

**HOW INDIVIDUALS WHO HAVE MOVED FROM SUBSTANCE ADDICTION
TO HEALTH, EXPERIENCE INTERACTIONS WITH OTHERS IN TERMS OF
FACILITATING OR IMPEDING THEIR HEALING JOURNEY**

by

ROMA SUSAN PALMER

B.A., The University of British Columbia, 1991

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

MASTER OF ARTS

in

THE FACULTY OF GRADUATE STUDIES
(Counselling Psychology)

THE UNIVERSITY OF BRITISH COLUMBIA

April 2005

© Roma Susan Palmer, 2005

Abstract

The purpose of this study was to examine the subjective experience of interactions with others that were either facilitative or impeding for individuals who have moved from substance addiction to health. A qualitative, phenomenological methodology was used for data collection and analysis. The study involved one in-depth, data collection interview with each of six volunteer participants. Interviewees included five men and one woman, varying in ages from 35 to 55. They all had extensive histories with substance abuse and were all connected to some extent with the Alcoholics Anonymous or Narcotics Anonymous programs.

Interviews were transcribed verbatim and analyzed using Colaizzi's (1978) method of phenomenological data analysis as a guide. Seven themes common to all participants were extracted from the data. These included: a sense of isolation and loss, a sense of support or discouragement, a sense of understanding or misunderstanding, a sense of belonging or not belonging, a sense of meaning or meaninglessness, a sense of hope or hopelessness, and a sense of shifting identities. The findings led to implications for counselling as well as suggestions for future research.

TABLE OF CONTENTS

Abstract.....	ii
Table of Contents.....	iii
Acknowledgements.....	vi
CHAPTER ONE: INTRODUCTION.....	1
Statement of the Problem.....	1
Rationale for the Study.....	2
Research Question.....	5
Significance of the Study.....	6
Definition of Terms.....	6
CHAPTER TWO: LITERATURE REVIEW.....	8
Introduction.....	8
History.....	9
Theory.....	10
Review of the Literature.....	13
Professionals Who Work with Individuals with Addictions.....	13
Social Support of Individuals with Addictions.....	27
Ethnic and Gender Issues.....	34
Summary and Synthesis.....	39
CHAPTER THREE: METHODOLOGY.....	40
Method Selection.....	40
Role of the Researcher.....	41
Selection of Participants.....	44

Recruitment of Participants.....	46
Data Collection.....	47
Data Analysis.....	49
Trustworthiness.....	50
CHAPTER FOUR: RESULTS.....	55
Introduction.....	55
Participants.....	55
Identified Themes.....	58
A Sense of Isolation or Loss.....	58
A Sense of Support or Discouragement.....	68
A Sense of Understanding or Misunderstanding.....	81
A Sense of Belonging or Not Belonging.....	87
A Sense of Meaning or Meaninglessness.....	95
A Sense of Hope or Hopelessness.....	104
A Sense of Shifting Identities.....	111
Conclusion.....	119
CHAPTER FIVE: DISCUSSION.....	121
Introduction.....	121
Comparison to the Literature.....	121
Implications for Counselling.....	127
Suggestions for Future Research.....	130
Limitations of the Study.....	132
Conclusion.....	133

REFERENCES.....	135
------------------------	------------

APPENDICES.....	141
------------------------	------------

Appendix A: Recruitment Poster.....	141
-------------------------------------	-----

Appendix B: Informed Consent Form.....	142
--	-----

Appendix C: Orienting Statement.....	144
--------------------------------------	-----

Appendix D: Interview Questions.....	145
--------------------------------------	-----

Acknowledgements

So many people have supported me throughout the process of writing this thesis; I hope I do not forget anyone. Firstly I would like to thank my thesis committee. I have felt their support during this whole process and that has been invaluable to me. In particular I would like to thank Dr. Judith Daniluk who, through her expertise, and excellent feedback has made this experience much more fulfilling than I ever could have anticipated. Her encouragement and availability have been unfailing. I feel fortunate and grateful to have had her as my supervisor.

To the numerous friends and family who have listened to me muse on my question, the paper, and the process, I thank you. To those who provided childcare time and again for me to be able to work, I am most appreciative. I must also remember everyone who has assisted me by reading over my work and helping me shape the end result.

My family have been a source of constant strength and encouragement throughout my thesis experience. My parents have guided me and listened to me endlessly. My children have endured hours and days away from their mother so she can do "her homework." They have been remarkably patient and, in their own way, have played an integral part in helping me complete this project. Lastly, I would like to thank my husband. He has held me through the roller coaster of this process and read every word I have written. My constant cheerleader, he has supported me and given me the space and time I have needed for this project and this degree. For his constant belief in me and my abilities I am forever grateful.

CHAPTER ONE

Introduction

Every interaction between people involves the exercise of some degree of social influence. Even the most superficial encounter leaves its mark, however minor, on the participants. Strictly speaking, every opinion we utter, every request we make, and every behaviour we undertake towards another person will in one way or another influence that person. (Forgas, 1985, p. 267)

Statement of the Problem

Social interactions involve influence between individuals of a verbal, emotional or physical nature (Sears, Peplau, & Taylor, 1991). Individuals interact with friends, family members, coworkers, therapists, and others in their lives all of whom may be perceived by the individual to influence their behaviours, attitudes, and beliefs. In the area of substance addiction, researchers continue to explore the reasons individuals develop substance abuse problems as well as the reasons for the cessation of addictive behaviours. Whether individuals disentangle themselves from their addictions with or without professional help, they are necessarily and inevitably influenced to varying degrees by their interactions with others on their journey. Although the literature suggests that social interaction is part of the process of healing from addiction (Akin & Gregoire, 1997; Reid, Marini, Sales & Kampfe, 2001), it is unclear what role these interactions play. The specific interactions this study was interested in were interactions that the individual him/herself experienced as being either facilitative of, or hindering to, their process of healing from addiction.

It is important to learn about what individuals healing from addictions experience as helpful and hindering social interactions because of the potential for counsellors to use this information in the counselling process. Knowing what types of interactions individuals perceive to have the greatest influence on their healing from substance addiction, and understanding how these interactions have made a difference, positively or negatively, may be helpful in teaching counsellors how to interact in a facilitative way with clients facing their substance addiction issues. Additionally, increasing counsellors' awareness of what interactions facilitate or impede a client's recovery, may help the counsellor to encourage facilitative interactions in the client's life.

Rationale for the Study

It is apparent from the addictions treatment and counselling process literature (Egan, 1994; Hackney & Cormier, 1996; Rotgers, Keller, & Mortgenstern, 1996) that interactions with others can potentially have an influence on individuals and that certain behaviours, beliefs and attitudes on the part of others, including clinicians, appear to be helpful to clients in facilitating and maintaining change. However, very little is known about what specific interpersonal interactions facilitate or hinder an individual's progress from substance addiction to health. The attitudes that professionals have toward individuals with addictions and the influence of social support on the individual healing from addiction have been examined mostly in quantitative studies (Amodeo, 2000, Matthews et al., 2002; West & Miller, 1999). Qualitative studies have begun to explore the experiences of individuals who have addiction issues in their relationships with professionals (Akin & Gregoire, 1997; Ashery, Carlson, Falck, & Siegal, 1995).

Biernacki (1986), in his book describing the process of natural recovery (without therapeutic intervention) from heroin addiction, suggests that research into addiction recovery needs to include studies that focus on the problems individuals with addictions face when they attempt to abstain and how these problems are, or are not, overcome. "Especially important here would be observations of how the various reactions of nonaddicts either facilitate or stymie the recovery process" (p. 197). Although Biernacki's research was written in 1986, there still appears to be very little literature relating to what is experienced as facilitative or impeding to individuals who have addressed their addiction issues.

The limited available literature tends to focus on the role of health professionals in the healing process. The existing research that examines interactions between clients and addiction and health professionals includes several studies that address the attitudes of health professionals in their interactions with substance addicted individuals (Amodeo, 2000, Matthews et al., 2002; West & Miller, 1999). This research suggests that negative attitudes are common among professionals who work with individuals with addictions. Typically, however, such negative attitudes are tempered when specialized training in working with substance users is provided. Certainly the attitudes of health care professionals have the potential to be helpful or to hinder clients in their efforts to overcome addiction. However, the extent to which the attitudes of professionals are perceived by clients as being significant in facilitating or impeding their healing process remains to be examined.

In terms of studies that explore clients' perspectives on their interactions with professionals, the experiences of drug users in their interactions with people in various

support services are described by Ashery, Carlson, Falck, and Siegal (1995) in their qualitative study of human services utilization by 44 injection drug users and crack-cocaine users. The experiences of drug users in their interactions with service providers were examined, but the study by Ashery et al. was not concerned with the perceived influence of the clients' interactions on their journey out of addiction.

In another qualitative study, Akin and Gregoire (1997) also explored the experience of substance abusing clients in their interactions with service providers. The study identified positive aspects of interactions that helped the parents reunite with their children as well as frustrating components of interactions they felt impeded their progress. This study provides valuable information about the subjective experience of clients in documenting the experiences they felt were facilitative or hindering in their process of healing.

Other interactions of potential influence in the process of healing from addictions include those with individuals from a client's social support network. The available literature seems to suggest that a broader, stronger social network has facilitative properties for individuals struggling with addiction (Ames & Roitzsch, 2000; Dobkin, De Civita, Paraherakis, & Gill, 2002; Reid et al., 2001). In general, these studies indicate that individuals who have strong social connections stay in treatment longer, and maintain treatment effects longer than those who do not have many social connections. What remains unclear is what it is about their interactions with others that facilitates the healing process of individuals with addiction.

The literature described above gives a picture of some of the different people who, through their interactions, may be perceived by individuals with substance

addictions to influence their healing process. The literature only begins to address the interactions that individuals who are struggling with addictions perceive as facilitative or hindering to their progress. To address this gap in the literature, in this study I explored how individuals with addiction issues experience their interactions with others as being helpful to, or impeding of their healing process.

Research Question

The question that guided this study was **“How do individuals who have moved from substance addiction to health experience their interactions with others in terms of facilitating or impeding their healing journey?”**

The lack of research on how social interactions facilitate or impede the process of healing from substance addictions prompted this question. From the results of this study I hoped to gain some insight into the experience of individuals who have healed from substance addictions. This research investigation sought to establish common themes of what interactions with others were perceived to have helped or hindered participants in moving away from addiction toward a healthier lifestyle. “Others” in this study was kept intentionally vague because we did not know who the individuals were who would be perceived by the participants to have played key roles (positively or negatively) in their healing journey from addiction. Ideally, this was one of the things that I hoped to uncover in this investigation.

Significance of the Study

The themes that emerged through this study may help increase the knowledge and shape the behaviours of professionals who work with clients who have substance addiction issues. Additionally, the results of this study may raise counsellors' awareness of what interactions are perceived by clients as being instrumental in their progress. This new awareness may help counsellors to work with significant others in their clients' lives to encourage interactions that help to support the healing process. The data from this study may also assist in the training of professionals who work with individuals who have substance addiction issues, by providing examples of facilitative interactions to help clients heal from addiction. The study will also potentially provide important information for friends and family members of what behaviours and attitudes are perceived as helpful in terms of supporting individuals with addictions through the healing process. Ideally this study will also contribute to both theoretical and addiction treatment literature.

Definition of Terms

The terms "addiction," or "substance addiction," "problematic drug or alcohol use," and "substance abuse" will be used interchangeably in this study. The DSM IV-TR (2000) defines substance abuse as a "maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (p. 198). I will follow the convention in the literature that tends to group substance addiction separately from nicotine addiction and other addictions.

The terms "healing," "healing journey," "healing process," or "progress" will be used in this study in place of recovery wherever possible. Denning (2000) states that the

term “in recovery” identifies an individual as working through a 12-step program. The term implies that no one can ever fully recover from addiction and implies a process of life-long recovery. Denning also states that there is no term to describe individuals struggling with addictions who are not a part of the 12-step movement. As a result, the terms described above will be used in this study whenever possible to indicate individuals who are no longer actively abusing a substance. This may mean the individual is abstinent or is using drugs or alcohol in moderation.

The healing journey, in my mind and as described by participants in this study, begins when an individual decides they are unhappy with their current addictive lifestyle and starts to think about changing those behaviours. The road on this journey is very rarely straight, as the individuals in this study outlined. Every interviewee relapsed at least once on their journey to free themselves from addiction. Consequently the descriptions of healing involve both positive and negative elements.

The definition of interaction has been taken from social psychologists Sears, Peplau and Taylor (1991) who define social interaction as occurring “when two or more people influence each other – verbally, physically, or emotionally” (p. 207). Based on the results from this study I will expand on this definition slightly. Along with interactions involving people I will include interactions with a “higher power,” “God,” or “god of one’s understanding” as well as interactions with the personified substance of abuse that were described in by participants in this study.

CHAPTER TWO

Literature Review

Introduction

In this chapter I will set the stage for this study of the experience of individuals with substance addictions in their interactions with others in terms of the theoretical and historical context of addiction and the pertinent literature relating to my question. In order to contextualize the research question, I will begin by giving some background on the history of addiction and theoretical perspectives on social interaction as well as that of counselling literature pertinent to addiction. The remainder of the chapter will include a review of the relevant studies relating to the topic of interactions individuals with substance addictions have with various people in their lives.

In reviewing the relevant literature related to the experience of individuals with addiction issues in their interactions with others, two major areas will be highlighted: literature on the professionals who interact with individuals who have addictions, as well as literature on the social support of individuals with addictions. Literature focusing on the relationship of professionals with individuals with addictions, from both the professional and client perspective will be addressed. The reason for inclusion of these studies is that many individuals come into contact with professionals over the course of their healing journey and there is great potential for clients to feel these individuals have influenced their progress in some way. The literature examining the role of social support will be discussed because it appears that the relationships individuals have with their friends and family members play a role in individual healing from addiction. Therefore, it is important to examine both the literature relating to social support as well

as how professionals interact with their clients and how these interactions are perceived by clients.

In addition to these two major areas, I will also discuss the limited research addressing the ethnicity and gender literature and its relevance in the area of substance addiction. There appears to be evidence that individuals of different ethnicities and/or gender may bring different perspectives to the issue of the utility of interactions with others based on their unique experience of addiction. I was, therefore, mindful of ethnicity and gender in recruiting participants and in analyzing data. The chapter will conclude with a summary and synthesis of the existing literature leading to the statement of the problem.

History

Over the last hundred years, attitudes toward addiction and toward individuals with addictions have evolved in North America (Boyd, 1991; Denning, 2000; Gray, 1998): starting as a racial issue then becoming a moral issue. From here, the view of addiction as a disease developed. The use of illegal drugs has meant that addiction has also been interpreted as a criminal justice matter. Presently, in Canada, addiction is being seen more and more as a public health issue.

Laws prohibiting substances like opium and marijuana were originally based on racial prejudice. These laws carried over to alcohol during prohibition in the United States from the years 1920-1933. However, the laws developed around alcohol came from the religious view of alcohol and alcoholics as evil and morally wrong. Since then, the Alcoholics Anonymous organization has construed alcoholism and drug use as a disease rather than a moral issue. In the 1970's the "War on Drugs" was introduced as a

way to rid society of the harm of drugs. This “war” has turned the issue of addiction into a criminal justice problem rather than viewing it as a public health concern.

Consequently, individuals with drug addictions are often seen as criminals rather than people with a health problem, and are treated accordingly. The history of North American society’s attitudes and approaches to alcohol and drug issues is relevant because the culture around an individual imparts the lens through which they see people with addictions and influences the way individuals with addictions see themselves.

Currently there is a shift happening in Canada toward a philosophy of harm reduction that views the problem of addiction as a biopsychosocial issue (Denning, 2000), rather than a disease or criminal phenomenon. The harm reduction approach advocates reducing harm to the individual and promoting their health. Abstinence is not the only goal of treatment within the paradigm of harm reduction. In viewing addiction as a biopsychosocial phenomenon, the harm reduction model looks not only at the biological effects of drugs on the individual, but also the psychological effects and the interaction between the individual and society and addresses both community and individual interventions. It appears that the harm reduction model may provide a more constructive way of viewing addiction and individuals with addictions than some of the historical alternatives. The nature of social interactions and facilitative counselling interventions from different theoretical orientations will be described in the next section.

Theory

In his book, *The Psychology of Interpersonal Behaviour* (1994), Michael Argyle, a social psychologist specializing in social interaction, identifies several motivating factors to explain why individuals seek social interaction. These drives include

biological needs, dependency, affiliation, dominance, sex, aggression, self-esteem and ego-identity, and other motivations which affect social behaviour (achievement, money, interests, values). Individuals seek to satisfy goals relating to these drives through their interactions with others.

The nature of a social interaction comprises verbal and non-verbal elements (Argyle, 1994). Non-verbal elements communicate attitudes, emotions and supplement the verbal exchange. Non-verbal communication is comprised of facial expression, gaze, voice, gestures, posture, touch / bodily contact, spatial behaviour, and appearance. Verbal communication and conversation convey meaning and are intended to influence the hearer in some way (Austin, in Argyle). Argyle breaks verbal communication into utterances and describes these different types of utterances: orders and instructions, questions, information, informal speech, expression of emotions and interpersonal attitudes, performative utterances (e.g., voting, judging), social routines (e.g., thanking), and latent messages. Verbal and non-verbal communication can influence individuals verbally, physically and emotionally. The specific interactions this study is interested in are interactions that are either facilitative or hindering in an individual's process of healing from addiction.

When counsellors work with clients, their interactions are intended to facilitate the healing process. The counsellor facilitates beneficial interactions with clients by displaying accurate empathy, genuineness, and an unconditional positive regard for the client (Hackney & Cormier, 1996). Certain behaviours are exhibited in order to demonstrate these helping characteristics. Behaviours associated with empathy include "verbal and non verbal attending, paraphrasing content of client communication,

reflecting client feelings and implicit client message, and pacing or synchrony of client experience" (Hackney & Cormier, p. 53). Behaviours that convey genuineness are "congruence, openness and discrete self-disclosure and immediacy" (p. 61). Positive regard is expressed through supporting nonverbal behaviours and enhancing verbal responses. The presence of these factors does not necessarily guarantee that the client will respond favourably to the counsellor; but the literature suggests these interactions are facilitative in nature (Egan, 1994; Hackney & Cormier, 1996).

The addiction counselling literature supports the efficacy of counsellor behaviours similar to the general counselling model discussed above, when working with clients who have addiction issues. Different theories discuss elements of the helper's role in facilitating the healing process of individuals with addictions. The Alcoholics Anonymous model suggests that a facilitator (Nowinski, 1996) should provide an environment of safety and acceptance for clients, reinforce the client's positive efforts, and work collaboratively with the client. The behavioural model (Rotgers, 1996) outlines a collaborative, empowering process that encourages the client's involvement in treatment planning and goal setting. Motivational interviewing (Bell & Rollnick, 1996) and psychoanalytic (Keller, 1996) approaches advocate the use of empathy by therapists and motivational interviewing also stresses client choice in goal setting. Harm reduction literature refers (Denning, 1998; McCann & Roy-Byrne, 1998; Tatarsky, 1998), as the general counselling literature does, to the importance of establishing a therapeutic alliance in effecting change with a client. Studies using the harm reduction approach to addiction treatment (Denning, 1998; McCann & Roy-Byrne, 1998; Rothschild, 1998; Tatarsky, 1998) suggest that interacting with the client from "where they are" and

working with the client's goals in a collaborative way rather than imposing a prescribed treatment strategy is the key to facilitating the healing process. "Harm reduction psychotherapy rests on the belief that the interactions within a relationship between the drug user and the clinician help create the environment within which change takes place" (Denning, 2000, p. 93). However we do not know what it is about these interactions that facilitates change for the client.

In the next section I review the literature pertaining to interactions between professionals and clients with addiction issues. The literature addresses studies that describe the resulting behavioural and attitudinal changes that occur among professionals who have received specialized training about addiction and working with individuals with addictions. In addition, the qualitative literature documenting the experiences of individuals with addictions with certain professionals will be described. These studies begin to give some idea of the types of interactions that may be perceived as facilitative or impeding in an individual's recovery from addiction.

Professionals Who Work with Individuals with Addictions

Amodeo (2000) conducted a study to examine the influence of substance abuse training on Social Workers in terms of their attitudes, skills and clinical behaviour with respect to clients with substance addiction issues. The sample of 81 Masters level Social Workers who completed a nine month, 84 hour training program between 1986 and 1995 was compared with a matched sample of 78 Masters level Social Workers who did not enroll in the training program. The sample was mostly female (87%) and White (96%). Participants with the training who had substance abuse experience prior to the training period were excluded from the study in order to minimize the possibility that outcomes

predated training. Telephone interviews in this long-term follow-up design involved a questionnaire developed for this study comprised of both closed and open-ended questions. The questionnaire included measures of behaviour, clinical skills and self-rated attitudes of interest, commitment, optimism, competence and confidence in working with substance-abusing clients. Participants' supervisors were interviewed in order to substantiate the claims of participants.

In terms of attitudes toward clients with substance addiction issues, the findings indicated that the trainees' scores and supervisor ratings of trainees were significantly more positive than those of comparison subjects. Trainees and their supervisors rated themselves higher on the extent to which they identified and intervened with clients who had substance abuse issues. Trainees had significantly more substance-abusing clients in their caseload in their primary work setting than comparison subjects. Additionally, significantly more trainees had made job changes to increase the focus on substance abuse related work. Subjects who completed training in the first five years scored significantly higher on the attitudinal components than those who completed the training in the latter five years. The authors interpreted this result as suggesting that attitudes may improve in time with more exposure to clients with addiction issues.

The study's strengths include the matching of the sample. Subjects were matched professionally and were also very similar on relevant background variables. The long-term follow-up nature of the study is rare and in this case seems to indicate that training effects stand the test of time and may improve over time. Supervisor corroboration of subjects' responses gives greater credibility to the results. The study is limited by the fact that the training program was voluntary and it is possible that individuals who took part

in the training program were already more interested in the area of addiction and could have had more positive attitudes about addiction and clients with addictions than the comparison group regardless of training. The generalizability of the study is limited because it relates to only one training program. Additionally, other than a focus group used to hone the questions for the interviews, no validity or reliability data were given for the scale developed for this study.

The findings of Amodeo's study (2000) converge with those of Matthews et al. (2002) who also found that a substance abuse training interclerkship assisted in improving knowledge, attitudes and skills of third year medical students in working with patients with substance addictions issues. In their study, Matthews et al. (2002) assessed the immediate and delayed impact of a one or two day intensive substance abuse training session (interclerkship) on the knowledge, skills and attitudes of 396 third year medical students from the University of Massachusetts Medical School between the years 1997 and 2001. The purpose of the interclerkship was to enhance knowledge and competence with substance abuse assessment and brief intervention. The interclerkship format involved interdisciplinary instructors (medical and community professionals) integrating teaching formats, emphasizing small group teaching and skill development.

