life. Your son, you know, without you even fighting or doing anything for me, you know?
Files\\Interview 2 - Connor
16 references coded, 4.16% coverage
Reference 1: 0.12% coverage
That was the only good thing about my childhood, was that sort of sense of…
INTERVIEWER: Community.
Reference 2: 0.12% coverage
So mum, my mum put me in a bed with him. I'll never forgive her for that. That was some twisted shit. Yeah.
Reference 3: 0.26% coverage
I didn't I didn't feel like I belonged anywhere like really to be honest and the only people I had were my people outside like my friends outside and they were like no
OPEN ITEMS
history - confusion
abandonment
cost of physical addiction
1 item selected
CODES › Nodes › abandonment

**Part B Appendix 13: Summary letter for ethics and participant(s)**

Below is a summary letter written for the ethics committee and another written for a participant.

Feedback to ethics

This paper aimed to explore the life story narratives of people using addiction services. People have a long and complicated life history not defined only by their addiction. Nevertheless, in order to ask for help from addiction services and engage with them, the addiction may seem to overshadow everything else. Services may not appear to give enough consideration to the other aspects of identity that are important, such as race, gender, values, and belief systems. This study aimed to highlight these important aspects of identity with the hope that it could have useful implications for services and clinicians.

After receiving ethical approval from the university and NHS ethics board, the researcher contacted two West London services to confirm recruitment was ready to begin. It passed ethical approval with their local research and development teams. Service sponsors at each site managed recruitment and provided participants with the information sheet and consent forms. Interviews took place between September and October 2022. Nine participants (seven men, two women) were interviewed using a narrative interview schedule. At the end of the interview, participants were given further information about the study if they asked. All participants were given pseudonyms and all names and places were changed or removed.

Narrative analysis was used to understand and interpret interview data. Summary narratives for each participant were created. An overarching narrative was developed which combined participant narratives. This overarching narrative was separated into life chapters.

The first chapter describes childhood. A common thread among participants was feeling disconnected to others and struggling to fit in. For all participants, drugs were a way to mask physical or emotional pain. Eventually, drug use spiralled out of control. This could be because their use escalated, they started experiencing withdrawals, or bad things kept happening as a consequence of their drug use but use continued. After reaching "rock bottom", people entered services. Difficulties with funding and with the help offered meant that maintaining engagement and sobriety was not always easy.

Crucially, positive aspects of the narrative involved participants being able to see themselves as more than their drug use. They were able to identify positive traits and be proud of themselves for living by their values. The researcher discussed how this was portrayed during interviews.

Finally, the researcher shared lessons from the research. It discussed the role of stigma in perpetuating a negative narrative about people with addictions. It considered how services could improve, such as creating abstinent groups, offering service users responsibilities within groups, and working with the concept of shame. It also discussed future research directions, including further purposive sampling of hard-to-reach or marginalised groups, such as the homeless population. It highlighted the low number of women sampled and suggested purposively sampling more women in the future. It also suggested focusing on

specific intersections, such as race and poverty or race and the criminal justice system and the impact on identity and addiction outcomes among service users.

Connor

Thank you for taking part in my study on addiction and identity. This paper aimed to explore the life story narratives of people using addiction services. People have a long and complicated life history not defined only by their addiction. Nevertheless, in order to ask for help from addiction services and engage with them, the addiction may seem to overshadow everything else. Services may not appear to give enough consideration to the other aspects of identity that are important, such as race, gender, values, and belief systems. This study aimed to highlight these important aspects of identity with the hope that it could have useful implications for services and clinicians.

After receiving ethical approval from the university and NHS ethics board, I contacted two West London services to confirm recruitment was ready to begin. It passed ethical approval with their local research and development teams. You had a service sponsor (Phil) who managed recruitment and provided you with the information sheet and consent form. Your interview was in September 2022. Nine participants (seven men, two women) were interviewed using a narrative interview schedule. At the end of the interview, you were given further information about the study. You were given a pseudonym (Connor) and all names and places were changed or removed.

Narrative analysis was used to understand and interpret interview data. A summary narrative for each participant were created. Yours is attached. An overarching narrative was developed which combined participant narratives. This overarching narrative was separated into life chapters.

The first chapter describes childhood. A common thread among participants was feeling disconnected to others and struggling to fit in. For all participants, drugs were a way to mask physical or emotional pain. Eventually, drug use spiralled out of control. For you, this was the escalation of your use after a significant loss. After realising you needed help, you entered services. This was not the end of your journey through recovery, as maintaining sobriety was difficult. when you first engaged, you did not want to stop using, but wanted help form times when drugs were inaccessible. Throughout your service engagement, you found sobriety difficult to maintain, often due to your experience of the world at your relationship with people in it.

Crucially, positive aspects of the narrative involved you being able to see yourself as more than your drug use. You were able to identify your loyalty, your honesty, your openness to others, and your generosity. You were able to share how others may describe you, as a good person with a good heart.

Finally, in the paper I shared lessons from the research. I discussed the role of stigma in perpetuating a negative narrative about people with addictions. I considered how services could improve, such as creating abstinent groups, offering service users responsibilities within groups, and working with the concept of shame.

I also discussed future research directions, including further deliberate sampling of hard-to-reach or marginalised groups, such as the homeless population. I highlighted the low number of women interviewed and suggested deliberately sampling more women in the future. I also suggested focusing on specific intersections, such as race and poverty or race and the criminal justice system and the impact on identity and addiction outcomes among service users.

I'd like to thank you for your invaluable role in making this research possible and remind you of the power of your story.

Yours sincerely

Lauren Cunningham-Amos