Students completed an initial questionnaire, a pre-interclerkship test, a final course evaluation and a post-interclerkship test. The initial questionnaire gathered demographic data including past work or personal experience with substance abuse disorders. Pre- and post-interclerkship tests asked questions related to attitudes and knowledge regarding substance abuse disorders and treatment. The attitude assessment instrument was adapted from the Substance Abuse Attitude Survey and the knowledge

assessment instrument was developed by this study's authors. Students were also asked two questions about their confidence in assessing substance abuse problems and providing brief intervention. Additionally, in 1998-99 each third year medical student participated in an Objective Standardized Clinical Examination (OSCE) that, in part, measured students' substance abuse assessment and intervention clinical skills. The OSCE may have occurred up to six months after the substance abuse interclerkship for some students, and others may not yet have taken part in the interclerkship. Students' performances on the OSCE were compared based on whether the OSCE was completed before or after their substance abuse interclerkship.

Findings were assessed in the following way. Pre- and post-interclerkship test scores for knowledge, attitudes and confidence were compared using non-directional paired sample t-tests and the authors found significant positive changes immediately after the interclerkship. Spearman correlations were calculated to examine the relationships among attitudes, knowledge, and confidence and self-reported past experience with substance abuse and to evaluate the relationship between students' performance on the OSCE and their responses on the pre and post interclerkship assessments. No correlation was apparent between past personal experience with substance abuse and knowledge, attitudes or confidence regarding substance abuse issues. However, prior work knowledge seemed to predict more positive students' attitudes and greater confidence levels at the beginning of the interclerkship. Chi square tests were used to compare the frequencies of OSCE performance ratings falling above and below expected levels for students completing the OSCE before and after the interclerkship. OSCE performance data showed significant improvement in the students' ability to assess and intervene with

substance abuse issues immediately following and up to six months after the interclerkship. Stepwise multiple regression was used to examine the contributions of the substance abuse interclerkship and the internal medicine and family medicine to the students' OSCE performance. Completing the family medicine or internal medicine components were not shown to demonstrate an effect on the substance abuse measures of the OSCE. The interclerkship remained the only positive predictor of performance on the OSCE. Positive strengths were comparable given both the one and two day format of the interclerkship.

The strengths of this study include addressing the issue of attitudes, knowledge and skills of medical students relating to patients with substance abuse issues as substance abuse appears to be an area without a great deal of training for medical students. In addition, the sample size and repetition of the study in successive years for comparison lends itself to the credibility of the study. However, the reliability and validity of the pre- and post-interclerkship tests was not sufficiently addressed in the study. Questions on the tests were modified from an existing substance abuse attitude survey. The authors also added and developed questions for this study. It is unclear whether these instruments were appropriate for use in this study.

Matthews et al. (2002) found an improvement in the attitudes, knowledge and confidence of students who completed a substance abuse interclerkship. This finding seems to support the idea that specific training in substance abuse can positively influence beliefs and behaviours of physicians who may interact with individuals struggling with addiction issues. The attitudes and behaviours of physicians have the potential to influence individuals in their interactions with them. Interactions are

comprised of verbal, emotional or physical influence between two people. Therefore, if the attitudes and behaviours of professionals interacting with their substance abusing patients are more optimistic, there may be a greater likelihood that their interactions with these patients could be facilitative rather than hindering.

West and Miller (1999) carried out a survey of 90 vocational rehabilitation counsellors to determine if differences existed in the attitudes of vocational rehabilitation counsellors toward serving substance abusing clients depending on the counsellors' training and education. Participants were employed by the Tennessee Division of Rehabilitation Services and the Tennessee Department of Health and Human Services. Of the respondents, 57% had been employed as vocational rehabilitation counsellors five years or less. The Substance Abuse Attitude Survey (SAAS) was administered to participants to gain information about rehabilitation counsellors' attitudes and beliefs about the etiology, course and treatment of addictions. Subjects were grouped according to their substance use and abuse training history. T-tests were conducted on the SAAS as a whole and its subscales of nonmoralism, treatment intervention, nonstereotypy, permissiveness and treatment optimism to determine the existence of attitude differences between groups.

No significant difference was found between the training and non-training groups on the SAAS as a whole although the results were approaching significance in the predicted direction. Of the five subscales of the SAAS, only two indicated a difference between groups based on their training. The subscales of nonmoralism and treatment intervention showed significantly more positive attitudes on the part of counsellors who had training compared with those who had none. This finding suggests that counsellors

with substance abuse training were less likely to see substance abuse as a moral failing and held more positive expectations of treatment intervention. On the whole, however, the attitudes of all counsellors in this study were found to be somewhat negative, perhaps because the type of substance abuse training received was not standard across all participants. Issues specific to rehabilitation counsellors such as their belief that rehabilitation clients with substance abuse issues cannot be helped, or that the care and rehabilitation of substance abusing clients will be more time consuming, may not have been addressed in the training the rehabilitation counsellors received.

The rehabilitation counsellors in this study met the criterion scores for individuals satisfied with working with a substance abusing population on only one subscale of the SAAS, suggesting that this group is unsatisfied on the whole in working with a substance abusing population. In the sample of the study, very little information was given as to how the 52 individuals were chosen for the training group. The authors also mentioned that all reported training was accepted without categorization so participants' training could vary from a one day workshop to graduate coursework.

In contrast to Amodeo (2000) and Matthews et al. (2002) the attitudes of the vocational rehabilitation counsellors towards individuals with addictions were largely negative even after training. However, most of the respondents in this study had five years or less experience as a rehabilitation counsellor. Perhaps, as Amodeo indicated in her study, greater experience leads to greater satisfaction or better attitudes in working with a substance abusing population. Alternatively, the difference may simply indicate that social workers and physicians respond differently to substance abuse training than vocational rehabilitation counsellors. The survey nature of this study is a general data

collection method resulting in the inability to comment on the reasons why these vocational rehabilitation counsellors were unsatisfied working with individuals with addiction issues. The strengths of the West and Miller study (1999) include the sample size and the use of an established instrument for measuring attitudes toward substance abuse.

In a descriptive pilot study of former drug, tobacco and former or moderate alcohol users, Cunningham, Koski-Jannes and Toneatto (1999) examined the reasons for stopping or reducing consumption of alcohol, drugs, and/or tobacco provided by these individuals. The data for this study were extracted from the results of a random digit dialing telephone survey conducted by the Centre for Addiction and Mental Health (CAMH) called the Ontario Drug Monitor. This organization collects data relevant to alcohol and drug use in a representative sample of 200 adults once a month. Separate questions for each drug were asked about present and past use of cannabis, cocaine/crack, tobacco, and alcohol. Summaries that had been generated by the interviewers from the CAMH study were provided to the first author of this study who coded statements from these summaries.

Twelve categories of reasons for change were derived from separating the coded statements into groups. Of the people who used drugs relevant to this study, cannabis users, cocaine/crack users and moderate drinkers indicated intrapsychic reasons for changes such as growing up or personal decisions. Situational changes or new responsibilities were also cited by cannabis users and abstinent and moderate drinkers as reasons for change. Abstinent drinkers also noted health concerns as a reason for changing their using behaviour. For cocaine users both finances and not liking the effect

of the drug played more significant roles than situational changes. The most notable data gathered in this study were that only eight respondents of 200 mentioned treatment or doctor's advice as relevant to changing their drug using activity. Additionally, treatment was not mentioned by participants as a reason for changing using behaviour.

The strength of this study by Cunningham et al. (1999) is that the sampling method was random making it closer to a representative sample than convenience sampling. However, small sample sizes of some drug groups means that the results may not define the drug class as a whole. The information available to the authors of this study was limited because the study was based on a population study that had already been completed. Additionally the retrospective nature of the responses to the survey may have affected their accuracy. The authors of the study were unable to ascertain the primary reason for behaviour change among participants when participants offered several reasons. The questions were not randomly presented, therefore users of multiple drugs may have been influenced in their responses to later questions by earlier responses in the survey.

In relation to my study, the results of Cunningham et al. (1999) suggested that individuals recovering from addiction did not find professionals to be as influential as we might expect in their recovery process. Experiences with doctors or treatment did not seem to play a significant role with many of the individuals polled in this study. However, this result may be due to the fact that these participants had less severe addiction problems than those in other studies.

The nature and extent of drug abusers' interactions with the social services system was examined in the study by Ashery et al. (1995). The study sample of 44 participants

included 29 injection drug users and 15 crack cocaine users who were not in treatment at the time of the study. The participants were recruited in Dayton and Columbus, Ohio by indigenous AIDS project outreach workers. The mean age of the men was 41 years and the mean age of the women was 35. The sample included 10 white men, 10 white women, 13 African American men, and 11 African American women.

Focus group methodology was used for the purpose of this study. Eight focus groups were conducted: four in Dayton and four in Columbus. The groups ranged in size from four to nine people and were organized by ethnicity and gender. The team moderator approach was used for the focus groups. The moderators took turns leading the group using a structured focus group protocol. To analyze the data from the focus groups, each interview was transcribed and edited by the moderators. The authors then analyzed the interviews for themes by reading through the transcripts numerous times and making notes on general themes that emerged. Themes were cross-checked with observations and interpretations among the authors.

The researchers found two major themes, regardless of type of participant drug use, ethnicity, or gender. Firstly, participants were very familiar with social services, especially financial programs, housing, food pantries, and drug treatment. Secondly, participants felt that they received demeaning treatment from staff at public financial programs in comparison with treatment by staff of private programs. The treatment that was perceived by participants as demeaning included the condescending attitude of workers, and through workers' tone of voice being made to feel inadequate and degraded. Participants also reported some instances of ethnic and gender overtones.

Food and shelter programs were more easily accessed by participants than financial programs and drug treatment programs. Participants felt there were many barriers when seeking financial assistance. Producing the documentation required was perceived as demeaning and arduous. Additionally, the high rate of turnover among public assistance workers was perceived by participants as an obstacle in acquiring services. Participants felt they and their needs slipped through the cracks because they had not formed a relationship with a worker. The long wait for their cheques led some individuals to turn to illegal activities in order to obtain funds. As well, one woman felt that her dire situation gave her no recourse but to return to drug use. When seeking assistance from social services, participants generally did not reveal their drug use because of their perception that knowledge of their drug using behaviour could negatively affect their acquisition of services, or worse, that their children would be taken from them. Perceived barriers to drug treatment included long waiting lists and the cost of treatment. However, when treatment was obtained, the experience was described by participants as educational and meaningful. Self-motivation was addressed as essential for treatment success. The positive effects of treatment were limited by the short duration of treatment programs and lack of aftercare.

The study has some strengths but requires some caution in interpretation. Studying social service utilization might attract people who have specific issues with social services, thereby raising issues that are not relevant for others. On the positive side, the focus group method seemed to be an effective way to capture themes among this group of participants. There is very little research on the phenomenon explored in this study. The researchers stated that there was next to no research on the use of social

services by users of illegal drugs who were not in treatment. The inclusion of both white and African American men and women is a strength of the study because it provides a good sample in terms of size and diversity. In terms of its relationship to my study, Ashery et al. (1995) discussed the experience of participants in their use of various services. This information provides indications that certain workers and situations were perceived by participants to have influenced their actions, but this perceived influence was only touched upon in Ashery et al.'s study. One of my goals was to explore further in my study the perceived influence interactions had on participants' pathways out of addiction.

In a qualitative study using extreme cases of parents who had successfully addressed their drug or alcohol addiction problem and regained their children from child welfare, Akin and Gregoire (1997) sought to describe the impediments and contributions of child welfare workers to the progress of these individuals. Five white women and six African American women in their twenties and thirties with an average of three children were interviewed individually using semistructured interviews to collect data. Constant comparative analysis of the data identified themes that fell into the categories of addiction experience, system shortcomings, and system successes.

In terms of system shortcomings and system successes, some experiences were described by participants that were negative or positive in terms of their recovery. Feelings of powerlessness and hopelessness were sometimes reinforced by social workers' who seemed more interested in paperwork than the client, who only visited twice in one year, and who the women felt treated them like a statistic. Alternatively, experiences that were positive for participants included trusting relationships with

workers, social worker availability and persistence, and demonstrations of care for and patience with the client. Additionally participants felt supported when social workers were able to share power with their clients by offering them choices and authority in making decisions. Knowledge of addiction by workers was also identified as a positive factor in participants' healing experiences.

The strengths of this study are numerous. Firstly the study provides an alternative view to traditional research in terms of a qualitative approach describing the experiences of clients, treating these clients as people with valuable and valid insights and experiences, and in documenting participants' success. In terms of gathering data and accurately reflecting participants' experience, both informal and formal member checks were used, by clarifying and paraphrasing throughout the interview and in seeking the feedback of participants on the preliminary data analysis. As far as cautions with respect to the study, this study was based on a very specific sample. Different results may be found with individuals who relinquished custody of their children or, who continued to struggle with addiction. Findings may also have differed if the participants included men.

The discussion of the system shortcomings in this study appears to reflect the negative attitudes of professionals mentioned in Amodeo (2000), Matthews et al. (2002), and West and Miller (1999). Additionally in Akin and Gregoire's study (1997) the frustrations of participants with services and service providers reflect the barriers to accessing services described in Ashery et al. (1995). The barriers and system shortcomings outlined included services that were not user friendly and service workers whose attitudes and behaviours were perceived as demeaning, degrading and uncaring.

However, it did appear from the data in Akin and Gregoire's study that a positive worker-client relationship made a difference in the participants' lives. Although it was not addressed directly in the literature, it appeared that the attitudes and behaviours of professionals in the lives of individuals who have addiction issues could be perceived as harmful or helpful in the individuals' journey out of addiction.

On the whole, the research described above suggests that professionals who had received training in substance addiction issues reported positive changes following their training in terms of their attitudes and behaviours toward individuals who had substance addiction issues. Additionally, research outlining client perspectives described both positive and negative client experiences in dealing with professionals. Although Cunningham et al. (1999) suggested that professionals may not play a significant role in the recovery of individuals from addiction, findings of the study by Akin and Gregoire (1997) may point in the other direction, suggesting that interactions with social service workers seemed to play an important role in helping clients manage their addiction in order to be reunited with their children.

The qualitative studies described above begin to explore the experiences of individuals with addiction issues in their interactions with services and service workers. The research alludes to the possibility that individuals in social service roles may be perceived by their clients with substance abuse issues as facilitating or impeding their progress out of addiction: an aspect of the literature I hoped to expand in the current study. Furthermore, the literature to date does not directly examine whether individuals perceive their interactions with professionals to have any influence on their success in addressing their addiction issues. An area I explored in my study was whether the

attitudes, knowledge and skills of practitioners were perceived by the client, and in fact, whether these interactions were significant to clients in their healing process.

Social Support of Individuals with Addictions

Another subset of the literature examines the possible role of social support in healing from addiction and in the maintenance of healthy choices in an individual's life. Through their interactions, the individual addressing their addiction may perceive their friends or family members to be instrumental in facilitating or hindering their healing process. It is therefore important to review the literature pertaining to the role social support may play in the journey from addiction and the maintenance of a healthy lifestyle.

In a study of inpatients in a substance dependence treatment program, Ames and Roitzsch (2000) examined the relationship between stress and drug cravings and whether social support mediated this relationship. Thirty nine of the 52 inpatients chosen for the study completed enough information to be included in the study. The sample was composed largely of men (59%) who were Caucasian (74.4%), employed (53.8%), the largest percentage were single (38.5%) with a mean age of 36.47 years. The instruments used to gather the data in the study were the Daily Stress Inventory (DSI) to assess minor stress, the Interpersonal Support Evaluation List (ISEL) to measure social support, the self-report Daily Urge Record Sheet (DURS) to measure cravings. A demographic questionnaire developed for this study was used to gather background data. The demographic questionnaire and the ISEL were completed at the time when participants were recruited. Participants were asked to complete one DURS sheet each time they experienced a craving and to keep track of minor stressful events and record them each

night on the DSI. Participants met with an experimenter each day to hand in forms and ensure accurate and timely completion of forms.

When the mean number of stressful events and their perceived influence were compared with a normative sample of adults living in the community, the participants in the study reported a similar number of minor stressful events but rated these events somewhat, but not significantly, more stressful than the normative sample. Within the time enrolled in the study (average 4 days) 64.10% (n=25) of participants did not experience any cravings. Consequently, participants were grouped into craving and no-craving groups. The number of minor stressful events and perceived impact of stress appeared to predict cravings. Perceived social support was found to moderate the association between the impact of stressful events and cravings.

The study begins to address the potential influence social support may have in mediating the stress-craving relationship. Another strength of the study is the vigilance of the experimenters in meeting with participants daily to ensure forms were completed correctly. However, the low level of cravings during this experiment means that more research is necessary to firmly establish patterns of stress and cravings. Perhaps individuals were not enrolled long enough in the study to obtain an accurate impression of cravings, or perhaps the rate of cravings post treatment may have been a better measure.

Dobkin et al. (2002) carried out a study of individuals at treatment intake and again six months later in order to compare them at the two stages in terms of high and low functional social support and the relationship between this variable and various risk factors that may interfere with the early stages of recovery. The researchers examined

the stress-buffering role of functional social support on treatment outcomes and whether level of functional social support at intake predicted treatment outcomes. Functional social support was defined by Dobkin et al. as “actual or perceived emotional and instrumental support” (p. 348).

The sample included 206 individuals at intake and 172 at six months. There were 100 individuals in the high social support group and 106 in the low social support group. The low and high social support groups were not significantly different on the demographic variables, legal status, or primary drug of abuse. Most participants were Caucasian (92.3%) and male (65.5%). Drugs of abuse by participants in this study included alcohol, cocaine, sedatives and “other.”

The high and low social support groups in this study were compared across several variables considered to be risk factors for early recovery success including: depressive symptomatology, negative life events, and severity of substance abuse. The Interpersonal Support Evaluation List (ISEL) was used to assess patients’ perception of functional social support. The Life Experiences Survey (LES) was used to assess life events in the six months prior to treatment intake and again in the intervening months between the initial and follow-up interviews. The Beck Depression Inventory (BDI) was used to assess depressive symptoms and the Symptom Checklist-90-R was used to assess psychological distress. The Addiction Severity Index (ASI) was administered to gather information on the number of days abstinent and the severity of drug and alcohol abuse. Two-way ANOVA with repeated measures was used to analyze the above data across the high and low social support groups and over time (intake versus six month follow-up).

Functional social support was a modest predictor of reductions in the severity of alcohol abuse at follow-up but did not predict reductions in drug abuse. Higher levels of perceived functional social support were related to more days spent in treatment and to higher rates of treatment completion. Both high and low social support groups showed marked declines in negative affect and severity of substance abuse over time. Symptoms of depression and psychological distress were higher among patients with low social support at intake and at six months. Patients with low social support at intake reported higher severity of alcohol and drug abuse at six months.

Number of days in treatment was also significantly related to number of days abstinent, improvement in severity of alcohol abuse, and improvement in severity of drug abuse. Hierarchical regression analyses were used to determine the main effects of stress and examine days abstinent from primary drug, severity of alcohol abuse, and severity of drug abuse. The number of days in treatment was used as a variable in all regression analyses to examine the independent and interactive effects of social support and stress on outcomes. Patients in the low social support group experienced a greater number of stressful life events than those in the high social support group at follow-up. Both stress and social support were found to have modest effects on treatment outcome. However, their interaction effect was not significant. Therefore the results failed to support a stress-buffering role of social support on the number of days abstinent and the severity of substance abuse.

The main strength of this study is that it adds to the research by taking measures at both intake and again six months later to document changes in risk factors that could interfere with early healing from substance addiction. Cautions of the study include the

demographics of the largely white, male sample as well as the appropriateness of the ISEL with a substance abusing population.

The study by Dobkin et al. (2002) and that of Ames and Roitzsch (1997) point to the possible benefits of increased social support to individuals in treatment for addiction. Social support seemed to be related to more days in treatment and higher rates of treatment completion in Ames and Roitsch's study. Additionally, Dobkin et al. found that individuals with high social support had lower symptoms of depression and psychological distress and lower severity of alcohol and drug abuse at six months than individuals with low social support. Although the results differ, they seem to complement each other in that social support may play a role in helping individuals cope in treatment situations. If social support does provide a coping mechanism for individuals healing from addiction, it is possible that the healing individuals may perceive people within their social support network as helping to facilitate their healing process. I aimed to explore in my research interactions with various people in participants' lives that were perceived as influential in their journeys.

In a descriptive, qualitative study by Reid et al. (2001) the authors explored the meaning and perceived influence of cocaine use in the lives of individuals who used cocaine in moderation. The authors hoped to identify factors the participants associated with their ability to function at an acceptable level while using cocaine. The sample included ten individuals: one West Indian male, one African American female, one Yaqui Indian female, two white males, and five white females all from 21 to 46 years of age. Level of functioning of each participant was determined using the Addiction Severity Index as well as a subjective assessment by a person who was familiar with that

participant. A screening interview was then conducted with individuals chosen for the study. Following the interview, a researcher-designed questionnaire was administered to participants to obtain information on participants' history, evolution of their drug use and the role it continued to play in their lives. Follow-up interviews were conducted with the participants to clarify any discrepancies between the ASI data and the data obtained from the researcher-designed instrument.

Through descriptions of their thoughts and behaviours, participants identified social factors, personal factors, and cocaine use factors that assisted them in their ability to maintain their cocaine use at a level that did not compromise their everyday lives. Social factors identified by participants included work ethic, involvement in socially oriented activities, family considerations, compassion for others, strong interpersonal relationships, and faith in God. Personal factors perceived as influencing the cocaine use of participants included positive self-image, self-discipline, and self-confidence. Methods to control cocaine use or cocaine use factors included minimizing the amount of cocaine used, choosing the times to use, and using when their attitudes and moods were positive. Older participants used less freely than younger participants who were not as concerned about consequences of their drug use and who also used in public more often and used larger amounts of cocaine. Women in this study used more conservatively than men with their reason being the need to care for, and set an example for their children. Participants from cultural minorities rejected the notion that cocaine use was "bad," and identified their culture as a reason for having positive attitudes about cocaine use.

The major strength of this study is that the participants in this study were not incarcerated or in treatment, making this an unusual sample. Additionally, the study

sample is a strength in terms of its diversity of gender, ethnicity and economic status.

Another strength of this study is that it focuses on the idea that all drug use is not abuse; whereas most research highlights the negative aspects of drug use. Qualifications in the interpretation of the study's results include that the sample was one of convenience using the snowballing method. Also generalization is not possible because of the small sample size.

When asked about what factors keep their cocaine use in check, participants in this study singled out social factors, including interpersonal and family relationships as part of that component. This evidence, combined with results from Ames and Roitzsch (1997) and Dobkin et al. (2002) that social support seems to play some role in helping individuals in treatment settings, underscores the possible formative role of social support in the process of healing from addiction and in maintaining individuals' positive lifestyle changes.

The research on the effects of social support in mediating stress and facilitating treatment outcomes as well as in maintaining moderate levels of cocaine use seemed to suggest that social support may play some role in helping an individual move away from addiction and maintain their new lifestyle. However, none of these studies addressed what it was about these social connections that may be facilitative in the context of recovery. In my study I tried to explore what individuals healing from addiction experienced in their interactions with their social support network in terms of facilitating or impeding their process of healing.

Ethnic and Gender Issues

The limited literature available on gender and ethnic issues in the area of addiction research seems to suggest that men and women as well as individuals of different ethnic origins may have different needs throughout their healing journey. Given this consideration I tried to include individuals in my study who represented different ethnicities and both genders in order to compare their experiences.

In their summary and critique of the literature describing the ways women experience addiction and how this differs from men, Nelson-Zlupko, Kauffman and Dore (1995) suggest that women with chemical dependencies differ from men with similar issues in terms of patterns of drug use, psychosocial characteristics and physiological consequences of drug use. It appears, from their explication of the research, that women were more likely to use legal drugs (tranquilizers, sedatives, psychoactive drugs, hypnotics, stimulants) and men to use illicit ones. The onset of drug use for women was described as sudden and heavy, typically after a traumatic event in their lives. In contrast, men often described a gradual, increasing pattern of drug use. Women were described as more often involved in multiple drug use than men. Physically, women experienced more harmful consequences of drug use at lower dosages and in a shorter amount of time than men.

The research indicated that women had fewer social supports to draw on than men with addictions. Women appeared more likely than men to use in isolation and in private places rather than public places. Women were more likely than men to be in relationships with drug-using partners or spouses. Additionally, women tended to have less education, fewer marketable skills, fewer work experiences and fewer financial

resources than men with chemical dependencies. It seemed from the research that, in treatment, women were less likely than their male counterparts to have someone supporting them. Women were even typically discouraged from participating in treatment by family members.

The discouragement from family members was not the only barrier to treatment for women that was described in Nelson-Zlupko et al. (1995). The lack of child care was mentioned frequently as a barrier to treatment. Mothers were either unwilling to give up their role as primary caregiver or could not afford child care while in treatment. Mothers also tended to distrust social services and were reluctant to admit their addiction issues. Women were also more likely to experience sexual harassment in treatment settings than men. Additionally, most treatment programs were designed for men, by men and based on research conducted with male participants. Nelson-Zlupko et al. suggested that as a result, the typical treatment format may not be ideal for women. Finally, there were more men in treatment than women and more male staff that dissuaded women from entering treatment depending on the issues they were facing.

From the summary of the research on women and chemical dependence by Nelson-Zlupko et al.(1995), it appears that women may face different issues throughout their addiction and recovery than men. The onset of addiction for women may differ from that of men. The social network of women facing addiction issues may be non-existent or certainly less extensive and not as supportive in comparison to men with addiction issues. Additionally, women may not get into and stay in treatment; thus maintaining the social isolation these women appear to experience. If differences

between men and women with addiction issues do exist, it is important to try and address these differences in the current study.

The purpose of Prendergrast, Hser and Gil-Rivas' (1998) study was to examine the differences in longitudinal patterns of narcotics use, other substance use, criminal status, treatment experience, and morbidity and mortality among Hispanic and white individuals with addictions. The sample comprised 323 Hispanic and 212 white male narcotics addicts who were admitted to a court-mandated treatment program called the California Civil Addict Program (CCAP) between the years of 1962 and 1964. The two groups did not differ significantly in terms of marital status, age at admission to the treatment program, or age of first opiate use. However, Hispanics had significantly less education than whites and age of first arrest was significantly lower for Hispanics than whites.

This study is a secondary analysis of data that were obtained from admission records of the CCAP as well as interviews conducted in 1974/75 and 1985/86. Prior to the 1985/86 interviews, 95 Hispanics and 58 whites died, so data is available for 203 Hispanics and 123 whites for both the 1974/75 and 1985/86 interviews. The initial intake interview was limited, comprising several demographic variables. The interview instrument used in the two subsequent interviews was adapted from another, previously designed interview. Information on demographic characteristics, family history, drug-use history, treatment experience, employment, criminal behaviour, and legal status was gathered during a two to three hour interview using the researcher-developed interview protocol. In order to corroborate respondents' reports, researchers had access to criminal records and urine samples were collected after interviewing participants who were not

incarcerated. Agreement between respondent reports and urinalysis was 73.7% at the first interview and 85.8% at the second interview. Eighty-nine point three percent of the sample agreed to provide urine samples at first interview and 89.1% of participants agreed to urinalysis at the second interview. Narcotic use was determined by urine test or incarceration: not self-report, and did not include the narcotic use status in the intervening years. In terms of test-retest reliability determined by comparing data from the two interviews, the test-retest correlation range was 0.63 to 0.71.

Hispanic addicts showed a progression of more persistent and severe narcotics addiction compared with white addicts. At each interview, Hispanics were more likely than whites to be using opiates or to be incarcerated. Hispanics were less likely than whites to remain abstinent and were more likely to relapse to opiate use. Hispanics had greater involvement in the criminal justice system, higher rates of cocaine use, and a higher proportion of deaths due to violence and accidents. However, rates of hepatitis and cigarette smoking were particularly high among white addicts. In treatment, Hispanic participants did not like sharing personal thoughts and feelings in a group situation with individuals of other ethnicities. Treatment participation was low for each group and there were no differences between the two groups for treatment participation.

The main strengths of the study are the longitudinal nature and the varied data gathered on drug behaviour. Additionally, the ability of the researchers to corroborate most respondents' answers by urine sample and by criminal records lends credibility to the data gathered.

The relevance of this research to my study is that it appears that individuals from a Hispanic background may have a different experience of addiction and treatment than

white individuals. Prendergrast, Hser and Gil-Rivas' (1998) study indicated that Hispanic individuals showed more severe addiction and criminal justice issues than white participants. Additionally, Hispanic individuals did not like sharing in a group treatment format with individuals of different ethnicities. These results suggest that the experience of addiction may be different for individuals of differing ethnicities or cultural backgrounds. I was mindful of this when selecting my participants and in listening to their experiences.

The limited literature on individuals of different genders and from different ethnic and cultural backgrounds who have substance addictions seems to suggest that the experiences of these individuals may be influenced by their culture or gender. In Reid et al. (2001) individuals from cultural minorities tended not to see cocaine use as "bad" in the way the prevailing culture does. The study by Prendergast et al. (1998) reported that Hispanic participants did not like the group format of treatment that requires personal disclosures with people of other ethnic groups. Ashery et al. (1995) noted that "in some instances ethnic and gender overtones were mentioned by the participants" (p. 79) suggesting that individuals may be treated differently because of their background or gender. The summary and critique of the experiences of women with addiction issues by Nelson-Zlupko et al. (1995) lists a variety of ways in which women may differ from men throughout the healing process. The above research suggests that individuals of different cultures and different genders may have different needs and different experiences throughout their healing from substance addiction. I was able to include in my study individuals of different ethnicities and genders and I tried to gain insights into the experiences of these individuals including interactions based on these factors.

Summary and Synthesis

From a review of the literature addressing the role of professionals, social support and ethnic and gender issues in the area of addiction, it is apparent that a gap exists in our understanding of the experience of individuals with addictions in terms of their experiences and perceptions of their interactions with others in their process of healing. It would be beneficial to gain insights into these interactions in order to be facilitative in the healing process of individuals with addiction issues. The social support literature (Ames & Roitzsch, 2000; Dobkin et al., 2002; Reid et al., 2001) suggests the possibility of social relationships being experienced as beneficial by individuals with addiction issues in their healing process. However, if indeed a relationship does exist between an extensive social support network and facilitated healing, the nature of the interactions between the recovering individual and their supports remains to be explored. The literature suggests that the training of professionals in substance addiction issues may be helpful in addressing the negative attitudes that may exist among professionals. What remains uncertain is whether these more positive attitudes are translated to the client and, moreover, whether interactions with professionals are among the perceived significant interactions of clients on their road to a healthy lifestyle. It was my hope that through a phenomenological study of individuals with addiction issues that I would be able to contribute to the literature by exploring the interactions with others that were experienced by participants as facilitative or impeding in their healing path away from an addictive lifestyle.

CHAPTER THREE

Methodology

Method Selection

In spite of much literature in the area of addiction, researchers are still struggling to understand the road out of the lifestyle characterized by addiction. Studies have investigated the role of addiction professionals' attitudes toward clients and the influence of a broad social network on client recovery. However, very limited research exists that examines facilitative or impeding interactions with others in the lives of individuals who have moved from substance addiction to health. It seemed fitting at this time to address the gap that exists in this area of research. If we can learn about the perceived facilitative and hindering interactions individuals have with others throughout their healing process, we can provide important information for counsellors and other professionals who are intended to play a helping role in the healing journey of individuals with addiction issues. Based upon a review of the relevant literature, the following question was generated:

How do individuals who have moved from substance addiction to health, experience interactions with others in terms of facilitating or impeding their healing journey?

The purpose of this study was to examine how individuals who have moved from substance addiction to health experienced their interactions with others in terms of facilitating or impeding their healing journey. This study was exploratory in nature because very little is known about the lived experience of this phenomenon. Exploratory research is undertaken in order to provide a better understanding or illumination of a process or a problem (Hart, 1998). Qualitative investigation is most appropriate for this

study because the purpose of qualitative research is “to identify the characteristics of phenomena” (Beck, 1993, p. 263).

The qualitative method that was chosen to investigate this phenomenon was phenomenology. The nature of phenomenology is descriptive rather than experimental. The purpose is to describe and understand experience instead of predict and control behaviour. The “aim of the research is to achieve perspectival understanding of a phenomenon and identify its structure” (Osborne, 1990, p. 82). Generally this understanding is sought through interviews with individuals who have experienced the phenomenon in question in order to gain a detailed description of the lived experience of the phenomenon (Colaizzi, 1978). The description is then analyzed for themes that form the structure of the phenomenon while attempting to accurately represent the lived experience of the participants.

In-depth, phenomenological interviews were used in this study to capture the common themes in the experiences of the participants. Phenomenological inquiry assumes that meaning is derived from the commonality of shared experience (Patton, 1990).

Role of the Researcher

In qualitative research the researcher’s process, presuppositions and possible influence on the research project are made explicit so the researcher’s biases and assumptions can be distilled from the data. Qualitative research does not assume that the researcher is unbiased (Colaizzi, 1978) as in quantitative research, where it is assumed that the researcher is objective or has no influence on the research process. The presuppositions and biases of the researcher are articulated prior to and during the

qualitative research process so the reader can take this perspective into account when reading the research report. Describing the researcher's presuppositions helps the reader determine whether the researcher has been true to the data or whether the assumptions of the researcher have affected the results of the study (Osborne, 1990). How I came to this research question and what I expected to find will be outlined in the following paragraphs.

My original interest in the area of addiction is derived from the history of alcoholism in my family. Living around individuals who have addictions has made me curious about the phenomenon of substance abuse and the process of overcoming this affliction. I feel that my personal experience in this area has helped me to understand my clients in counselling situations and I feel this was beneficial in the research process as well.

After counselling individuals who have substance abuse issues, my compassion for those who suffer with addictions grew. My belief is that the plight of people who suffer from addiction is worsened by society's and certain individuals' attitudes. I suspected that these attitudes would be communicated in their interactions with addicted individuals. Aspects of interactions that I thought might be experienced by participants as negative included impatience on the part of others, dismissiveness, unrealistic expectations, and expecting that addictive behaviours could change without addressing an individual's entire lifestyle. If an individual with addiction issues was treated as a criminal rather than an individual with a health problem I believed this might also be construed by individuals as hindering in their recovery. I also thought that imparting the

belief “once an addict, always an addict” to an individual in the recovery process might also be perceived as limiting by these individuals who are trying to change their lifestyle.

I assumed that individuals who were moving toward a healthier lifestyle would be aided if they have more people around them: family, friends or professionals, who had positive attitudes about the individual’s struggles to overcome their addiction, and therefore more facilitative interactions with these individuals. I imagined that some of the attitudes and behaviours that might be perceived by participants as facilitative would include patience, encouragement, conveying optimism about the individual’s progress and potential, acceptance and respect. In a professional relationship, I imagined that working collaboratively with clients, treating each person as a unique individual rather than as “an addict,” being patient and accepting of the cyclical nature of change involving relapse as part of the process, empathizing with the difficulty of quitting or cutting down, encouraging persistence in reinventing clients’ lives, and working toward reducing harm to the individual and promoting healthful behaviours could be perceived by participants to be facilitative in their healing journey.

My reasons for choosing my specific question emerged from my addiction counselling background. Historically (Boyd, 1991; Gray, 1998) individuals with addictions have been treated as outcasts rather than as individuals who need help. The harm reduction model (Denning, 2000) is trying to change this practice by treating individuals with addictions with respect, and by encouraging health promotion and harm reduction as the goals of treatment rather than abstinence. In-keeping with this model of approaching individuals with addictions with respect, I chose a qualitative thesis question that allows the data to come from the experts: those individuals with substance addiction

histories who have healed from their addiction and who are now leading healthy lives. I would like to add to the literature that exists that treats individuals with addictions as worthwhile, contributing people who have expertise to offer the academic, research and professional communities.

I was aware that my belief that those who suffer from addiction are marginalized in society might have led to biases when I was analyzing data; whether I was looking for confirmatory evidence or trying to counter my preconceived notions. To address my assumptions, I engaged in a process of "rigorous self-reflection" (Osborne, 1990, p. 81) throughout the duration of the research that was documented in a journal. I was also prepared to consult with my supervisor when necessary to address any of my assumptions and the influence they may have played in data analysis and interpretation.

As a helping professional I hoped to find throughout the data collection interviews that counsellors and others in helping roles played a significant part in facilitating healing from addiction. I was prepared, however, for the possibility that this would not be the case. I hoped to be open enough in my thinking to allow for responses and opinions that differed from my expectations and to be able to reflect the participants' experiences accurately in the data analysis.

Selection of Participants

Although there are no strict guidelines for the number of required participants in a phenomenological study, Osborne (1990) and Kvale (1996) suggest that sufficient participants are needed to illuminate the phenomenon of interest. To explore the phenomenon in this study the sample was comprised of the first 6 individuals who met the research criteria. Only 6 participants were chosen because at this point the themes

appeared to be saturated. Participants appropriate for this study had not been abusing substances for at least the last six months but had experienced their substance addiction within the past five years. Six months without relapse is the time required for an individual to be considered to be in the "maintenance" stage of change with respect to their addiction (Denning, 2000; Prochaska, DiClemente, & Norcross, 1992). Relapse occurs when individuals revert to an earlier stage of change (Prochaska, DiClemente & Norcross), characterized by addictive behaviours. Six months without relapse hopefully gave participants enough time to reflect on their experiences in order to give a retrospective account. However, in order to illuminate the phenomenon with reasonable accuracy, participants were required to have experienced their substance abuse within the last five years. Eligible individuals for this study had adequate familiarity with the phenomenon in question in order to give a rich description of their experience in an in-depth interview. Familiarity with substance addiction refers to the problematic substance use participants experienced within the last five years.

For the purposes of this study, the sample was restricted to adult participants. Developmental literature (Berk, 1996; Carlson & Lewis, 1998) suggests that adolescents differ cognitively, emotionally and socially from adults and therefore adolescents were not included in the sample for this study. Individuals interested in participating in the study also agreed to an audio-taped interview, a time commitment of two to three hours, and agreed to discuss their experience of interactions that they perceived to facilitate and impede their healing from addiction. Participants did not have any impairment that rendered them unable to give informed consent or respond coherently in the interview.

Additionally, participants were able to communicate effectively in English for the interviews.

The available literature suggests that interactions may be shaped by an individual's ethnicity or gender (Biernacki, 1986; Denning, 2000; Nelson-Zlupko, Kaufman, & Dore, 1995; Prendergast, Hser, & Gil-Rivas, 1998). With this in mind, I tried to include in my sample individuals of different ethnicity as well as women and men, in an attempt to capture any differences in experiences based on these factors. Included in the participants were one man with South Asian and Swedish heritage, and one woman who was African Canadian.

Recruitment of Participants

Participants were recruited using posters placed in various locations around the city of Vancouver including the Alano Club, Avalon Women's Centre, Daytox at Vancouver Detox, Dunbar Community Centre, Family Services of Greater Vancouver: Vancouver East Office, Hey-Way-Noqu, Pacific Spirit Community Health Centre, Raven Song Community Health Centre, St. Mary's Kerrisdale: Anglican Church, Turning Point Recovery House, UBC Counselling Psychology Department, and Vancouver Recovery Club (see Appendix A).

I conducted initial telephone interviews to give participants an overview of the study's nature and purpose and establish participant suitability for the study (Osborne, 1990). Once suitability and willingness were established, an appointment was set up to meet for the data collection interview.

Data Collection

When I met with each participant for the data collection interview, I introduced myself and endeavoured, through casual conversation, to establish rapport. Rapport is important in encouraging accurate descriptions from participants of their experience (Osborne, 1990). Informed consent was discussed next. This discussion included the purpose of the study, the use of a tape recorder to record the interviews, and addressed any questions the participant had about the study. An informed consent form was completed outlining the purpose of the study, requirements of participants, issues of confidentiality, freedom of participants to withdraw from the study at any point, and storage of data (see Appendix B). The participant and I both signed the consent form and a copy was given to the participant. Once the consent form was completed, I read the participant an orienting statement to give the participant a context for the interview (Kvale, 1996)(see Appendix C). The orienting statement provided a consistent introduction to the interview for each participant.

The duration of each data collection interview was between 1½ hours and 3 hours. An unstructured, open-ended style of interviewing was used in order to gain insights into how participants experienced the phenomenon of their interactions with others that they felt facilitated or impeded their healing journey from substance addiction to health. In-depth interviews are appropriate for this study because the interview process enables the researcher to uncover participants' views through their eyes and from their unique perspectives (Marshall & Rossman, 1999). The primary interview question was "Would you please tell me about your experiences of facilitative or impeding interactions that you felt were significant to your process of healing from addiction?" I used paraphrasing and

reflection to help prompt the participant. Follow-up and clarifying questions were also asked about the particular nature of the interactions in order to gather a rich description of the phenomenon (Osborne, 1990; Kvale, 1996). Some examples of these follow-up questions include: "can you tell me more about what you were feeling or what went through your mind when that happened?", "how did the interaction affect you?", "would you like to say any more about that?".

I responded to statements using the techniques mentioned above, as well as using the counselling skills of active listening and empathy in order to facilitate a more in-depth exploration of each participant's experiences. Questions in the interview schedule (Appendix D) were available for me in order to move the process along, draw out explications from participants, help to facilitate a well-rounded description of each participant's experience, and to help focus the interviews.

Although it was not anticipated that this research process would cause any undue stress on the participants, a list of counsellors' names were available if the participant felt they would like to follow-up. The interviews were tape-recorded in order to transcribe the data for analysis. I collected and analyzed all data in the study.

Following each interview I wrote down detailed notes about the interview, including information about the participant's verbal and non-verbal behaviour, the interview content, and my impressions of the interview proceedings including any personal feelings that arose for me in the interview. This information helped in contextualizing the analysis of the interviews.

Once the data were analyzed, I conducted validation interviews with 4 of the 6 participants. The summary data analysis and their own biographical information were

presented to each participant for them to examine prior to our second interview in order to confirm that the information and analysis were consistent with their experience.

During a follow-up interview, participants were asked for their feedback about the data analysis and to relate how well the themes reflected their experience. The interviews lasted an average of one hour. Participants were able to offer any additional insights during the validation interview based on the themes that emerged through data analysis.

Any feedback or comments were taken into consideration in the final analysis.

Participants were pleased with the results and felt accurately represented. Interviewees felt they could relate to most of the findings, whether from their own experiences, or the experiences of others they knew who had a history of addiction.

Data Analysis

Following my first interview my supervisor checked my interview procedure to ensure that I did not inadvertently influence the interview process. At that time she also gave feedback and suggestions about my interview style prior to subsequent interviews. I then completed the remaining data collection interviews.

Once the data collection interviews were finished and transcribed verbatim from the audio-tapes, the data were analyzed for common themes according to Colaizzi's (1978) method of data analysis. The transcript took into consideration verbal and nonverbal behaviour wherever possible (i.e., pauses, crying, laughter, tone of voice). The field notes I kept, detailing my experience of the interview, complemented the transcript information. First I read over the transcripts to "get a feel for the data" (Osborne, 1990, p. 85). I then read and re-read the transcriptions in order to become intimate with the data and seek out further insights (Smith, Jarman, & Osborn, 1999). Significant

sentences and paraphrases that pertained to the phenomenon being examined were extracted from each participant's transcript. The resultant paraphrases were then examined with the aim of formulating the meaning of the original statement. This process is not interpretation of the participant's intention so much as the illumination of the meaning or experience of the participant (Colaizzi).

Illumination of meaning was focused on extracting the "deep structures which characterize the phenomenon" (Osborne, 1990, p. 85) rather than simply performing a literal content analysis of the data. This process differs from interpretation which looks for meaning based on a preconceived theory whereas illumination seeks meaning directly from the data (Osborne). Similar formulated meaning statements were clustered into themes. The themes that emerged were then clustered and the clusters were grouped into higher-order themes. The clusters of themes were referred back to the original transcripts for validation. The purpose of this referral was to ensure the themes accurately reflected the original protocols. The resulting themes comprised the structure of the phenomenon. Clustering of themes was conducted for each participant as well as across participants to determine a shared thematic structure. Interviewing and data analysis continued until no new information or themes emerged from the data.

Trustworthiness

The rigor of the findings in a qualitative work is an indication of whether the results can be trusted - whether the phenomenon exists and whether I have measured what I have said I would measure (Marshall & Rossman, 1999). The key in trying to ensure the reliability and validity of qualitative research is not to detract from its contribution by doing so. What makes qualitative research so rich is the ability to

examine in great depth and detail the experience of individuals and through this exploration come to some agreement on the structure of the experience. That the same results may not be achieved by another researcher or with different participants does not necessarily render the work invalid (Sandelowski, 1993). Different results simply serve to deepen our understanding of the breadth of the phenomenon.

However, it remains necessary to establish criteria for evaluating the worth of qualitative research. Beck (1993) addresses the need for evaluating qualitative research on its own terms rather than trying to fit quantitative terms and ideas around qualitative methodologies. For the purposes of phenomenological inquiry, reliability, termed auditability (Beck, 1993), is measured by consistency (Beck) or dependability (Marshall & Rossman, 1999). As with reliability, the purpose of auditability is to ensure that the results can be repeated by another researcher. In order to ensure auditability in this study I audio-taped all interviews and kept detailed field notes about the interviews including contextual details about the interview situation. I also detailed my process of decision-making in determining my thematic analysis. Making my "audit trail" (Beck) explicit in these ways will help the reader and other researchers follow the path I took in obtaining my results.

The corresponding qualitative measure of internal validity is credibility which is a measure of the "truth value" (Beck, 1993) of the results of a study. This is "how vivid and faithful the description of the phenomenon is" (Beck, p. 264). The ways that credibility were addressed in this study were by including in my field notes information about my relationships with the participants and my personal feelings and reactions throughout the research process, considering and accounting for the influence of my

presence on the data collected, remaining open to the possibility of negative or conflicting themes (Colaizzi, 1978) in the data analysis, and having my supervisor review my first interview to substantiate that I was not leading the participants in the interview situation. I tried to uncover meanings from the data, given the context of the participants' comments. This hopefully led to a more accurate reflection of the participants' intentions. I also conducted validation interviews with the participants to ensure that the emergent themes accurately represented their experience (Colaizzi, 1978; Osborne, 1990).

External validity or generalizability is described in qualitative research by the term fittingness. Fittingness measures the applicability (Beck, 1993) or transferability (Marshall & Rossman, 1999) of the findings. The issue of fittingness was addressed in this study by sampling from a range of participants where possible and by trying to be true to the original data by detailing differences as well as common themes. In addition I confirmed the results with two individuals who had substance addiction histories but who did not participate in the study. These independent individuals were able to verify that the themes were a valid and accurate reflection of their experiences of the phenomenon of facilitating and impeding interactions with others throughout their healing journey from substance addiction. One individual did suggest, however, that I include in my paper a definition of the term healing journey. He was unclear on my meaning because I described in my themes both times of substance abuse or relapse and times when individuals were not abusing substances. One feeling I discussed in the role of the researcher section that I perhaps did not make explicit is my belief that the healing journey involves both progression and regression. That is to say, relapse is a part of

healing. Relapse may be a setback, but contemplating change and the continued efforts to move away from an addictive lifestyle constitute a healing journey in my eyes. When I described it as such, the interviewee said he felt it was important to state this orientation because thinking of these stumbling blocks as merely a necessary part of a healing journey is a helpful orientation for individuals struggling to overcome addiction.

The quantitative ideal of objectivity is replaced in qualitative research with the concept of confirmability (Beck, 1993). Unlike quantitative research, the qualitative approaches do not deny the existence of researcher influence but try to expose this influence in order to tease it apart from the experience of the participants. (Colaizzi, 1978). Neutrality of the researcher in qualitative research is more concerned with being true to, or accurately reflecting the phenomenon (Colaizzi), than trying to remove the researcher influence from the equation. The influence of the researcher is what allows for rich, in-depth data collection. Neutrality is achieved by staying true to the data and not imposing presuppositions and biases on the data analysis.

In order to expose the potential for researcher influence several steps were taken. To begin with, my role as the researcher was documented. This process gave me an awareness of the assumptions and biases I had that could influence the research process. This awareness allowed me to set aside my presuppositions in order to uncover accurately the participants' experiences. The process of reflection and maintaining of field notes about the interviews continued throughout the research. These reflections were then summarized in the research report so the reader could determine whether the phenomenon of interest was accurately captured from the participants' perspective. The procedures mentioned above hopefully helped reduce the contamination of data by

researcher influence. A detailed description of my procedure and data analysis was included in the report to help the reader determine neutrality.

CHAPTER FOUR

Results

Introduction

This chapter includes biographical sketches of the six individuals who participated in this study as well as the description of the five themes that emerged from analysis of their in-depth interviews. The biographical summaries provide demographic and drug and alcohol information about the participants. The themes following these biosynopses describe the participants' experiences of interactions with others that they feel have influenced their healing process from addiction in impeding or facilitative ways. Descriptions involve interactions during times of active substance abuse during relapse as well times of sobriety, given that healing journeys are not linear. The themes described will be supported by quotations from the participants that seem to capture, most accurately, the experience of participants.

Participants

The participants in this study included five men and one woman between the ages of 35 and 55 who are to some degree connected with the Alcoholics Anonymous or Narcotics Anonymous program. Three of the men have been married and two of the three are now divorced and one is estranged from his wife. These three men are also parents of children ranging in age from 7 to mid-30's. The substance abuse histories of the participants are varied, all but one involving drugs as well as alcohol.

Robert

Robert is in his late 40's, Caucasian, has never been married and has no children. He was formerly a journalist who considered himself a communist. He now works in

construction. He is from Vancouver and has lived in Vancouver and Toronto throughout his life. His years of substance abuse problems involved alcohol, crack cocaine and to a much lesser extent, marijuana. At his lowest point he moved from living in his single occupancy room in the Downtown Eastside to living in the park. Since going to detox in August, 2003, he has been through the support recovery program at Together We Can and is now living in a transition house and is involved in the Narcotics Anonymous Program. At the time of our interview Robert had been clean and sober eight months.

Phillip

Phillip is 35 years old, and divorced with two children, ages seven and eight. His father is South Asian and his mother Swedish. Originally from Vancouver Island, Phillip is now living in Vancouver. He is a logger by trade, although an accident in which he broke his back has meant that he is on disability at the moment. In addition to logging, Phillip has also been involved in drug dealing and has spent some time in prison. He has been through the Together We Can program and is living in a group home. He is involved with Alcoholics Anonymous and had been abstaining from heroin and alcohol use for seven months at the time of our interview.

Stan

Stan was born and raised in Vancouver. He is 55 years old, Caucasian, and has a wife and three children in their 20's and 30's. He was a successful businessman who hit his "bottom" as a result of crack cocaine use. Prior to his cocaine use, he had been a binge drinker and dabbled in drugs in his late teens and twenties. He is now working, living in an apartment on his own after starting his journey toward health in a recovery house. Our interview took place when Stan had been clean for almost one year.

Currently Stan's daughter is very supportive of the efforts Stan has made to address his addiction, however his wife and two boys do not want to associate with him.

Mark

Formerly a journalist, Mark makes his living as an artist. He was born and raised in Vancouver, is Caucasian, and has recently moved back to Vancouver from White Rock. Mark is 41, has never been married and has no children. Mark's primary substance of addiction has been alcohol. His drinking became a problem for him as early as his teens. He did not attend any residential treatment program as part of his healing process. At the time of our interview Mark had been sober almost five years and has been supported greatly in his journey by Alcoholics Anonymous.

George

Originally from Montreal, George now lives in Vancouver. He has been in various management positions in the restaurant industry over the years and has also been involved in organized crime. He has struggled with cocaine and alcohol addiction over the last 18 years. Our interview took place when George had been clean and sober for seven months. George is divorced with two boys (ages 17 and 21) both of whom are also in recovery. He also has a daughter from another relationship who he sees regularly. He is currently working in the alcohol and drug recovery field. George is 47 years old and Caucasian.

Elise

Elise is a 39 year old African Canadian who is originally from Montreal. She is a social worker by profession. She has a long-standing addiction to alcohol. She has been diagnosed with bipolar disorder and also has multiple sclerosis. She has not been married

and does not have any children. At the time of her interview she had been sober for seven months. She is currently on disability and living in a supportive living situation for individuals with substance addiction issues.

Identified Themes

Detailed phenomenological analysis of the in-depth interviews revealed seven themes common to all participants in the study. The themes are presented below in random order, not reflecting the importance of the theme in participants' experience:

1. A sense of isolation or loss
2. A sense of support or discouragement
3. A sense of understanding or misunderstanding
4. A sense of belonging or not belonging
5. A sense of meaning or meaninglessness
6. A sense of hope or hopelessness
7. A sense of shifting identities

Aspects of the themes overlapped with each other. Certain themes were more significant to some participants than others. However all themes were reflected in each participant's experience. The themes that emerged seem to encompass the interactions participants felt were facilitative or impeding in their healing.

A Sense of Isolation or Loss

Each of the participants in this study described interactions influential to them in facilitative or impeding ways that involved either loss or isolation during the course of their healing process. The various losses described included deaths of people that they had been close to, loss of significant relationships, and loss of interactions around status,

power or money. Other losses included loss of control, and loss of self esteem or identity. Sometimes these losses left the individuals in this study feeling isolated, but isolation was also experienced as a result of participants separating themselves from others. Loss and isolation were experienced by interviewees as negative, positive or sometimes both, in terms of their healing journeys, depending on the individuals and situations involved.

Three of the participants described the deaths of individuals that they felt motivated their choice to change their addictive lifestyle. Two of these interviewees indicated that the deaths of friends or acquaintances who were users provided a “wake up call” for them, their fear prompting them to realize that they could have been the ones who died. The deaths reinforced a feeling of “being sick and tired of being sick and tired” as well as feeling “all used up.” They described the feelings of guilt and disappointment in themselves as a result of these deaths. One participant expressed his disappointment in his behaviour after his friend died:

He dies and I uh – I kept using drugs. Like right after the ambulance came and hauled his body away – I just kept using drugs...it made me think... what am I doing? ...What kind of a human am I? I didn't even care.

Another interviewee reflected on how he felt “shocked, stunned, just going through the motions” in the face of the deaths of three people he “had been close to” and who were fellow users. His sense of despair was compounded by his frustration at his powerlessness and inaction to address the deaths of his friends. He said that the deaths of his friends “were bad deaths. This was not a good way to go. Too soon and wrong.” One individual had been murdered, one drank himself to death and the other overdosed.

However, out of his feelings of powerlessness this participant reported that he became angry, and his anger became a motivator. "Why am I accepting this? Why? How can I accept this? And I couldn't, I couldn't accept it, right? ...So something changed inside me at that point." His "passion" and "desire" to stop drinking and using drugs "led to his courage to change." He said:

This is enough. I can't take this anymore.... I had to kind of run out of gas but my heart had changed.... Somehow it was no longer fun.... I had to grind myself down. I had to run out of gas.... I got fed up. My life got smaller and smaller and smaller. So in terms of I guess that's experiencing interaction with others. They died. I didn't. I wanted to go on. I felt a deep sense of loss.

With respect to the influence he perceived the deaths to have had on his process of healing he said:

Their deaths facilitated, but while they were alive they were an impediment.... They're still in my heart. But maybe if they'd lived we wouldn't have been friends by now. Who knows.

Another type of loss experienced by all participants that appeared to influence their healing processes was loss of intimate relationships. Three participants described losing relationships with spouses and three described the break-ups of other romantic relationships they felt were instrumental in both positive and negative ways during their healing journeys.

One of the participants felt "abandoned" by his wife when he was "thrown out of the house" after she found out about his crack cocaine use.

I always thought we would be there for each other, through thick and thin, no matter what happened. But anyway it didn't happen that way. I found myself alone, with no place to go, lived in a hotel, things that just created more chaos, more addiction.

Similar painful feelings were echoed by another interviewee after losing his wife when he admitted his infidelity. "Losing her at that point in my life was just devastating. And I think there's a big part of me that still hasn't gotten over that." One participant talked about how he "just went crazy" when his wife and kids left him because of his involvement with drugs. He "didn't want to feel they were gone." He expressed his feelings of loneliness and hurt by becoming angrier. "I was angry before my wife left but it just got worse." "The only way to escape those feelings was by getting high." Another participant's fiancée left him when he was still drinking. He was desperate to hold onto the relationship and was afraid that losing her would devastate him. He described his thoughts and feelings about why his relationship with his fiancée failed:

...dealing with my problems is the most important thing in the world, right. More important than anybody else, right.... I felt like my problem was more important than the relationship. I put myself ahead of the relationship, you know. And I would rather escape from my feelings and escape from my issues rather than deal with them in a healthy way because I didn't know any better at the time, right... Losing her was like a very very tough blow for me, right. And I was like completely bewildered by it. I didn't have a clue.... Why can't I be happy? I did not have a clue what was wrong with me. Why do I feel miserable? Everybody else – other people don't seem to feel miserable. Other people don't seem to have

this longing. Other people don't seem to have to drink like I do. How come, right? I didn't know. All I knew was, I am miserable.

He believed the end of this relationship worsened his drinking problem and impeded his healing. However, after a more recent break-up with another girlfriend this participant reacted very differently. He managed to maintain his sobriety and realized that he could lose her and still survive.

The funny thing is like – she's gone, right, but sobriety is way better. This is a way better way of life. In the end I knew that it was right to let her go and I learned such an important lesson.

The loss of significant romantic relationships in the interviewees' lives, although largely impeding in the experience of participants, was also a marker of progress for another.

Individuals in this study also reported that separation from family members or friends was influential for them. These losses, particularly of family support, were perceived by the interviewees as impeding to their healing journeys. For example, following the news that his ex-girlfriend and daughter might move away from Vancouver, one participant became very discouraged. He felt "slapped in the face" by the news of their pending move when all he had been trying to do was to prove his commitment and ability to be responsible and dependable with his daughter. He described his feelings of frustration, anger and pain:

I show her [his daughter's mother] all the stuff I've been doing and now they're moving. So I look at it like – what's the message now? I might as well be a drug dealer. I was happier. Really. That's where I go.

Another participant also talked about feeling abandoned by his sons, daughter, and brother when he initially admitted his drug problem. His brother and daughter have since come back into his life but others in his family have not. This disconnected family continued to be difficult for him to accept, particularly given his perception that most addicts regain their family and friends once they're clean. He struggled to understand why this was not the case in his life:

The one thing I see, quickly happening to most people is their families come back in their life very quickly.... An addict seems to, or an alcoholic seems to make the move to get better and their families seem to rally around them. And um – it's extremely rare when that doesn't happen.

Feelings of abandonment, lost love, and longing were perceived by most participants as significant impairments to their healing. As one participant noted: "The biggest hindrance to my recovery is my feelings for my family. The fact that I basically can't...go back and see them." "That's the reason I relapsed. I crashed because I missed my family." The inability to repair their relationships with certain family members and past failings with respect to family have resulted in feelings of regret, as well as "shame and guilt" for several of the individuals in this study. As one stated: "I still punish myself for what I've done to my kids. I still feel bad about that...I mean I swore that I wouldn't do what I did."

Aside from losing family members, participants also reflected on their sense of loss at having grown away from friends they used with; although it was a necessary part of their healing. As captured in the words of one interviewee:

You grow attached to people, to a certain lifestyle and it's harder to break free....the attachments to the drug and using together. It becomes part of your routine. So that if you stop using, you pretty well lose the relationship too. He stated that fear of the emptiness from losing his friends kept him in the addictive lifestyle longer. "Several people I think just slowed me down."

Another aspect of loss mentioned expressly by five participants was the loss of interactions based on their social or economic position. These individuals perceived a sense of failure as a result of their loss of status and success, power and control, as well as their loss money. These losses dealt hindering blows in most cases. Five of the participants talked about losses of relationships, possessions, careers and money. Some individuals lost their businesses, their homes, and their vehicles. Along with the loss of material items, it was the interactions involved in their previous lifestyles that three of the participants mourned. As one participant explained: "I really miss the limelight...best years of my life. And that's what I miss...I miss the wheeling and dealing, the setting up deals, the setting up people." This interviewee and others referred repeatedly to the loss of their reputations and the respect they held in the eyes of others. The impeding nature of these losses was expressed by participants in their reluctance to accept their new way of life without alcohol or drugs.

Some of the participants talked about having moved from being respected in their previous lives to starting from scratch, building an identity for themselves in an unfamiliar world. This change in status reportedly has meant a change in the interactions in which these individuals engage. One individual described it this way: "it's not fun being an alcoholic or a drug addict. 'Cuz all of a sudden you're an outcast – not an

outcast – yeah an outcast. You know you're put on a different level, you know." They reflected on how their feelings of authority have been replaced by feelings of inadequacy through their drug use and the reactions of others to their addiction. Beginning again has been difficult for some of the participants. Most reported a deep sense of failure and loss at their inability to hold onto their previous lifestyles.

Included in the loss of lifestyle of interviewees was a sense of loss of control and power in their interactions. One individual described himself as "controlling and addicted to power...and money and drugs." Another participant described his loss of control: "control of other people, control of myself, control of my addiction." Some interviewees described feelings of anger because of the changes in power and control in their lives. They believed the interactions they experienced have changed from ones reinforcing their power or authority to those highlighting their lack of status and prestige. Many reported feeling the change in status and the perceptions and judgments of others have led them to behave differently in their interpersonal interactions because of their sense of shame and guilt. As well, from being autonomous in their decision-making, some participants expressed difficulty in reconciling that aspects of their lives and decisions are now subject to others' authority. On a more accepting note, one individual said "most of my life I have run my affairs pretty well. I can't do that anymore. I've got a brother who helps me with my finances. If he wasn't there to help me I'd screw up." On the whole, the loss of interactions around status, control and power were largely hindering for participants in their healing journeys. Interviewees described the difficulties they had adjusting to their new lifestyle and their reluctance to do so.

A final aspect of the experience of loss and social isolation was the awareness on the part of participants that in many cases these losses were self-induced by their withdrawal of attention, affection and caring for others, or by their choice to continue on the socially unacceptable and destructive path of addiction. On several occasions participants described addiction as "a selfish disease" that led them to isolate themselves from others. Isolation was perceived as impeding and the interactions involved expressly avoiding contact with other people, pushing others away and responding negatively to others' attempts to engage them. One interviewee was very aware that he was "not attracting anyone by being in the mode" he was in. "I'm not a happy camper." People were not responding to his pleas for help and he felt like he was "being neglected." As a result of his frustrations he was "gonna scare everyone away." He was ready to "really raise holy hell" or "just play silent" to unsettle people and worry them. "Either I'm gonna snap, or I'm gonna get drunk."

Other cases of isolation involved four of the participants who described times when they actively tried to resist acceptance by individuals in the AA movement. Some talked about being "put off by the spiritual language." Others were afraid of feeling like they would be walking "naked" if they revealed themselves. Although they had a desire "to be healthy" they did not want "to accept that pathway." These interviewees attended AA meetings, but said they still felt they were "dealing with it alone." One participant described trying to get well on his own in the following words: "It was like dragging a sled over gravel. It was horrible. Who the heck would want to be sober? This sucks."

A sense of isolation was also experienced by one of the men who described feeling "afraid of women" and being "afraid of any relationship, especially with

women...People scared me and in order to overcome that, I became something I wasn't...brash, loudmouth and pushy." Another participant sought escape. He said he would "rather escape from my feelings and escape from my issues rather than deal with them in a healthy way because I didn't know any better at the time." Two of the interviewees imposed isolation on themselves by choosing to use their substance in the privacy of their homes. One participant described alcoholism as "a very lonely disease" that he did a lot on his own: "just alone with my twisted thoughts and not really anything I wanted to go out in public and do." Another talked about how she isolated herself in her home playing Scrabble on her computer. She also spent a lot of time sleeping. She described the isolated world she created for herself:

It was a very dark – when I think – it was a very dark place to be. And a very lonely place to be. Like it got so bad that I just had my phone disconnected. I didn't want to talk to people....Just totally total isolation. And when I had my phone hooked up I had it turned off. You know – didn't return calls. You know what I mean? I was just existing to exist.

Participants felt that isolating from others impeded their healing.

To summarize, individuals in this study experienced various personal losses as well as a sense of isolation that played an important role in either facilitating or impeding their progress toward a healthier lifestyle. Sometimes these losses, although they appeared negative, such as the death of friends, provided the necessary wake up call in order for participants to cease their using behaviour. On the other hand, losing relationships with a spouse, partner, children and family members, or losing prestige and status in business and social life was experienced as setting individuals back in their

progress. Isolation appeared to exist for participants in this study as a result of them either pushing people away or feeling and fostering a sense of separateness and choosing not to connect with others around them. Whether self or other imposed, the isolation was perceived by the individuals in this study as hindering their progress toward a healthier lifestyle.

A Sense of Support or Discouragement

Several factors were described as important in the interactions of the theme of a sense of support or a sense of discouragement. Both the specific individuals involved in these interactions as well as the positive or negative experience of the interactions were described as important by participants in this theme. Also, asking for help surfaced as important in receiving the support interviewees needed. The individuals who were mentioned frequently in interactions by participants that affected them in terms of acknowledgement, support, or discouragement were other individuals with addiction issues, as well as friends, family members and the god of their understanding. In addition, influential health and addictions professionals appeared to fall into two categories in the experience of the individuals interviewed: those interactions where professionals' personal addiction histories were relevant to participants and those interactions where the professionals' addiction histories were not felt to be significant to the interaction. Other individuals of perceived influence in the lives of participants were those from their previous lifestyle, characterized by substance abuse, who participants believed at the time to be supportive but who actually kept the participants in their destructive lifestyles.

Particularly facilitative to the individuals in this study were their supportive interactions with others who shared a history of addiction. Individuals with a personal history of addiction had immediate credibility with the participants because of their common experience. Within this category, three participants described important, positive relationships with their sponsors. One individual described his sponsor as "mentor," "guide," "tutor," "coach," and "teacher." He felt his sponsor was supportive in terms of giving his "time" as well as being "demanding" of him. He described his sponsor as "critical," "respectful," "trusting" and "honest." This participant described feelings of trust toward his sponsor and a sense of "fellowship" and "solidarity" with him in a relationship that he felt was continually growing. Two interviewees mentioned the individuals at AA who were warm and welcoming and helped to provide them with a sense of connection and community. A simple, yet important aspect of the support from individuals in AA was expressed by one participant in the following way: "basically they've just been nice to me." Another participant noted on his third try at AA it was important for him to know he "would be accepted." One participant mentioned that he went to a meeting everyday just "to have that interaction with people." He said the interaction itself was an important support mechanism in his life. He also went on to say, "you can't do it alone....There has to be interaction with a human being." One participant described his step group, a small group of AA members who meet to work through the twelve steps and traditions, as an important source of support for him because it was a safe place of "honesty" and "empathy" where they "struggled together over some things that were difficult." The similar experiences of group members allowed them to

relate to and support each other. This interviewee also talked about how “important and quite valuable” it was to belong to a group where he felt free to disagree with others.

One aspect of the support from individuals in AA that seemed to be particularly meaningful to participants in their healing journey was that “nobody ever tells you what to do.” One interviewee asked someone from AA whether he thought the interviewee was an alcoholic. The individual replied “only you can say if you’re an alcoholic.” His response made the participant feel “that recovery could be safe” because no one was going to make him do anything he did not want to do. This interviewee felt that by not inflicting opinions and advice on someone it “encourages the person to take ownership....’Cuz if somebody tells you what to do, it’s not like you’re owning the solution.”

The significance of trust in facilitating healing for participants was apparent in interactions with people who shared a history of addiction. People in AA were described by some participants as people who were “doing it. They have no motive to lie.” One interviewee described his feelings about his roommate in the recovery house where he lived when he first stopped using drugs. He “was very supportive, very wise because he had been there for two months and straightened himself out.” Another way individuals were perceived to provide support for the participants in the study was through sharing their stories and giving out information about resources for people with addictions.

Participants felt supported when provided with a safe, trusting place to share experiences and stories at meetings. “Mostly we talk more about these underlying feelings connected with the hopelessness before and the feelings of, now.” After one interviewee described his misdeeds to an individual in the program, the individual

showed support by listening to him and making him feel “accepted” and “loved.” When talking about his sponsors, another participant mentioned his sense that they were “genuine,” they did “care” and they had “faith” in him. He said he did not require anything more than listening from his sponsors at times: “They don’t need to tell me what to do, just by sharing, by talking about it, it feels better.” The support garnered from individuals in AA was instrumental in facilitating the healing process for participants in this study.

Other individuals who seemed to play a largely facilitative role in providing acknowledgement and support for participants in this study were addictions and health professionals, particularly those with their own addiction histories. The experience of addiction on the part of addictions and health professionals appeared to help in establishing a bond of trust and credibility with participants. Two of the individuals in this study expressly mentioned that it was important for them that the addictions professionals they dealt with had their own history with addiction. For one participant, knowing his counsellor was “in the program” gave him the trust to express his “fear about counsellors and shrinks.” His fears included “that you would have me committed if I told you what I really think and stuff. And the second one, that you’re gonna, sort of, you know, keep me sick, so that you can bill me.” This counsellor reassured him by saying “these sessions...will only continue as long as you feel you’re getting something out of them.” The discussion reportedly put the participant “at ease” because he felt he was “in charge” of the process. The trust established by virtue of the counsellor being in Alcoholics Anonymous allowed the participant to be vulnerable and honestly confront his fears.

However, for other individuals in this study, the addiction history of the health and addictions professionals assisting them did not seem to hold importance. It appeared to be the nature of the exchange that was significant for these individuals. Several times participants mentioned interactions where professionals had gone the extra mile for them and how meaningful that was for them. Some examples of this from one participant included a doctor who has always treated him "very decently, very respectfully," a welfare worker who "jumped through hoops" to make sure he received the financial assistance he needed, and a support recovery house that provided "safe" living conditions including "heat, light, phone. I didn't have to work. In fact I wasn't allowed to work. So you just have to concentrate on your health" Additionally, the individuals in his dental clinic were "welcoming" and went out of their way to help him restore his "self-esteem" and "health." Professionals demonstrated to the participants good will, and gave freely of their time and space to attend to participants' health.

Although being told what to do was not seen as helpful by most interviewees, education apparently was an important part of the role of some health professionals in facilitating the healing of individuals in this study. One participant described his expectations of an effective counsellor:

A skilled counsellor won't tell you what to do. They sort of ask questions...to draw it out of you so that you can kind of discover it for yourself....Then you can kind of own it....And it's not like a foreign substance in your body.... It makes sense because you kind of helped create it.

It seemed from the interviews that education in the area of a professional's expertise was welcomed by most participants. For example, one participant who had been struggling

with family of origin issues found the knowledge gained from a counsellor “helpful” to him about this matter. “The fact he was a professional gave his word some weight.” The interactions this individual found helpful included helping him “understand the issues” involved in his family situation and his part in their problems. The counsellor “guided” him and “explained” to the participant. The counsellor “didn’t give advice” and he “helped...establish boundaries” and helped him “get insight” into the issues. Another interviewee talked about her experience of her doctor who was clear and straightforward with information about the steps she needed to take in her healing process. “My big plan was – I’m gonna get my stuff. Get an apartment. Get my stuff out of storage. And my doctor said ‘well no. That’s not part of the plan....If you want disability,’ he said, ‘this is what you have to do. And if you choose not to, that’s your choice.’” Her doctor also told her she needed to “be in recovery” and stay in a support recovery facility “for at least a year.” At Vancouver General Hospital the staff were also very clear about her situation. “They’re the ones who told me you’re an alcoholic and...this is what we’re doing.” Another doctor gained one participant’s trust because he was a “well respected and learned professional.” Additionally he had credibility because “he was an MD. He knew about brain chemistry.”

Participants described supportive reactions on the part of addictions and health professionals that stood out as facilitative in their healing journeys. One interviewee returned to his recovery house after a relapse and staff there were supportive. Their support helped him to get back on track. Another individual who asked to stay longer at his recovery house after his allotted time, was given permission to stay longer. A social worker in detox listened to one participant, and using his expertise and experience, was

able to make suggestions to him for a course of action to help him navigate his first steps without substances. He showed a belief in the participant as well as support of him through his actions. For another interviewee, being given time and space in a safe place and feeling listened to by her social worker was very important. She described her experience in the following way:

They saw me right away. Surprisingly....I had a wonderful worker. And I just sat there and cried and cried. I said 'what am I going to ...do? Like I'm homeless. I have no apartment. I have nowhere to go.' And uh I was there from 11:30 in the morning. I left there at four o'clock in the afternoon.

This participant also discussed the support and availability of the staff in the recovery house where she lived: "The staff are over the top....You can just talk to them. Anytime. They have an open door policy....It's just so nice that they have this open door policy." In one conversation with the director of the facility where she lived, she told him she would be living there a long time because her "needs were being met." The same interviewee praised a staff member at Vancouver General Hospital: "She's just the neatest woman. I gotta call her and tell her where I am at. Cuz I mean, they, VGH saved my life." The participant also described this staff member in the following way: "she's a wonderful woman." "She was very inspirational." Even though this woman was a hospital administrator, this interviewee appreciated the genuine concern and time she took with patients.

The emotions experienced by individuals in this study in their relationships with health and addictions professionals were key to determining whether interactions were perceived as facilitative. Participants described the importance of feeling comfortable

with the professionals in question, as well as trusting them. This trust was experienced by interviewees when the professionals listened to them, put in effort with them, showed faith in them and supported them.

Interactions with friends and family were expressed as significant to participants in their healing journey in both facilitative and impeding ways. Participants experienced support in terms of others' acknowledgement of their experience, listening with an openness and lack of judgment, sympathy to their situation, and a show of faith in them. For three individuals in this study support was garnered from their families. One participant felt a sense of acknowledgement when his sons came to him, to help *them* with their drug problems. He was "amazed" that they asked for his help and was pleased he "was in a position to help them." For another, his family was divided. He described his family situation in this way: "My family's now split in two. Those that remain angry and those that understand and support me." This participant felt supported not only by the family members who learned about addiction but also from their desire to help him on his path. "They have been able to support me – not just voluntarily – but be there. Want to be there. Make me think that they want to be there. Know that they want to be a part of my life." For another interviewee, acknowledgement of both his current health and of past experiences by his grandmother was particularly meaningful for him. He described a visit to his grandmother in hospital:

Me and my girlfriend...we went to visit her....She started cryin'. She says 'I'm so happy that you're doing so well,' she said. 'I remember when you were six years old and your Dad smashing your ... head off the ...cement'.

Having someone important to him admit to witnessing the violence he experienced and acknowledge his progress helped to keep him on track in his healing journey.

Friends, sponsors and partners, as well as complete strangers, provided support and acknowledgement for participants that they felt facilitated their healing. One participant mentioned the acknowledgement by his girlfriend of how well he was doing both in ceasing his addictive behaviours and taking responsibility in his life. He felt as though he had really accomplished something because she had given him her encouragement. As he noted: "She's very proud of where I'm at right now." When times were tough for another interviewee she said, "the only thing that was holding me together was my visits with my friend." Now that things have improved in her life she continues to find support among her friends and her sponsor. Support has sometimes meant being challenged on her behaviour by her friends.

A number of participants mentioned finding it difficult to build trust in relationships and suggested trust is not easily regained after a breach. One interviewee said he found it easier to talk with strangers about his experience at times. After one such conversation he received the encouragement he needed. The stranger told him, "You're a powerful, loving, caring individual....Go after what your heart's telling you to do." This message helped him to stay on his path and refrain from drug use. The encouragement from friends, family, professionals as well as strangers was expressed as helpful in keeping participants on their path toward health.

Four of the participants cited spiritual support as an important facilitative factor in their healing journeys. One individual described his spiritual connection as a belief that "something greater than" himself was helping him. The spiritual relationship these

individuals described emerged largely from the AA movement. In explaining his rationale for being open to a higher power, one participant described how the individuals in AA had framed the idea:

All your best thinking got you here, right. So don't you think it's time you thought about something...some other solution other that you can come up with....So that kind of opens the door a little bit that something other than me is gonna help me.

This same individual described his feelings of trust towards his higher power:

I pray to my higher power, my God, which, I don't know what it is, but I believe in it. I believe that it cares about me and can help me whenever I ask. If I trust, right. And I believe that you know it won't give me what I always want. But I do believe it will give me what I need....It's like a partnership, a team. I'm doing my part, I need God's help.

When talking about his belief in God he said, "I believe it, right. And I believe it because I've felt it....It's like the most ephemeral thing has become the most powerful thing." He also explained that his experience of God came in many guises:

We say God is so many things. I mean I believe in some divine being that I pray to, right. But also, you know, Group Of Drunks. G – O – D. Sitting in a meeting - these people they're sharing their truth and their caring – for their benefit and for my benefit. That's kind of like God in a way. There's love there, right.

Asking God for help was instrumental in the healing process of two participants in particular. As one interviewee articulated, asking God for help "basically reinforces that

I can't do it by myself." He continued, "I need faith. Without me reaching out to God, He's not gonna help me."

Three participants described interactions with others that felt supportive at the time but they now realize these interactions actually impeded their healing journeys. One participant felt a strong sense of loyalty to members of a bike gang to which he belonged. They had been a solid source of support and security throughout the many years was involved with them. They were there for him no matter what. He said, "any given time that I want to be involved in any illegal crime, whether it be drug dealing – drug dealing I would say put at the top of the list that I can get involved any time." That sense of connection was very important to him and provided a strong pull back to that life at times.

For another participant, his connections to people from Main and Hastings were a negative influence on him. "My relations with them certainly impeded, they harmed me." This community of friends provided the illusion of support. "It seems that it can support you and the outside – outside that warm circle – can seem so scary. 'I can't leave my friends behind.' You can think that. But I tell you, you get desperate enough to." Another participant spoke of his peer group supporting his habit. They supported his feeling that, "I really need this stuff. I like it and I need it and I want it...to feel okay inside." The emotional interactions described depicted situations that were hindering for participants in their healing journey.

The lack of support described by individuals in this study did not appear to simply reflect abandonment. The other end of the spectrum from support, characterized by discouragement on the part of participants, seemed to be related to feeling undermined,

judged, not trusted, betrayed, abused, as well as simply the absence of acknowledgement and support. All of the participants described some form of discouraging interactions throughout their healing journey. One participant described not feeling “appreciated” or “trusted” by certain people in his life. He also described feeling “neglected” and “degraded” although he was “crying out for help.” “Not getting much support” left him feeling frustrated, hurt and as though “they don’t care.” His sense of betrayal and broken trust reportedly made him feel like giving up on his progress. “I’d rather be a drug dealer.”

Another participant described feeling betrayed by coworkers who had been “concerned” about him and “coerced” him into going to AA meetings. He took AA on as a “discipline” but was not really interested at that time. He found a lot to get “annoyed at.” This same individual mentioned “frustrating times” living in a recovery house with “annoying idiots” who “get on your nerves.” He was able to describe them as “challenges” and realized that he, “had to learn how to cope with annoying people.”

Lack of family support was especially difficult for one participant. He said his wife, “stopped supporting him or having anything to do with him.” When they were together he described his experience of verbal abuse that reinforced his feelings that he belonged in a crack house. Of his family he said, “they don’t want me in their lives. They don’t want any trace of me in their lives.” He described that the reason for his relapse was missing his family. “The biggest hindrance to my recovery is my feelings for my family. The fact that I basically can’t...go back and see them.” Another individual described her painful experience in one support recovery facility: “I’ve watched them tear people down but they’re not putting people back together again.” As a result, she

reported feeling unsafe in this environment. "I felt I had nothing – I had no control over anything in my life there." This participant felt the staff at this facility were not approachable either. She described her experience of talking with the program director at this recovery house: "You know when you'd speak to him...you'd sit in his office and you'd speak to him and then he'd start wiggling his keys. It's like 'I'm done'." This professional's nonverbal behaviour was experienced as "demeaning" and "unprofessional" by this participant. Interviewees described a lack of support from various individuals in their lives as a hindrance in their pathway toward health.

In conclusion, interactions that participants perceived as supportive and facilitative in their healing journeys included feeling as though others had faith in them, feeling welcomed, and being treated with kindness by others. Participants described the importance of individuals giving their time and providing a safe space to explore their newfound sobriety. Teaching, information sharing, and going the extra mile were also mentioned as instrumental in aiding the healing process of participants. The shared past experience of addiction provided an immediate connection with others and established other people's credibility with the individuals in this study. This connection allowed participants to freely give those individuals their trust. Hindering interactions for interviewees involved not only a lack of support but open rejection, disrespect or betrayal on the part of others. Individuals in this study described the importance of feeling they were setting the pace of their healing journeys. They learned rather than being taught. They asked for and accepted help. Interviewees acknowledged and stressed that supportive interactions with healthy individuals were essential to the process of healing. In the words of one participant, "you can't do it alone."

A Sense of Understanding or Misunderstanding

Another set of interactions that were influential in both positive and negative ways for participants were those involving feelings of understanding or misunderstanding. Interactions described by individuals in this study often involved situations where they felt either understood or misunderstood by others. Participants felt that others who did not understand their drug or alcohol abuse had not made the time or effort to acquire the appropriate knowledge. Health professionals were sometimes regarded as having academic knowledge but not experiential knowledge of addiction, furthering participants' feelings of being misunderstood and impeding their healing. Interactions with others also seemed to expose the lack of understanding participants had of themselves and others with addictions.

Individuals in this study reported that they felt their circumstances and feelings were best understood by individuals who also had a history of addiction. In a similar vein, now that they had some knowledge of their own addiction problems, interviewees felt that they could better understand the situation of other individuals with addictions. Interactions that participants perceived as helping them understand addiction as well as those where they felt understood were described as facilitative in their healing. Interactions where participants felt misunderstood or where they lacked understanding of themselves or other addicts were perceived by participants as impeding their healing journeys.

Three participants referred to interactions where they felt misunderstood by others. The interactions involved family, colleagues from work, and health professionals. One interviewee described feeling misunderstood at work. He said this particular feeling

made him want to “go and get drunk.” He felt he’d “had enough” hassles in his work and personal life. Another individual felt his wife had “not been very helpful at all” because she “didn’t want to understand what was going on” and chose to see his behaviour as “wrong.” He commented on their relationship: “The only way my wife and I will ever be together in the same room again is if she starts to understand.” Two out of three of this participant’s children were not speaking to him. He felt that “they didn’t understand. That’s the difference between – understanding the sickness or thinking someone is an evil person. I can’t convince people I’m not an evil person. I can just try to change.” He described the steps some of his family took in order to understand him:

Those that understand and want to support me are the ones that took the time to get the knowledge, to get the understanding, to read the books, to talk to experts.

To find out what was wrong with me.

Lack of understanding on the part of some family members was experienced as impeding for this participant whereas he felt the attempts made by others to understand his situation facilitated his healing journey.

Individuals in this study felt that health professionals did not always understand their situation. For example, one participant mistrusted his psychiatrist’s motives: “there was always this little itty bitty thought in the back of my mind that I bet he’d just love to have me coming back for many, many, many sessions so that he can make more money.” This individual described his concerns about his psychiatrist’s understanding of addiction: “I sort of felt like you’ve got that degree on your wall, right, and you’ve probably read a lot of books and stuff but what do you really know about it from...personal experience.” This concern about health professionals was echoed by

another participant: "With all due respect to academics et cetera, they don't necessarily understand anything. You have to walk with it, be involved with it, meet people in it to begin to understand." These feelings of misunderstanding were experienced as impeding participants in their healing journeys.

Some interactions described by participants highlighted their lack of self-understanding that kept them isolated and stuck in their addictive patterns. As one participant noted:

Up until the time I went into recovery which was I guess a year ago I felt isolated and I felt I had an evilness inside me and I didn't know what I was going to do about it. My thoughts were bizarre, weird – centered on self-gratification, self-centered et cetera. I know today that I'm not that way. I can accept it. I would walk into a room and I would think everybody was looking at me. I can walk into a room now and people accept me for who I am.

Another participant tried to understand and come to terms with some of his past actions. He described himself as "twisted" and "antisocial." When he was young he said he just wanted to be "normal. Just live a normal, mediocre life." His fear motivated him to ask a psychiatrist if he "was a head case." He expressed his fear of others knowing his thoughts. About AA meetings he said, "I never share there. I never say a word. Never. I haven't once." He said that the idea of sharing "makes me feel like probably I'd be naked." Another participant admitted his fear of exposing his thoughts to others. He only saw his psychiatrist once because he was "terrified that if I really talked about my real feelings that I would get locked up." Interactions with others highlighted

interviewees' fears. The fear of exposing their thoughts and feelings to others was experienced as impeding participants' healing journeys.

Interactions with others also emphasized some preconceived notions participants had about individuals with addictions. One interviewee felt he needed to separate himself mentally from the people in his transition house. He described them as "a bunch of losers." He made it clear that he paid his own rent; the government did not. He also gave an indication that he did not want to identify with other addicts. He described the individuals he met in various recovery settings as "freaks," "losers" and "skids." In his refusal to make connections with individuals in the AA program, he described feeling pulled between his old world and the new one of healing. The preconceived notions held by participants were experienced as hindering their healing process.

As a result of changing their lifestyles and educating themselves about addiction, a number of participants' feelings toward other addicts shifted. One participant commented on how the rewards of visiting with addicts in detox benefitted his understanding of addiction:

We all understand what we're going through. Back in the old days I used to think those people were just degenerates, bad, bad human beings. You know, if they'd just clean up their act, get a job, they'd be okay. I didn't have the understanding. That's the way I understood them....The biggest road block to me to the whole process is that understanding. Understanding why that uh that drunk is falling down in the gutter, why that girl is standing on that street corner selling her body. Um – it's not because they're bad people. It's because they're sick people. I feel if I could get my – if I could – if my wife and two kids would understand that,

they would probably not have the desire to have me out of their life. They'd want to have me back in their life.

Of meeting up with addicts from his past, this individual noted:

I've met some people...who've stolen from me...and ripped me off. But I have no animosity. If I saw them on the street tomorrow, I'd give them a hug. Because I know what they're going through is is – is pain.

As participants began to understand other individuals with addictions, so did they come to feel understood. Often these interactions involved individuals in the AA program or individuals with addictions. One interviewee made clear the importance of the addiction history of individuals he dealt with:

The people in the recovery house had a huge effect on me. They're all former addicts or alcoholics. I couldn't – when I spoke about my problem with drugs - I can't deal with people who haven't used drugs. Well – not that I can't deal with them – they don't understand.

Another participant also endorsed this idea by describing individuals from AA: “these people understand that it's okay to have suicidal thoughts and that it's okay - some of the crazy shit we've done while we were, you know, intoxicated.”

Two interviewees discussed the importance of the understanding they received from their sponsors. One individual commented about his sponsors:

I have faith in them. It's like faith, you know. I just know it. I know that I could uh – you know I could talk to them about stuff that I could not talk to, for example, my brother or my mother, you know, or my friends that I've known since grade two. Because those people are, you know, not alcoholic. Right, like

they don't have the same emotional, mental wiring that I do, right. But my two alcoholic friends do.

One participant's employer was also in the program. He felt an acceptance and understanding from him. He said, "We can talk about the program. Instantly....So – if I have any difficulties at all, as long as you put it on a spiritual level, I can ask him for help. He knows exactly what asking for help is." His felt his step group also understood his situation. He commented that the individuals in his step group were in a position to say to him, "yeah, I've been there. Yeah, I understand." Interactions that highlighted participants' growth in understanding of self and others were experienced as facilitative in their healing journeys.

A negative side of understanding came from interactions where users supported each other. One participant described that his girlfriend was sensitive to his situation while he was using drugs. He commented: "I felt that she understood me. She was a fellow-addict. We used together." Another interviewee reflected on the nature of interactions between users:

They could even seem – in a momentary way – helpful. You're in a jam, you need a job or a place to stay or you want to borrow some money or something like that, then people will – there is a sense of community there. They can be helpful in a short term kind of way.

Understanding that originated in relationships among users was experienced by participants as impeding their healing journey although they felt helpful at the time.

In conclusion, individuals in this study felt that interactions involving understanding or misunderstanding were influential to them in their healing journeys.

Participants felt that interactions where they were understood by others who were not addicts were facilitating in their healing. As well, when they understood themselves and other addicts these interactions were perceived as facilitative of healing. However, interactions involving misunderstanding were experienced as impeding of health as were those understanding interactions that involved other users.

A Sense of Belonging or Not Belonging

Another theme that was significant for individuals in this study was that of belonging or not belonging. Sharing their stories and lives in a supportive context with other addicts or within AA gave interviewees the sense, sometimes for the first time in their lives, of belonging to a group. Some participants had previously felt a sense of belonging and connection with other users or among drug dealers. Others felt trapped between their upstanding life and their life of drugs and alcohol. Interviewees reported that feeling a sense of belonging among individuals they felt were healthy influences was helpful to them on their path of healing from addiction. Alternately, participants expressed that feelings of exclusion or belonging in circles involving drugs or alcohol use were impeding in their healing journeys.

One participant expressed his feelings of pain and anger after his friend died and his wife left him. He did not believe he had anyone to confide in about his problems or his feelings because the individuals he was surrounded by were other drug dealers. He noted:

You don't go pour your heart out to these drug dealers and criminals, right....So it just – you just bury it and bury it and bury it and cover, cover, cover, cover, right.

So the only way to escape those feelings is by getting high.

This participant also excluded himself from the category of recovering addicts. He described his sentiments about them:

Those people are perfect strangers. I can't – the only thing that I have in common with them is that I used to use drugs. And that's the only thing. Other than that – maybe I'd get somebody to sell them drugs. I would never associate with them.

Another interviewee chose to classify himself according to his addiction status. He separated himself from “normys” or ‘normal’ people who did not struggle with addiction issues. As he stated:

I put myself in a different class because of the alcoholism and drug addiction – some people look at it as they're blessed because they've got this problem. This disease. I don't look at it that way. I'm not too proud of being an alcoholic or drug addict. I would have rather lived my life as a normy.

When one participant felt his drinking and drug use was getting out of control he was reluctant to talk to anyone about it. He was concerned with how his friends or brothers would respond. He wanted to maintain an outward appearance of being “able to go with the flow.” At the time he felt “it would be uncool to not be able to handle it, right.” One interviewee reported enduring verbal abuse from his spouse in order to continue his connection with her. He described his feelings:

I missed her so much I wouldn't mind being called an asshole, a loser and an asshole by her right now because that would be better than not having her around. That's the sort of craziness...that's the addiction – that you would accept the abuse because it's better than nothing.

Interviewees described avoiding interactions where they could discuss their pain and concerns. As well, they recounted interactions involving staying in unhealthy relationships for fear of being alone. The resulting experience by participants of not belonging or belonging to a group where the influence was negative, reportedly had a impeding effect on their healing.

Participants described their life with drugs as a place where they felt they belonged, even though it impeded their healing journeys. One participant noted the pull he felt to the world of drugs: "I always felt some affinity for that world. I felt I belonged." Driving to and from work he would drive by Main and Hastings. Of this he said, "I always felt that some day I'd end up there and I did. I don't know why. Maybe – I thought that's where I belonged." Another interviewee described similar feelings about his history as a drug dealer:

It's who I am....That's who I was. How do you change that? I'm 47 years old. Been dealing drugs all my life. I've always been in a management, controlled situation. Now you're saying I have to give it all up. For what?

Although maintaining unhealthy marital interactions and interactions with individuals in the drug culture helped participants maintain a feeling of belonging, they realize now that these interactions hindered them on their pathway out of addiction.

The sense of belonging stemming from relationships with other users and their substance of choice also involved impeding interactions for participants in this study. One participant described the draw of other addicts for him: "certainly people you use with, the people you drink with end up being an impediment. Because you get attached to them. It becomes your community." He further described this illusion of belonging

and community in the following way: “when you drink – you go to the same bars and you have the same pals and you get into this routine. It seems to support you.” Another interviewee talked about addiction allowing a person to push certain boundaries. As he noted, “you end up doing things and being involved with people you would not be involved with” if addiction was not part of the equation. In describing his girlfriend, he reported that their connection was largely based on using together. She was from a “totally different socio-economic background.” This same participant remarked that he needed to separate himself from his girlfriend when she started using drugs again. However, he said to some extent he felt he belonged in that world. “Part of my brain says do it, do it, do it you’ve got to go back there. You’re a loser...you’re a loser, she’s a loser.”

Although some participants felt they belonged in the drug world, a number of them also expressed a sense of never quite feeling as though they fit into that world. At one point on his healing journey, one participant questioned his alternatives. He was thinking “Is that it? Is that my option, hopeless addict or Jesus freak? Was I condemned to this?” This same individual commented on his sense of not belonging:

I think at the heart of drug addiction is some kind of dislocation with life, some fear and loneliness at the heart. And it’s difficult to get along with other people, to fit in with the world and feel good about yourself....The addiction is answering that underlying problem.

A “feature of all addicts” he continued, was that:

They all have that problem – of needing love, needing to love and to be loveable and they don’t get it. They don’t think they’re getting it and they think drugs will

be the solution. Makes them feel good. You take drugs or you drink because it makes you feel good. A day later you can't stop.

Three individuals in this study discussed feeling as though they were living two lives, the upstanding citizen and the drug addict or dealer, yet not really belonging completely to either world. One interviewee felt his double life was discovered when he was "coerced into going to meetings" by colleagues at work. He felt he needed to "clean up" his act. The double life for another participant involved having a job where he "did all the right things," but he also dealt drugs on the side.

Still another individual described the double life he was living. At age 25 he was married, had three children, a mortgage as well as a "wonderful career." He sat on the "board of directors for a couple foundations" and was the "president of the hockey association." He even "walked away from drugs and alcohol when he first got married." However the alcohol crept back in to his life and then he started using crack. He described his feelings about doing crack:

It was just like going to a place I shouldn't have been at and I knew it...I shouldn't have been there. But it was the place I figured I belonged....I was comfortable there. I was comfortable smoking crack with other crack addicts. I was very, very comfortable sitting in a crack house with a bunch of other crack addicts. Rats running around. Needles on the floor. I had no qualms about that and I thought this was the place that I belonged. I felt that's where I should be.

He expressed the attraction the drug world had to him: "I'd drive by Main and Hastings and it's not a pretty sight at the best of times it's not a pretty sight....But I still have the feeling there's a party going on and I wasn't invited." Although this participant kept up

the appearance of the upstanding businessman, he was uncomfortable in that role and felt he was more suited to the drug world. At the height of his career, he was required to go to many receptions and parties where he said he, "always felt uncomfortable, always drunk, always at the bar, always fearful." Now he acted out his sense of belonging to the world of addiction in a more positive way. He explained, "I go to a detox centre and I know that in that room are drug addicts, thieves, possibly a murderer or two but I feel very safe." He said he now feels like he is "part of something – bigger than me." The unfulfilling interactions involved in belonging to the drug world or feeling trapped between a life of substance abuse and 'normalcy' were experienced by participants as impeding on their journeys toward health. However, the involvement in rehabilitation of addicts gave one interviewee a constructive sense of belonging that he felt facilitated his healing.

Five participants described interactions involving other former alcoholics and addicts, family members, and friends that fostered their sense of belonging and facilitated their healing. Former addicts and alcoholics were described by one participant in the following way: "We're all the same. Sort of like you go into a club....I never belonged up to then. A sense of belonging." He elaborated on what gave him this sense of inclusion: "We have something in common. The thing we had in common was not necessarily our drug and alcohol abuse....It was the feelings that made us use drugs and alcohol....Isolation, fear, loneliness." Another interviewee indicated he was willing to invest more in his family in order to maintain his sense of belonging. He said, "That's family. That's blood. It's a little bit thicker than water." Living in a house where she felt at ease instilled a sense of belonging for still another participant. She described the

recovery house where she was living as being “a place I call home....I feel very comfortable there.” She talked about her roommate: “She rocks. Like we sit up to one, one thirty just laughing. You know. And just talking. And gelling. You know, it’s so nice. That’s what recovery should be about.” She also reported being very happy with the other people living in the recovery house:

Like at ten o’clock at night during the week we have snack. That’s where – you can just sit down and just talk with people. Like it’s so nice, you know. Uh – mealtimes. Is a time to talk with people, you know. It’s, it’s a great group. It’s a really nice group.

She described the staff where she lives as very open and supportive so that she feels her “needs are being met.” She contrasted this experience with her encounters at the previous facility where she lived. She described the staff there as very “unapproachable” and “demeaning” toward her. This participant’s newfound stability allowed her to appreciate and take part more fully in life. She enjoyed “socializing” with her sponsor and friends. She has played “tourist” with her friends. She was “reconnecting” with other people in her life and meeting new people.

The acceptance and common experience of addiction among individuals in AA has provided a sense of belonging for several participants. When one interviewee first went to AA he said:

The first thing I remember was the smiling face this guy – middle aged man – smiling face, hand out, ‘welcome’ you know....So that was like a human being, right. With a smile, right, looking me in the eye, welcoming me....That was so important.

He acknowledged the value and importance of feeling welcomed and accepted, as he put it, "by his kind." Another interviewee had been to AA before. Of his sense of belonging he mentioned that this time "I knew I would be accepted. The question was whether I accepted them." This participant said of his new life in AA:

It's filled with other people. New associations. New associations that are also warm and – I welcome them. I wanted them and they were there. People were nice to me so you welcome them. You look forward to seeing people. A lot of the reason I go to meetings now is social.

This participant's step group was "quite important" to him. He considered them his "friends." The "honesty" and "empathy" of the group gave him the opportunity to share what was going on in his life. This participant also noted the "empathy" and "understanding" of his sponsor through the personal stories he would share with him. The transition house, where this participant lived at the time of the interview, also provided him with a sense of community. As he noted, "There's always people around to talk to. You're always in a community of some similarity, some unity, some solidarity." The individuals living in the house shared a "common vocabulary" so that this participant felt "when I go home I know I'm safe....and you get some sense of feedback. And often good-natured." Participants felt their experiences with former alcoholics and addicts, supportive and understanding family and friends, as well as supportive staff where one participant lived were largely positive: facilitating their healing process.

In closing, individuals in this study all described experiences where they felt either a sense of belonging or not belonging. On the whole, when associations were inclusive and welcoming and came from a source not involving drugs or alcohol, the

interactions described were reported as facilitative in the participants' healing journey. On the other hand, participants described interactions with individuals who were still involved with drugs or alcohol that fostered a sense of belonging or commonality at the time by stemming their fear and loneliness. However, these interactions were experienced as impeding their healing progress. Finally, interactions where interviewees felt excluded were experienced as hindering in their healing journey.

A Sense of Meaning or Meaninglessness

The theme of a sense of meaning or meaninglessness includes descriptions by participants of interactions that helped to provide meaning or failed to bring meaning to their lives. Interactions described by participants as meaningful to them included those where there were opportunities for them to make positive contributions or leave favourable legacies. Individuals in this study described turning points as situations where they struggled to find or make meaning of their life circumstances. Participants outlined many instances where connecting with a spiritual force was important for them in bringing meaning to their lives. Interviewees expressed the need for meaning as crucial to them in their decisions about changing their addictive patterns and in maintaining the changes they had made in their lives.

Three interviewees expressed impeding interactions that underscored times when life felt meaningless and without purpose. One of these situations occurred when a participant, as part of his job, was helping a young woman find space in a recovery house. She had been sleeping on the beach and he went to help her. She did not want his help and consequently he felt "frustrated" and "on edge." He was "exhausted" from trying to help and not being appreciated. Another participant described her despair at the

depth of her depression at the height of her drinking problem. She said she felt she had “no purpose” and she “did want to die.” She commented on her feelings of apathy when psychiatric services had decided to give up her apartment and put her belongings in storage: “I don’t think I really cared.” She said at that time she was “detaching from everything.”

Two individuals in this study described circumstances where they were seeking meaning and trying to sort out the messages that life was handing them in terms of their addiction. In his prayers, one participant asked, “What does God want me to do? What would God do? You know the answer I come up with? Be nice. But I get tired of being nice.” This same individual described looking for rules and guarantees in his new life that compared with the very explicit rules of his old way of life dealing drugs. He said it felt scary jumping into a life without drugs. He was trying to figure out why he would give up his drug-involved life that involved his previous social network. “What do you do? Well, what’s right? Does it get better? I don’t know.” The results of past interactions returned to haunt him, making it difficult to step with both feet into a new way of life. He commented on his current circumstances: “the hurt and the pain and the shame and guilt I’m feeling today is a direct result of what I have done in the past.” Another participant described his old ways of seeking meaning and connection with others:

If I can’t relate to people on a socialist level – through campaigns or projects, or whatever we’re working on, well there’s always the camaraderie of the bar, the tavern. Empty in a way. But it answers that same kind of need for purpose. Or tries to answer that need that is behind – I said drinking is a symptom and there is

something behind there – a sense of loneliness. We all want to love and be loved and to be loveable.

The times of uncertainty were described by interviewees as “frustrating.” The anger and uncertainty felt by participants in their interactions at these times tended to be experienced as impeding in their journeys toward health.

The meaning or lack of meaning in four interviewees’ lives was highlighted by instances of near-misses or turning points where it became apparent to them that their chances to change their ways were running out. For two participants the deaths of friends made them question the meaning of their lives, and ultimately, they felt, facilitated their healing journeys. Several interactions had occurred with one of the participants that made him very aware that his chances were running out to change his ways. He had escaped conviction on cocaine and heroin trafficking charges. When we met he still had marijuana growing charges he was hoping his lawyer would have dismissed. He also talked about the significance of his age to him in terms of changing his lifestyle: “My life’s half over, man....freaks me out. It’s, I don’t know, it’s like, man, it’s too late.”

The wake up call for another participant came in the form of a car accident. He expressed his realizations at the time of the accident:

There but for the grace of God I could have killed that person. Or crippled that person for life, right. And gone to jail for like a long time. Or just the guilt, or hurt myself...I thought well now it’s up. The jig is up.

Although the wake-up calls recounted by individuals in this study sounded potentially negative in influence, they were experienced by these participants as turning points that

made them question the meaning of their lives and resulted in heading their lives in healthier directions.

Three participants articulated interactions that seemed to personify their substance of abuse, and painted a relationship with this 'other' that formed the purpose for their existence. One interviewee described the nature of this relationship and the meaning it held for him and continues to hold in his life. He expressed his "powerful" relationship with alcohol:

My life totally pertains to alcohol. Even today. Even though I haven't had a drink for almost five years, right. Because, you know, I'm in recovery like I need to...have to treat this disease on a daily basis, right....So my life still has a lot to do with alcohol. In fact you could say that my life still revolves around alcohol even though I don't drink it anymore.

He went on to describe his love-lust relationship with alcohol:

I adore alcohol. I mean I still think about it almost like one would think about that relationship you had a long time ago that was – so magical and even in hindsight it sometimes seems even more wonderful, you know. And you start to think 'if only' and 'what if.'"

The powerful interactions with drugs or alcohol were described as consuming by participants, to the exclusion of much else in their lives. The continuation of this relationship in the form of using was experienced as detrimental to participants' healing journeys. Those participants who were able to channel this focus into a spiritual realm expressed how their relationship with a higher power, "filled the hole" that their drug of choice had previously occupied and greatly facilitated their healing.

A meaningful spiritual connection with God or a higher power was expressed as influential for three interviewees. One participant described his desire for a spiritual connection: "Alcoholics are spiritually bankrupt kind of people....Spiritually thirsty. Just spiritually starving. Like I'm dying for some – spiritual solution." He defined alcoholism in terms of his spiritual journey: "Our disease is our distance from our higher power. The fact we're not walking a spiritual path." This individual explained how his spirituality fills the hole that the alcohol used to fill for him:

That same longing that used to make me drink is now the longing that drives my spirituality....Please God...don't let my life be a waste. Please let me find some way to let me make a positive contribution. Help me be a good person, a loving person. Help me to stay sober....I so want to know God. It's sort of like a spiritual release for me. I want to have God in my heart. It's like the same way that I wanted that alcohol inside me.

Four participants talked about prayer being an important part of their lives now. For two interviewees in particular, prayer has become "routine," or "a habit," and even "a way of life." One individual emphasized his feeling of connection with God through prayer: "when I'm praying and meditating and making a connection with whatever God I believe in, I'm not in self. I'm in a relationship."

Aside from prayer, another way of following a spiritual path that participants described included helping others:

When people ask us for help in this program we're supposed to help if we're able to. That's partly why I answered your flyer. I thought 'yeah, that's like a request for help.' I thought – I read it – I thought 'I fit.' There's spiritual things there,

right. You can say God puts opportunities in your path, you know, like – opportunities to be of service to others. You're supposed to say yes. You're supposed to. It's supposed to be good for me.

Two interviewees described AA as helping to shift their focus to a spiritual path. Interactions with others have played a key role for them, but they described the overarching role of other people was how they fit into God's plan. One participant defined God as, "whoever listens to and responds to my prayers." God "speaks to me through people." Another individual commented about his experience of the AA program:

This is about God. It's not just about the 12 steps and it's not just about meetings and sharing. I mean those – the steps and the people sharing – the interactions have been crucial to help me come to understand about a God of my understanding. Have helped me come to understand about love and – helped me understand about courage and about facing reality and about being a human being who makes mistakes and that it's okay.

Participants described the experience of a higher power as helping to give meaning and a positive direction to their lives.

Individuals in this study described that a sense of meaning or purpose in their interactions served as a reminder of how their lives were evolving constructively and helped them continue on their healing paths. One interviewee reflected on the experience of our interview: "Being here today and telling you this stuff is really good for me. It reminds me – to share with somebody else with a reasonable amount of honesty. That

feels good.” One participant reported that making amends to others helped to provide meaning for him:

Some people have basically not been too happy to see me or hear from me again. But it was for my benefit. I take responsibility by offering – admitting to that person I hurt....I acknowledge that I hurt you and here's why. That doesn't excuse it but I just want you to know I'm very sorry and I'm trying to be a better person.

Another individual strengthened her resolve to stay on her current healing path when she compared her situation with a woman she knew. She described her experience with the woman who had been living in the same facility but had not chosen a healthy path:

There was a woman here. And it just reinforces your sobriety or whatever, that was drinking in her car. That was basically living – that lived in the house but spent most of her time in her car, because she lived in her car for the last year and a half....It just reinforces that I can have this or I can be like that.

In her descriptions of several interactions this participant expressed her gratitude for the chance she has been given to experience life anew. In recounting visits with her sponsor she marvelled, “I'm able to do these things. And if I was drinking I would not be doing them.” Interactions that allowed participants to examine their progress in healing were meaningful for them and were experienced as facilitative.

Along with experiencing a new sense of meaning in their lives, some participants described trying to create meaning for themselves out of situations that arose for them. One interviewee was in the process of making choices about what was meaningful for her. Of the AA meetings she attended she said, “I don't necessarily listen to everything

that's going on. I take what I want. Or what interests me out of the meeting." She also reflected on choosing the people with whom she spends time:

It doesn't mean everybody you meet in recovery you're gonna be friends with.

You know like in life, you gotta pick and choose who you want in your life. And

I'm in that process and I'm okay with that.

For another participant, the work he did with others throughout his healing process allowed him to gain some perspective on his experience. He recounted:

Recovery's funny. As you start pulling off these masks, pulling back the layers, things start popping up at you....So now one thing recovery has allowed me to do is put a lot of the pieces of the puzzle together.

He reported that recovery has given him an appreciation of "what got him to where he is today." Throughout the experiences recounted by interviewees, the interactions that they felt provided a sense of meaning or purpose whether through a spiritual connection, turning points, reflection on life circumstances, or making healthy choices, were experienced as helpful in keeping participants on track in their healing journeys.

Five individuals in this study gave examples of situations where they were trying to make a positive contribution to others or desired to leave a favourable legacy. The opportunity to "give back" was important for the healing of participants in helping them feel their life had not been a waste and that they were able to make amends for past behaviours. One interviewee had volunteered to become an ESL tutor. Another said, "my goal in life now is no longer to do for me, it's to do for others." Still another participant mentioned, "I'm taking care of myself and I'm helping others." One interviewee was quite distressed at the legacy he perceived he would leave if he were to

die at the time of the interview. He said: "When I die I don't want people to remember me as being 'holy fuck that guy was fuckin' crazy.' That. And as it stands right now that's probably how they will." Two participants considered how their past actions had affected their children and what they could do to assist them in their futures. One individual was trying to help his daughter deal with the "issues" that she had from growing up in an alcoholic home. Attempts to leave a positive legacy or make a positive contribution to society gave participants a sense of meaning and this was perceived as facilitative in their healing journeys.

Four participants expressed the importance to them of giving back to the addictions community. Prior to his own struggles, one interviewee held negative views about individuals with addictions. He commented on his changing views: "I guess I'm trying to recover from those years of thinking those people weren't better people. It's not a guilty feeling, it's just that I was so wrong." He volunteered regularly at detox and felt his contribution there helped alleviate his guilt and also assisted others. He noted, "Even if I go back out and become a drug addict tomorrow I will have done something right. That makes me feel good today." He and another interviewee also mentioned wanting to contribute in a more global way to others with addictions. As this participant stated: "I'm not well enough to do it. But if there's anything I can do when I get better...I desperately want...to see what I can do to help other addicts in a bigger way." Still another participant commented on his reason for taking part in this research project: "That's why I rode my bike up here. I feel so good that I can help maybe somebody else down the road through your research." Contributing in positive ways gave participants a sense of meaning and they expressed that this helped to facilitate their healing journeys.

To summarize, participants described various interactions that were helpful and hindering in their search for meaning. A lack of meaning was experienced when interviewees were involved in discouraging interactions in their lives. Individuals in this study also described interactions where they sought meaning and expressed frustration at not getting answers. Turning points were recounted as constructive experiences, although sometimes difficult. Facilitative interactions were reported when participants felt a sense of meaning and purpose in their lives and were open to experiences with a higher power or wanting to contribute to others through their interactions.

A Sense of Hope or Hopelessness

Individuals in this study recounted interactions involving hope and hopelessness that they felt were influential in their healing journeys. Feeling hopeful was reported to be an integral facilitative experience for participants in their journey toward health. Situations where hopelessness prevailed generated feelings of futility, frustration, powerlessness, and failure. Alternately, when they were hopeful, participants described feeling openness to change, and with that, a willingness to follow the good examples of others. Included in interactions that provided hope, interviewees also described the optimism that a connection with the spiritual realm gave them.

A sense of hopelessness emerged throughout the interviews in descriptions by interviewees of their feelings of depression, suicide, futility, frustration and pain that impeded their healing. One participant discussed his downward spiral after the deaths of his friends:

I changed and I became more depressed. My life became more limited....It seemed hopeless. I was angry and then the anger had nowhere to go. So the

reaction for me is to get depressed. You know you have this passion and it's kind of useless. It's just disruptive....I get these strong feelings, right? And then nothing to do with them. I can't stop the traffic like I suggested.

For this individual, drinking and socializing with other drinkers helped him to face the "loneliness" and "emptiness" he was feeling. Two other interviewees described suicidal feelings during their journey through their addiction. One participant expressed how his suicidal feelings led him to crack cocaine:

My most suicidal I was, was when I stopped drinking. I was sober for five years. That's when I was most suicidal. Because I didn't have a place to go and hide....So I was always thinkin' about goin' off the bridge or – I felt like I was trapped into something. And that's when I discovered crack. Crack took away all that shit. Took away the suicide. Took away all those desires to hurt myself et cetera.

Feelings of pain and frustration were also described by two participants wrapped up in feelings of futility in their lives. After experiencing a number of painful blows to his life including his daughter moving away, not being trusted at work, and not feeling appreciated, one participant described feeling a lack of power to change those events. His powerlessness left him feeling "hurt," "punished," "angry," and in terms of his daughter, as though his heart had been broken. He felt like he "didn't know who to trust anymore" and expressed confusion about all the events that were happening in his life. His feelings translated into him isolating himself from people and pushing others away. Another interviewee expressed his distress over his inability to help his family in the following way: "The only way my children are going to get help is if there is a

crash....So I'm powerless and helpless and it's frustrating." The painful feelings were expressed by participants as impeding their healing process.

Descriptions of failure pervaded three participants' interviews. One interviewee felt he was an example of failure to his sons, having been in and out of recovery for 18 years. His uncertainty about how to change was clear from his comments about his relationship with his older son:

I used to treat him like my Dad used to treat me. And why did I do that? Because I didn't know any better. No one ever taught me any different. So – we are who we attract and we act like who we've been brought up by. Period. What is that? Behaviour. How do you unlearn that? Well break the cycle. Well how do you break the cycle when you're 47 years old. How do you change? Well – I don't know.

Participants expressed feelings of "shame" and "guilt" as a result of their sense of failure. Interactions reflecting this feeling of failure fostered a sense of hopelessness and futility for participants that they felt impeded their progress towards a healthier lifestyle.

A sense of hope was discussed by all the individuals in this study as facilitative in their healing journeys. Participants experienced hope in their connections with other people, in following or being inspired by the examples of others, and also as a result of their connection with things spiritual. For one individual, having welfare top up his employment insurance helped him take his first steps on his journey toward health: "I was grateful towards my welfare financial eligibility officer who jumped through hoops to make sure this would happen." At AA meetings he said he looked for signs of hope:

“I listen for advice and strength. Hope and ways of people continuing – are just part of my daily life now.”

One interviewee garnered a sense of hope from the support and encouragement she received at the Recovery House where she was living. She also felt hopeful after resisting very strong cravings for alcohol she felt just before she got into the recovery house where she was living. She was accepted to the house because she had “more sobriety time” than others on the waiting list. She felt this was a sign that she “was on the right track.” Spending time with friends also helped her to find hope and enjoyment in life again. One visit to Spanish Banks with a friend brought this reaction:

Beautiful beach!...And we walked out...one Sunday. We had to walk out 45 minutes to get to the water because that’s how far out it was. And I was like – this is the life. You know – this is why I’m here.

She described going swimming on this visit: “we were just swimming in the ocean and laughing and just having fun and I’m thinking this is the life. This is all a part of recovery.” She said her world was “brighter. It’s amazing. Like the grass was always green. I just didn’t see it.” She was enjoying recovery and her new lease on life, fuelled by the individuals surrounding her and the sense of hope and optimism that interactions with others gave her. She was romantically interested in someone at the time of our interview and she was reconnecting with friends.

Participants also experienced the examples set by other individuals as helpful in their healing journeys. The individuals providing positive examples included sponsors, others in AA, and people in general. Three interviewees mentioned experiences with their sponsors that helped them to achieve and maintain a positive outlook and approach

to life. For one individual this experience came in the form of a road trip, for another it was the previous shared experience of working together, and for another one important interaction involved encouraging him to go back to meetings when he was feeling disheartened. One sponsor was described as “a good guy,” “a reliable fellow and peer,” “considerate, courteous, helpful, and knowledgeable,” “a person I trusted, person I respected. I knew he wouldn’t bullshit me.” This participant’s sponsor helped make it safe for him to take the next step in his healing journey.

Another interviewee mentioned that his sponsor was important to him as a role model and has helped him out in difficult times. He described his sponsor in the following way:

He’s not a guru or whatever. He’s not a clinical psychologist or whatever. He’s just an alcoholic who’s been sober over 28 years and he’s a human being. He’s got faults and he uses the program and sometimes he gets all twisted. You know he’s just – I want what he has. He has an ability – he just – he can deal with life and he seems to really – like a pretty happy guy, right.

Others in the AA program were also examples of hope for participants. One participant noted: “you see people who are good people. I can recognize idealism. I can recognize zeal and I could see that people were sincere and I could see they were healthy.” Of his step group, this individual mentioned he “liked their stories.” He was impressed by the fact that “they still find the patience. And the compassion. But the toughness too” to help others with their addictions. Another participant thought he would “get recovery for a couple three weeks. Straighten his life out. Overnight. Get back on the street.” It didn’t happen that way. He was “affected profoundly by the people in the recovery

house.” His openness to suggestion and change was evident in the influence that the staff and the residents at his recovery house had on him. His roommate was an important role model for him. He had “been there for two months and straightened himself out.” This individual was “very supportive” and “very wise” because of his experience and had credibility for this participant because of his addiction experience.

Other positive examples for participants came in various forms. A character on a TV show was a “positive figure” for one interviewee. This character had a substance abuse problem and he got help and was sober in the show. The character was “not a basket case. He’s like this in-command, take charge guy with the beautiful wife.” This allowed the participant to feel that substance addiction was something he could face if he had to: “It was okay because it was okay for him.” For one interviewee, the individuals in his dental clinic were “a picture to me of people involved in service. It’s detail, it’s scientific, it’s technical. It’s almost like jewellery, fixing teeth. At the same time it’s incredibly social.” The people in the clinic helped to restore his “self esteem” and “health.” For this participant, he felt: “Everybody I bump into in a way facilitates my healing journey. ‘Cuz they’re there. I learn something. Maybe I just notice that they’re cheerful.” Interviewees’ felt their healing journeys were facilitated by the hopeful, positive examples set by other individuals in their lives.

Hope was also evident for participants through their spiritual connections. Maintaining a positive outlook was assisted by prayer and gratitude for all that they had. One interviewee felt he was on the upswing of a rollercoaster ride and hoped the trend would continue. In order to keep his focus positive he said “I’m not the most religious person in the whole world or anything but I do pray to God. And I ask him for help and

some strength.” Another participant felt that “the purpose of praying is the effect on the person who prays.” Still another expressed gratitude for the example of others and for all that he had in his life. This connection was made for him through his belief in a higher power. He explained:

When I take my time to get to know that person, in the end, I’m so happy I did.

The ones that are really worthwhile keeping are the ones that have it. That have sobriety. Or have life. A good life. That have the message that I believe what God wants us to be, or Creator, or whatever you wanna call Him. That gift of – the gift of giving, to be so childlike, to be forgiving, to be forgiven and give and give and give. And that’s what I do. And don’t expect anything in return.

There’s a lot of times where if I don’t expect anything in return and I tell you, boy, it’s turned over ten fold. Like my daughter, back in my life. My sons coming into recovery. That I’m not using dope or drinking today. That I have a job to complain about.

Participants’ spiritual connections gave them hope; and they experienced this feeling as facilitative in their healing.

To conclude, individuals in this study experienced interactions involving hope and hopelessness as instrumental in both facilitative and impeding ways in their healing journeys. Interactions that were experienced as hopeful by participants were described as helpful in their healing journey. Participants described situations where hope was absent as hindering them in their healing process. Hope was described by participants in spiritual interactions, interactions with professionals, family, friends and individuals in the AA program. Hopelessness was experienced in interactions with other users as well

as in discouraging interactions where participants felt a lack of control over the outcome of the interactions.

A Sense of Shifting Identities

The final theme that emerged during this study was a sense of shifting identities for participants. The interactions in this theme involved positive changes in behavioural response or perspective on the part of interviewees from how they would have reacted before ceasing their addictive behaviours. Participants perceived these shifts as facilitative in their healing journeys. The interactions that highlighted these shifts involved turning points, or making connections with others or God. Interviewees also described interactions that helped them realize they could make more positive choices in their lives. Some other interactions expressed in this theme included instances where participants realized that it was acceptable to experience unpleasant emotions, when they would have tried to avoid these emotions in the past. Additionally, individuals in this study became aware through interactions that they could choose to avoid encounters they perceived as negative or harmful. Key for two participants in changing their behaviour was their part in asking for help and accepting the help that was given. The interactions reported by interviewees in this theme exemplified positive behaviours and attitudes that differed greatly from how they would have responded when they were actively abusing substances.

Every participant reported interactions where they behaved in more constructive ways than they had when faced with similar situations in the past. For one interviewee, an example of a more favourable response involved his reaction to his ex-girlfriend's news that she was moving out of town with his daughter. Rather than showing his

distress, he responded to his ex-girlfriend more constructively: "I tried to be understanding with her and she – and I didn't have to yell at her and I didn't have to scream, which is really good progress for me." Another instance of behaving differently for this participant was trying to feel secure in his sobriety before he tried to help his grown children with their addiction problems. In the past he would "always jump to the kids 'cuz of shame and guilt." He was aware this time, however, that if he could not save himself, he could not help his children. Another participant felt that during his active addiction he "led two lives": one of businessman and father, the other of drug addict. Now, he says his "relationships are built on honesty. They never were before." After engaging in activities that were "centered on self-gratification" and "self-centeredness," this participant described going to AA meetings where "being around a room full of alcoholics makes me forget about myself and start thinking about other people." From the "self-centered, secretive" activities of his previous lifestyle, this participant appreciated the difference between how he was then and how he is now. "You don't become a monster overnight. It takes time and it's not taking me long to discover that. I'm not a monster nowadays but I was a monster." The changes in behaviour and acknowledging these changes were experienced as facilitative by participants in their healing journeys.

For two interviewees, asking for help was key to facilitating their healing journeys. One participant stated: "What was really important for me was asking for help. And somehow accepting the help that I was given." "So you have to ask for help. And people are there. I was amazed....I was amazed at how much help was there....if I have

the right kind of attitude it will probably come.” Asking for help kept this participant on track in his healing journey. He noted:

I have to ask for help everyday. Somehow. Even if I just ask God for help. But it's helpful if I ask a person. Puts me in a position of humility. Puts me in a position of service. Or dealing with service. I don't know. Everybody, everybody I bump into in a way facilitates my healing journey. 'Cuz they're there.

Four individuals in this study described interactions that were turning points for them. For one participant, being welcomed by someone at an AA meeting seemed to solidify his decision not to return to drinking. “I guess for what ever reason I decided, I'm done. I've had enough.” For two other interviewees their turning points came after the death of friends. As one participant noted, “Something changed inside me at that point.” “I've seen a few people that have died. But uh – (this death) was different. It was different. I don't know how it was but it was just different.” Still another experience described as a turning point was when one participant's girlfriend began “selling herself” so that the two of them could pay for their drugs. At this point he said “this is enough.” “I don't want to be causing somebody to do that.” These turning points provided important interactions for these participants in their decision to lead healthier lives.

The spiritual aspect of the AA program was mentioned by all of the participants but seemed to be very significant in establishing the newfound lifestyles of two interviewees in particular. These two mentioned that they pray regularly now. One individual said that in his previous life he “would not have sought spiritual solutions.” Of his current spiritual life, he commented: “I certainly do need to pray. The effect of prayer

is often about the pray-er....The purpose of praying is the effect on the person who prays.” Another participant described the 12 steps as being:

All about sort of trying to connect and maintain a relationship with a God of your own understanding. Higher power, whatever that is, right. And I believe that’s because that’s what alcohol was. Alcohol was you know – I will worship you, I give it all to you, you know, do with me as you will, right. I completely submit to you.

This participant outlined how he saw interactions with people fitting in to his spiritual life:

The 12 steps and the interactions with people – is all – part of – me having a relationship with God, right, Um – but ultimately God is with me 24/7. You know in my heart, right, and I need to talk to people and stuff, right, but people are not always there and people sometimes make mistakes. But God, of my understanding, is always there and has unconditional love and wisdom. And if I don’t understand, I just believe.

The spiritual aspect of their lives was new to both of these participants but played a key role in establishing their new, healthier identities.

Three individuals in this study mentioned the significance to them of connecting with other people instead of isolating themselves, in terms of helping them to maintain their lifestyle free from addiction. The perspective other individuals were able to give to interviewees in difficult times seemed to be valued. In the words of one participant:

There have been times when I really wanted to drink and I was pissed off, right, and I didn’t pray or anything, right. I didn’t pray. Um – I was pissed off, you

know, but I just thought well I'm just not gonna take that drink just for today....The next day or maybe later that night I'd speak to one of my friends and say this is how I'm feeling, you know and I would get some perspective from a sane mind....So again, you know, I connect with some other alcoholic that's like a power bigger than myself. Sometimes I pray – if I'm feeling – weak or troubled or whatever. I'll pray and that's also making a connection.

For another participant, “reconnecting” with people in her life has helped her maintain her health. She said some of the individuals she contacted have previously only heard from her was when they “were bailing her out.” This individual also described the importance of the staff at Vancouver General Hospital to her healing process: “VGH saved my life. I mean when I was in there they saved my life. They obviously did something right. Even though maybe at the time I didn't think it was right. Um but they saved my life.”

Avoiding negative interactions was important to three of the interviewees in terms of rejecting addictive behaviours. One participant mentioned avoiding downtown because he would bump into people he knew and he would not know what to say to them. He did not want to be a “poster boy” of recovery for them. He also mentioned “there were other people I used with. It would be hard for me to hang around with them today without using. I'm not sure what we'd have in common anyway.”

Another interviewee realized he needed to stay away from his family until he had more time to establish his new lifestyle. Previously he had “crashed” and relapsed because he missed his family. He quickly pulled out of his relapse but he noted: “I can't go back and see them....I know if I went back into that I'm inviting trouble for myself.

I'll start using drugs again." He also recognized that he "can't even speak on the phone" to his girlfriend because will end up using again. This was a sad realization for him because his relationship with his girlfriend was the "only loving relationship" in his life. He was aware, however, that he needed to avoid that relationship in order to maintain his health.

For another participant, staying connected with God and choosing to focus his attention on positive things continued to keep him away from negativity. Prior to this turn around in his life, when faced with trying times his response was "feeling hard done by" and "self pity" as well as "poor me," "things aren't going my way," and "what's wrong with me?" He described his current experience in the following way: "That's part of what recovery is. It's cultivating and encouraging a positive spiritual point of view and, discarding negativity, negative points of view."

One participant described negativity as "part of the isolation" of addiction. This individual realized that she can choose the people with whom she spends time. "In life you gotta pick and choose. You know, who you want in your life." She chose to avoid people who exhibit a negative influence on her. She said: "I find I have to stay away from negativity. I find that that just really doesn't work for me." Participants realized that avoiding negative or unhelpful interactions was important in staying on the path of abstinence they have chosen.

Learning to manage unpleasant emotions that arose during interactions constituted a different category for participants from steering clear of negative interactions. Four individuals in this study discussed being able to experience uncomfortable emotions in interactions now without turning to substance use. One interviewee expressed how

disagreeing with members of his step group was “quite important and quite valuable” to him. He also mentioned an awkward altercation with an individual where he felt “frightened and intimidated” but he was able to react non-defensively. Another participant stated “I’m getting good at dealing with people that are hurtin’ me without physically hurting them or anything like that.” One situation that put this to the test was when he reported that his girlfriend had cheated on him. In this instance, this participant did not turn to violence or drugs. Instead, he prayed about the situation and he sought support from friends.

Another awkward circumstance mentioned by one interviewee involved learning to cope with the “annoying idiots” in his recovery house.

Life is – you don’t always get what’s pleasant. I have to learn how to cope with annoying – people. With people who aren’t at the same point on the path, say. I have to find somewhere in me the patience, the strength, or the ability to just walk away from them. I have to somehow find that – inside me. I have to accept the situation.

Lessons for one participant in this study included ending a relationship without resorting to drinking and giving himself permission to feel sad. After praying about whether to end the relationship he had a “feeling in his heart” that he was going to have to let the relationship go. He described the “awakening” he had:

I always thought if you felt sad about something then – wrong decision. Don’t do that. Must avoid feeling sad. Don’t want to ever feel sad, right. That was another reason to drink, right. And I learned at that moment, you know what? Sometimes you feel sad about something even if it’s the right decision.

He said he felt “stronger now” because he had “been through stuff.” This courage, strength and “faith” in a “power greater than” himself helped him in difficult situations such as moving house, away from his “support system.” He said it was “stressful” and he was “a bit lonely.” He commented further:

I’ve learned to deal with stuff like that. I’ve learned that stuff like that is part of life and I’ve learned an alternative to my old coping skill which was oblivion, right. And uh – it works for me – and I’ve proven that it works because I’ve been in this space before.

Another instance where this individual reported that he honestly expressed unpleasant emotions where he would previously not have admitted them was telling his counsellor that he was fearful about being placed in a psychiatric institution and that the counsellor would keep him sick so that he could continue billing him. Of this, the participant said, “that’s the thing the program has taught me about is to be honest about my fears.” By confronting his fears and being honest about them, “then it was dealt with. Before it was like all these fears and stuff and they all became a big mass, right. Didn’t know what I was afraid of, right.”

Still another interviewee described a test of his newfound honest approach to life. He had to go to Revenue Canada to resolve some issues about his taxes. He said he was “so frightened” he “just about started to cry.” He said “that was good” because:

In the old days I would go there and pick a fight with the guy....That was just all because – I didn’t realize it at the time – I was scared. Now I went there and I knew I was scared and uh – petrified and I can get over that. I don’t have to use drugs or alcohol.

Learning to accept that negative emotions are part of life and to permit themselves to experience difficult emotions without the consequent using behaviour was a step forward for these participants in terms of establishing a new identity.

In summary, interactions that reflected a change in the participants' response or perspective from how they would have responded when they were using appeared to comprise a theme of shifting identities. The categories of interactions that seemed significant for participants included: those where participants actively asked for help and accepted the help that was given, and instances where interviewees chose to avoid unnecessary negativity. Additionally, individuals in this study described the significance of choosing to connect with people or God instead of isolating. Also of consequence to participants was keeping their perspective, and recognizing choices instead of feeling miserable and resorting to using behaviours. Finally, in this theme were situations where interviewees acknowledged their feelings and gave themselves permission to experience negative emotions. Included in these interactions were situations that seemed to test participants' responses. The interactions in this theme all highlighted a change in interviewees' response that was more constructive than before they began their healing journeys. Recognizing these interactions as indicative of a new way of life was facilitative for participants in their healing journeys.

Conclusion

The data collection interviews in this study were used to extract five themes that reflected the common experience of both facilitative and impeding interactions of the participants in their healing journeys away from substance addiction. The descriptions of the participants yielded experiences of feeling supported or discouraged, isolated or at a

loss, and feeling understood or misunderstood through their interactions. Additionally participants reported experiencing in their interactions a sense of belonging, meaning and hope or the lack thereof, and a shift in their identities now that they were on healing paths.

CHAPTER FIVE

Discussion

Introduction

This study was designed to explore the interactions individuals experienced as facilitative or hindering in their process of healing from addiction. The research question that guided this study was: **How do individuals who have moved from substance addiction to health, experience interactions with others in terms of facilitating or impeding their healing journey.** This chapter will include a comparison of the findings in this study with those from the existing literature. Following this comparison, implications for counselling, limitations of the study and thoughts about future directions for research will be discussed.

Comparison to the Literature

The literature reviewed for this study (Akin & Gregoire, 1997; Ames & Roitzsch, 2000; Ashery et al., 1995; Dobkin et al., 2002; Reid et al., 2001) gives the impression that individuals healing from addiction could possibly be influenced positively or negatively in their interactions with professionals and others in their social support network; however, the perceived influence on their healing journeys is not addressed in this literature. This study, although only describing the experience of six individuals on their healing paths from addiction, contributes to the literature in describing what was helpful or hindering to participants in terms of interactions involved in their healing. The in-depth interview process detailing interactions from the participants' own experience allowed me to uncover a number of findings that were not apparent in the literature reviewed for this study.

Firstly, this study supports the idea that individuals healing from addiction do perceive others to have an influence on that process. Participants reported interactions with others as facilitative or hindering in their healing from addiction. Often the interactions that were experienced as negative by participants such as avoiding others out of embarrassment or emotional pain, or discouragement from verbal abuse or betrayal, reflected a hindering influence. Interactions experienced as positive such as support or empathy were reported to be facilitative. However, this was not always the case.

One interesting finding of this study was that in certain situations, seemingly negative or painful interactions led to positive change. Participants described the deaths of friends that prompted cessation of their drug and alcohol abuse, the hopelessness of losing relationships, or a car accident that provoked one participant to change his drinking habits. Although initially participants often experienced these interactions as setbacks, they frequently provided the impetus for them to change their addictive behaviours. The influence of interactions in this way appears to be a finding unique to this study.

Another finding that is not reflected in the literature reviewed for this study but reflects other available studies (Nealon-Woods, Ferrari, & Jason, 1995; Ratliff, 2003; Swora, 2002) is the importance for participants of a sense of inclusion in a community with a notion of common ground. In the current study, feelings of belonging appeared most often for participants within the AA movement. Interviewees expressed that elements of the AA program addressed their need for connection with other people, and they also provided a connection with the spiritual. Prior to ceasing the use of their addictive substance, some participants described their substance of choice as the 'other'

in their lives that gave to them a sense of belonging and connection. These results reflect that for participants in this study, some connections were perceived as healthier than others. Other participants reported feeling as though they were living a double life: one side trapped in civility, the other comprising a feeling of evilness. Participants experienced the pull of two worlds yet felt as though they belonged to neither one nor the other. Once participants stopped abusing substances, several mentioned feeling a loss of control and power. However, these feelings appeared to dissipate once new, healthy bonds were made with other people. Interactions with God or a higher power also gave participants a sense of belonging in a constructive way. The sense of spiritual connection is reflected in the addiction recovery literature (Green, Fullilove, & Fullilove, 1998; Sherman & Fischer, 2002; White, Wampler, & Fischer, 2001). Connections with others, as well as with God, were reported to have given participants new meaning, a sense of support and hope in their lives and resulted in a change in their identity and way of thinking about themselves.

One particularly salient finding in this study was the description of personal growth among participants, in terms of the changes in their response to various interactions. As participants shifted their identities away from that of 'addict,' they began to ask for and accept the help of others, and chose more constructive behaviours in interactions. These behaviours included learning to accept and experience unpleasant emotions and make the choice to avoid negative or unhealthy encounters with others. Additionally, participants described choosing how to spend their time and focus their energy, particularly in wanting to make a positive contribution in the world. Similar

descriptions of growth and change were not apparent in the literature reviewed for this study.

There were, however a number of findings in this study that were consistent with the prevailing literature. The results from this study reflected the addictions and counselling literature (Bell & Rollnick, 1996; Egan, 1994; Denning, 1998; Hackney & Cormier, 1996; Keller, 1996; McCann & Roy-Byrne, 1998; Nowinski, 1996; Tatarsky, 1998) suggesting the efficacy of empathy, genuineness and unconditional positive regard with clients. Creating an environment of safety and acceptance was experienced by participants as facilitative in their healing process. Additionally, the addictions counselling literature (Denning, 1998; McCann & Roy-Byrne, 1998; Rotgers, 1996; Rothschild, 1998; Tatarsky, 1998) suggests the effectiveness of encouraging clients' involvement in treatment planning, goal setting and allowing clients to set the pace of therapy sessions. In this study the sense of involvement and control achieved by actively participating in the direction of therapy was experienced as facilitative for participants.

Findings of this study included both helpful and hindering experiences with addictions and health professionals. This is consistent with the findings of Ashery et al. (1995) that illustrated both positive and negative experiences of drug abusers with social service programs and Akin and Gregoire (1997) that described various experiences with child welfare workers of individuals who had successfully addressed their addiction issues. Certainly attitudes of addictions and health professionals were perceived by participants in the current study as influential in their interactions and in their healing process. Verbal and non verbal behaviour was experienced by participants in both positive and negative ways. Creating an environment of safety, giving of time and space,

responding with kindness, and empathy were all emphasized by participants as facilitative in their healing. Alternatively, feeling demeaned, not listening and not being generous with time were impeding influences on participants' healing.

Findings in this study did not reflect the results of Cunningham et al. (1999). Individuals in Cunningham et al.'s study reported that addiction treatment and doctors' advice were not influential for them in their decision to reduce their using habits. In the current study, both the staff at various treatment or supportive living residences as well as doctors' advice were seen as facilitative by participants in terms of their healing from addiction. Perhaps the focus of Cunningham et al.'s study on the reasons for changing using behaviour patterns is sufficiently different from facilitative or impeding interactions in an individual's healing journey to warrant the difference in result.

In the current study participants expressed the critical role of healthy social support in facilitating their healing journey. Interviewees described healthy social support as including individuals within the AA movement, whether in groups, or individually. Additionally, for some participants, family and friends who did not abuse drugs or alcohol or deal drugs, were important in facilitating their healing from addiction. These findings are consistent with the results of Dobkin et al. (2002) and Ames and Riotzsch (2000) that suggested beneficial effects of social support on healing from addiction.

Family, in particular, were influential for participants in this study in both facilitative and impeding ways. Facilitative interactions included acknowledging the interviewees' efforts, making efforts to understand substance abuse and the addicted individual, and helping participants manage their affairs. Individuals in this study also

recounted interactions with family that impeded their healing progress. Interviewees described unsupportive and verbally abusive spouses, partners who they felt abandoned them, and children who did not understand their substance abuse and consequently avoided the interviewee. Although not addressed in the literature, both the healthy social support of family members and the impeding interactions with family described by participants speaks to the potentially strong influence family may have on individuals healing from addiction in both positive and negative ways.

With respect to ethnicity and gender some aspects of this study were consistent with the literature and others were not. Participants did not report that either their gender or ethnicity was significant in their healing. This may have been a failing on my part in gleaning this data or these factors were simply not relevant for the participants in this study. From the one woman involved in the current study, her situation at the depth of her addiction was congruent with the research (Nelson-Zlupko et al., 1995) on women who tended to use in isolation and had fewer social supports. However, the findings of this study differed from the literature in that the female participant in this study was single, without children, and had marketable skills. It is hard to say whether the findings from the current study support the research on ethnicity (Prendergrast et al., 1998) because of the limited numbers. However, the one individual in the study of South Asian and Swedish descent who was involved in the criminal justice system alluded to a great deal of violence in his life. He also discussed his reluctance to disclose personal information in group settings. These factors are consistent with the evidence for Hispanic participants in the study by Prendergrast et al..

Implications for Counselling

The results of this study provide some insight into the experience of the participants in their interactions with professionals in terms of what was helpful to them in their healing process. Findings are from the participants' perspectives so we can learn what they found helpful or unhelpful in terms of their interactions with health and addictions professionals and can apply this information to counselling. A number of the interactions described by participants in this study directly involved individuals in counselling roles, if not counsellors themselves. These findings may be useful to counsellors who work with clients who have addiction issues.

Participants described the necessity for them of trust and faith in the relationship with the health and addictions professionals with whom they were working, in order for them to share their experience. Believing in the credibility of the professional was essential to the counselling relationship. A personal addiction history on the part of the professional helped establish trustworthiness among participants. However, other factors were important in establishing rapport in the interactions discussed. Creating a safe space for clients to share, giving of a counsellor's time and a listening ear were instrumental in facilitating participants' healing. Consistent with the counselling and addictions counselling literature (Bell & Rollnick, 1996; Egan, 1994; Denning, 1998; Hackney & Cormier, 1996; Keller, 1996; McCann & Roy-Byrne, 1998; Nowinski, 1996; Tatarsky, 1998), these findings confirm that establishing the relationship with clients is important for counsellors working in the addictions field.

On a number of different occasions participants reported difficulty in establishing trust with others, including health and addictions professionals. At times professionals'

motives for continuing counselling were questioned, along with their understanding of addiction. Participants feared the professionals' knowledge was merely academic rather than experiential. Sometimes fear in counselling situations stemmed from insecurities over participants' own thoughts, feelings and fears of being locked up or kept sick.

Reassurance from the professionals made an important difference in alleviating anxiety and allowing participants to share their problems and get the help they needed.

Unconditional positive regard is well documented in the literature (Hackney & Cormier, 1996; Nowinski, 1996) as is establishing rapport (Denning, 1998; McCann & Roy-Byrne, 1998; Tatarsky, 1998). Allaying participants fears about the counselling relationship and process, as well as any fears about feeling judged, would be advisable for addictions counsellors.

Along the lines of establishing rapport and defining the counselling relationship, participants expressed that feeling in control of their healing process was important to them. Allowing the clients to set the pace in the counselling sessions and reassuring them that their counselling sessions will only continue as long as the client feels they are warranted was expressed by one client as giving him a sense of safety and control. This point was emphasized by the fact that participants' responses to certain interactions appeared to be related to a level of readiness to accept the support being offered. The idea of working collaboratively with clients is supported in the existing addictions literature (Denning, 1998; McCann & Roy-Byrne, 1998; Prochaska et al., 1992; Rotgers, 1996; Rothschild, 1998; Tatarsky, 1998) It would, therefore, be prudent for addictions counsellors to work from the client's level of readiness in their sessions.

Additionally counsellors would benefit from considering that the client is the expert on their addiction and the counsellor the expert on psychology or counselling. Although participants did not appreciate advice or being given instructions, education was welcomed. Participants accepted that professionals may have expertise in certain areas such as behaviour patterns or brain chemistry and imparting this knowledge to the client was helpful to them in understanding their addiction better. Addictions counselling literature (Denning, 1998; McCann & Roy-Byrne, 1998; Rotgers, 1996; Rothschild, 1998; Tatarsky, 1998) supports the idea of collaborating with clients in the therapeutic process and working with the clients' goals. Counsellors working with clients who have addiction issues would probably benefit from the knowledge that their help may be best offered to clients in the psychological aspects of their addiction, the relationships they hold and navigating work situations that are affected and entangled with their addictive patterns.

An interesting finding in this study was that two participants described their addictive substance of choice as the "other" in some of their interactions. The relationship described by these participants was one of the substance being the lover, the community, the understanding, giving a feeling of belonging, and the one who will always take you back. Existing counselling literature that relates to this idea is that of the empty-chair technique from Gestalt therapy (Corey, 1996). It could be useful for counsellors working with individuals who have addiction issues to be mindful of this personified relationship and work with it as such, rather than viewing the substance merely as an object.

Although the actual individuals who may make an impression on a client's life may differ from client to client, knowing that others are influential for clients in their healing process from addiction opens the door for counsellors to find out who are the key people in their clients' lives and work with their clients in fostering or seeking supportive relationships wherever possible. Healthy interactions that were perceived as facilitative were felt to be supportive, gave participants a sense of hope or meaning in their lives or helped encourage a feeling of mutual understanding and belonging. Counsellors could assist their clients in establishing and maintaining these types of facilitative relationships in their lives. When appropriate, counsellors may suggest that clients get involved in a group or groups that could provide positive social support. Additionally, counsellors might ask clients who in their lives gives them the kind of support they need.

Counsellors are in a position to help clients discover what kinds of support they require to assist them in their healing. Finally, counsellors could encourage clients to be clear with individuals in their lives about how they can support them during their healing process.

Suggestions for Future Research

The findings of this research are the result of an exploratory study in which six individuals with substance addiction histories shared their experiences of interactions that they perceived to help or hinder their healing process from addiction. As an exploratory study describing the experiences of only six participants, the results cannot be generalized beyond the individuals in this study. In order to broaden our understanding of the phenomenon in question, it would be beneficial to explore this phenomenon further. Interviewing more individuals could refine themes or reflect new themes that might emerge. Following participants over a period of time with several interviews

might help to further explicate the shape of the phenomenon. If a longitudinal study were undertaken it might be possible to identify factors that distinguished one participant's experience from another. Additionally, a more in depth study might uncover whether different aspects of the themes were highlighted at different stages of the healing process. Participants in this study described instances that were helpful or hindering and the importance to them of asking for help. It would be interesting to tease out whether similar interactions are perceived differently given the participants' stage of healing.

Another factor that would be of interest to investigate in further studies of this nature, is whether individuals healing from addiction without the support of AA reflected the same themes as the participants in this study. All of the interviewees in the current study were connected in some way with AA. Most participants drew a great deal of support, life meaning and hope from their interactions with individuals in the AA organization. Perhaps for individuals lacking this experience, findings would reflect different themes. Additionally, most of the participants in this study also went through some sort of residential program as part of their healing process. Individuals who did not have this experience may report different influential events for them in their healing process. A study including individuals who were not abstinent but still used in moderation may yield different results also.

This study included individuals of different ethnicities and genders. However, in the descriptions of participants these factors were not expressed as relevant to them in their healing journeys. Another study with different participants may report different findings.

Given the experience of this research project I would also suggest that in future studies, the length of time since participants had ceased their addictive behaviours prior to the study be lengthened to closer to one year. I was unable to contact two of the participants in this study who had the shortest periods of abstinence (7 months) for their follow-up interviews. I had several different numbers for one participant, including a cellular phone number. None of his personal phone numbers were working. The person who answered the telephone number of his previous AA group said she had not seen him for months. The staff at the facility where the other participant lived at the time of our interview did not have a forwarding number for her. My best guess from the information I received is that they are both back out using again.

The exploratory nature of this study and its limited sample size and single data collection interview made it impossible to draw conclusions about the findings that describe the substance of abuse as "other" by participants. As well, the issues of feeling trapped in a double life were not explored to their potential. It would be interesting and useful to counselling professionals to further explore the relationship between addictions professionals and their clients in terms of clients' perspectives on trust, credibility and comfort. This study provides a first step in viewing what is perceived by individuals with addictions as facilitative or impeding to them in their healing journeys.

Limitations of the Study

This study had a number of limitations. Firstly, the study was limited in terms of recruitment. Not everyone eligible was informed of the study. The sample was gathered from individuals living in the Vancouver area who speak and read English. I interviewed the first six respondents who were interested and who met the criteria for the study;

therefore, they were not necessarily representative of the population of individuals with addiction issues. The small sample size in this study also makes it impossible to generalize the results.

Participants were volunteers so there may have been something in the research question that particularly appealed to them. The participants of this study may have felt they had something to offer. Those individuals for whom interactions were not felt to be influential in facilitative or impeding ways would probably not have volunteered for the study.

Individuals of varied ethnic backgrounds and both genders were included in the study. However, the results did not suggest that these factors were relevant for participants in their healing process. Whether this was, in fact, the case or whether a shortcoming on my part in interviewing was responsible for that oversight is uncertain.

Finally the quality of the results may be limited by a number of procedural issues. My interviewing ability, capacity to establish trust, the participants' ability to describe their experience, all may affect the credibility of the final results. Additionally my skill in engaging in the phenomenological process and accurately extracting the emergent themes from the data collection interviews may have limited the findings of the study.

Conclusion

In conclusion I would like to share my personal experience of doing this research. I came to this research from both personal and professional avenues. The history of addiction in my family gave me a certain view of the world of addiction. Working with individuals who have addiction issues helped to broaden my understanding and empathy for their struggles. This research has, once again, expanded my understanding of, and

appreciation for, the winding pathway out of addiction. I began this research hoping to address issues of individuals who were not part of the AA program because I felt they were underrepresented in the literature. Additionally, I believe I had a personal bias against the AA program. I have traditionally reacted negatively to individuals involved in the program because of my experience of feeling a barrier between myself and individuals within the AA organization. However, as a result of the sample in this study, my understanding of the program and an appreciation for what it gives those who need the support offered by AA has grown significantly. As well, I have a greater understanding of the barrier that I have felt between myself and individuals in AA. I am so grateful to the participants in this study for sharing their stories so openly with me, an outsider.

References

- Akin, B. A., & Gregoire, T. K. (1997). Parents' views on child welfare's response to addiction. Families in Society: The Journal of Contemporary Human Services, 78, 393-404.
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed. TR). Washington, DC: Author.
- Ames, S. C., & Roitzsch, J. C. (2000). The impact of minor stressful life events and social support on cravings: A study of inpatients receiving treatment for substance dependence. Addictive Behaviors, 25, (4), 539-547.
- Amodeo, M. (2000). The therapeutic attitudes and behavior of social work clinicians with and without substance abuse training. Substance Use and Misuse, 35, (11), 1507-1536.
- Argyle, M. (1994). The psychology of interpersonal behaviour (5th ed.). Toronto, Canada: Penguin Books.
- Ashery, R. S., Carlson, R. G., Falck, R. S., & Siegal, H. A. (1995). Injection drug users, crack-cocaine users, and human services utilization: An exploratory study. Social Work, 40, (1), 75-82.
- Beck, C. T. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. Western Journal of Nursing Research, 15, (2), 263-266.
- Bell, A., & Rollnick, S. (1996). Motivational interviewing in practice: A structured approach. In F. Rotgers, D. S. Keller, & J. Morgenstern (Eds.), Treating substance abuse: Theory and technique (pp. 266-285). New York: The Guildford Press.

- Berk, L. E. (1996). Infants, children, and adolescents (2nd ed.). Needham Heights, MA: Allyn & Bacon.
- Biernacki, P. (1986). Pathways from heroin addiction: Recovery without treatment. Philadelphia: Temple University Press.
- Boyd, N. (1991). High society: Legal and illegal drugs in Canada. Toronto, Canada: Key Porter Books.
- Carlson, J., & Lewis, J.A. (Eds.) . (1998). Counseling the adolescent: Individual, family, and school interventions (3rd ed.). Denver, CO: Love Publishing Company.
- Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.) , Existential-phenomenological alternatives for psychology (pp. 48-71). New York: Simon & Schuster.
- Corey, G . (1996). Theory and practice of counseling and psychotherapy. (5th ed.). Scarborough, Canada: Nelson Canada.
- Cunningham, J. A., Koski-Jannes, A., & Toneatto, T. (1999). Why do people stop their drug use? Results from a general population sample. Contemporary Drug Problems, 26, 695-710.
- Denning, P. (1998). Therapeutic interventions for individuals with substance use, HIV and personality disorders: Harm reduction as a unifying approach. In Session: Psychotherapy in Practice, 4, (1), 37-52.
- Denning, P. (2000). Practicing harm reduction psychotherapy: An alternative approach to addictions. New York: Guilford Press.

Dobkin, P. L., De Civita, M., Paraherakis, A., & Gill, K. (2002). The role of functional social support in treatment retention and outcomes among outpatient adult substance abusers. Addiction, 97, 347-356.

Egan, G. (1994). The skilled helper: A problem-management approach to helping. Pacific Grove, CA: Brooks/Cole Publishing Company.

Forgas, J. P. (1985). Interpersonal behaviour: The psychology of social interaction. Willowdale, Canada: Pergamon Press Canada Ltd.

Gray, M. (1998). Drug crazy: How we got into this mess and how we can get out. New York: Random House.

Green, L. L., Fullilove, M. T., & Fullilove, R. E. (1998). Stories of spiritual awakening: The nature of spirituality in recovery. Journal of Substance Abuse Treatment, 15, (4), 325-331.

Hackney, H. L., & Cormier, L. S. (1996). The professional counselor: A process guide to helping (3rd ed.). Toronto, Canada: Allyn and Bacon.

Hart, C. (1998). Doing a literature review: Releasing the social science research imagination. Thousand Oaks, CA: Sage Publications.

Keller, D. S. (1996). Exploration in the service of relapse prevention: A psychoanalytic contribution to substance abuse treatment. In F. Rotgers, D. S. Keller, & J. Morgenstern (Eds.), Treating substance abuse: Theory and technique (pp. 84-116). New York: The Guildford Press.

Kvale, S. (1996). InterViews: An introduction to qualitative research interviewing. Thousand Oaks, CA: Sage Publications.

Marshall, C., & Rossman, G. B. (1999). Designing qualitative research (3rd ed.). Thousand Oaks, CA: Sage.

Matthews, J., Kadish, W., Barrett, S. V., Mazor, K., Field, D., & Jonassen, J. (2002). The impact of a brief interclerkship about substance abuse on medical students' skills. Academic Medicine, 77, (5), 419-426.

McCann, B. S., & Roy-Byrne, P. (1998). Attention-deficit/hyperactivity disorder, substance abuse, and posttraumatic stress disorder: A case study with implications for harm reduction. In Session: Psychotherapy in Practice, 4, (1), 53-67.

Nealon-Woods, M. A., Ferrari, J. R., & Jason, L. A. (1995). Twelve-step program use among oxford house residents: Spirituality or social support in sobriety? Journal of Substance Abuse, 7, 311-318.

Nelson-Zlupko, L., Kauffman, E., & Dore, M. M. (1995). Gender differences in drug addiction and treatment: Implications for social work intervention with substance-abusing women. Social Work, 40, (1), 45-54.

Nowinski, J. (1996). Facilitating 12-step recovery from substance abuse and addiction. In F. Rotgers, D. S. Keller, & J. Morgenstern (Eds.), Treating substance abuse: Theory and technique (pp. 37-67). New York: The Guildford Press.

Osborne, J. W. (1990). Some basic existential-phenomenological research methodology for counsellors. Canadian Journal of Counselling, 24, (2), 79-91.

Patton, M. Q. (1990). Qualitative evaluation and research methods. Newbury Park, CA: Sage Publications.

Prendergast, M. L., Hser, Y., & Gil-Rivas, V. (1998). Ethnic differences in longitudinal patterns and consequences of narcotics addiction. Journal of Drug Issues, 28, (2), 495-517.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. American Psychologist, 47, (9), 1102-1114.

Ratliff, J. (2003). Community identity in an alcoholics anonymous group: Discourse contention and integration. Alcoholism Treatment Quarterly, 21, (3), 41-57.

Reid, C., Marini, I., Sales, A. P., & Kampfe, C. M. (2001). Counseling casual cocaine users and factors associated with level of functioning. Journal of Applied Rehabilitation Counseling, 32, (3), 28-34.

Rotgers, F. (1996). Behavioral theory of substance abuse treatment: Bringing science to bear on practice. In F. Rotgers, D. S. Keller, & J. Morgenstern (Eds.) , Treating substance abuse: Theory and technique (pp. 174-201). New York: The Guildford Press.

Rotgers, F., Keller, D.S., & Mortgenstern, J. (Eds.) . (1996). Treating substance abuse: Theory and technique. New York: The Guildford Press.

Rothschild, D. (1998). Treating the resistant substance abuser: Harm reduction (re)emerges as sound clinical practice. In Session: Psychotherapy in Practice, 4, (1), 25-35.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. Advanced Nursing Science, 16, (2), 1-8.

Sears, D. O., Peplau, L. A., & Taylor, S. E. (1991). Social psychology (7th ed.). Englewood Cliffs, NJ: Prentice Hall.

Sherman, J., & Fischer, J. M. (2002). Spirituality and addiction recovery for rehabilitation counselling. Journal of Rehabilitation Counseling, 33, (4), 27-31.

Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing interpretive phenomenological analysis. In M. Murray & K. Chamberlain (Eds.) , Qualitative health psychology: Theories and methods (pp. 218-240) . Thousand Oaks, CA: Sage Publications Inc.

Swora, M. G. (2002). Narrating community: The creation of social structure in alcoholics anonymous through the performance of autobiography. Narrative Inquiry, 11, (2), 363-384.

Tatarsky, A. (1998). An integrative approach to harm reduction psychotherapy: A case of problem drinking secondary to depression. In Session: Psychotherapy in Practice, 4, (1) 9-24.

West, S. L., & Miller, J. H. (1999). Comparisons of vocational rehabilitation counselors' attitudes toward substance abusers. Journal of Applied Rehabilitation Counseling, 30, (4), 33-37.

White, J. M., Wampler, R. S., & Fischer, J. L. (2001). Indicators of spiritual development in recovery from alcohol and other drug problems. Alcoholism Treatment Quarterly, 19, (1), 19-35.

APPENDIX C

Orienting Statement

The following statement will be read by the investigator to all participants at the beginning of the first interview:

I am interested in learning about your experiences of interactions which you feel have been influential in your healing process from addiction in both positive and negative ways.

I want to be sure that I understand your feelings and experiences as fully as possible. So, during the interview I may ask you for more information or clarification about something that you have said. You do not have to answer any questions or discuss anything you do not feel comfortable with. Please describe your experiences as completely as possible until you feel understood.

There may be many different interactions that you feel have influenced you, both positively and negatively, during your healing from substance addiction. These interactions may be as impersonal as a comment from a stranger, or as personal as a conversation or experience with a professional. The interactions could also be experiences with someone very close to you, such as a friend, partner or family member. I would like to hear about as many of these interactions as you feel are relevant. Take some time to reflect on your experiences, and when you are ready, please start by describing the first example that comes to your mind.

APPENDIX D

Interview questions

General Research Question

How do individuals who have moved from substance addiction to health experience their interactions with others in terms of facilitating or impeding their healing journey?

Main Interview Question Asked of Participants

Would you please tell me about your experiences of facilitative or impeding interactions which you felt were significant to your process of healing from addiction?

Backup questions

Who

- What was your relationship with this person? (with whom you had the interaction)

How

- How did the interaction affect you?
- What was it about this interaction that either facilitated or impeded your healing from addiction?
- Can you tell me more about what you were feeling or what went through your mind when that happened?
- What went on for you during this interaction?
- What influence do you think this interaction had: on your healing process?: on your self perceptions?
- Would you like to say any more about that?

When

- In what way was the timing of the interaction significant in terms of being influential to your recovery process?
- Could you describe a turning point for you in your healing process?